



## **2013 VOLUNTEEN PROGRAM**

### **GENERAL INFORMATION**

**Age:** The age requirement for the CIVISTA Volunteen Program is **14-17**.

**Volunteen Program Dates:** The Volunteen Program will start on **Monday, June 24, 2013** and end on **Friday, August 16, 2013**.

**Application:** Application must be in writing and signed by applicant and parent(s) or guardian(s). Return application, permission slip and two letters of reference to:

**Human Resources Department  
CIVISTA Medical Center  
6 Garrett Ave  
P.O. Box 1070  
La Plata, MD 20646-1070  
ATTN: Nickeisha Hamilton**

**Selection:** Applications and **two** letters of reference will be reviewed to determine eligibility of applicants. All applicants will be notified immediately once completed packets are received.

**Requirements:** After acceptance to the Volunteen program you will be required to:

1. Submit approval from the school counselor **with this application** and retain a copy for your personal files if you are volunteering to complete **community service requirements**.
2. **Required to attend Orientation on Monday, June 24, 2013.**
2. Purchase a uniform. (Acceptance Letters will have this information included.)
3. Complete the Medical Screening Requirements.

**Orientation:** Orientation will consist of:

1. Tour of the hospital.
2. Uniforms and grooming.
3. Regulations & Requirements.
4. Descriptions and demonstration of services and duties of **Volunteens**.

**Please note that due to the overwhelming response in previous years, there will only be 25 individuals selected to participate in the Volunteen Program.**

**In order to be considered, all application materials, must be returned by Friday, May 24, 2013.**

**Direct all inquires to:  
Nickeisha Hamilton at 301-609-4446.**

**Civista Medical Center's Volunteen Program**

### **What is the Volunteen Program?**

Civista Medical Center offers a Volunteen Program which is a great way for a teen to be exposed to the healthcare environment while deciding if healthcare is the career for them. Volunteens learn about the hospital setting while assisting staff members and patients. Possible duties of volunteens include: answering the phone, transporting patients in wheelchairs, making patient beds, reading to patients, washing hands and faces of patients, refilling water pitchers, transporting laboratory specimens and more. This program replaces the traditional "candy striper."

### **How do I get Involved?**

Students between the ages of 14 and 17 apply to the program. Following the submission of a completed application, students come to the Medical Center for an interview. Interests of the students are identified and the program begins in June.

Volunteens spend between 4 and 30 hours each week at Civista Medical Center over the summer.

### **ADVANTAGES OF BEING A SUCCESSFUL VOLUNTEEN**

The Volunteen Program provides:

1. Experience working in a professional setting at an age younger than possible otherwise.
2. Exposure to hospital atmosphere helping Volunteen to decide for (or against) a career in the Healthcare Field.
3. Satisfaction in serving human and community needs.
4. Excellent reference for future education or job application.
5. Opportunity to obtain further information about career fields.



**2013 VOLUNTEEN APPLICATION**

1. Name \_\_\_\_\_  
(Last) (First) (Middle)

2. SSN \_\_\_\_\_

Address - Street/Post Office Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month / Day / Year

5. Parent/Guardian

Name \_\_\_\_\_

6. In Case of Illness – Contact

Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_ Contact Tel. No. \_\_\_\_\_

7. Name of School \_\_\_\_\_

8. Special talents or Interests \_\_\_\_\_

9. Two (2) adult references (Adults you have worked with or for; for example, teachers, youth leaders, 4-H, Church). Please give the enclosed LETTER OF REFERENCE to each reference listed below (Pages 6-7, Reference #1) (Pages 8-9, Reference #2) and ask that they respond ASAP otherwise you will not be considered for the 2010 Volunteer program.

1. Name \_\_\_\_\_ Tel. No. \_\_\_\_\_

Address \_\_\_\_\_

2. Name \_\_\_\_\_ Tel. No. \_\_\_\_\_

Address \_\_\_\_\_

10. How did you hear about CIVISTA's Volunteer Program?

\_\_\_\_\_

11. Why are you interested in doing volunteer work?

12. Have you been around anyone who has been ill? Yes  No

13. Are you interested in a Health Career? Yes  No

14. In what type of hospital services are you especially interested?

15. Do you have any problems that might prevent you from carrying out the duties of a  
Volunteer? Yes  No

If Yes, explain

I understand the requirements of the Volunteer Program at CIVISTA Medical Center.

Also, I authorize persons of reference listed in #9 above to furnish CIVISTA Medical Center with any information regarding my character, whether or not such information is on their records. I hereby release said persons of reference from any damages whatsoever resulting from furnishing such information. I am aware that CIVISTA Medical Center may use this information in the selection process.

Signature of  
Applicant: \_\_\_\_\_

Signature of  
Parent/Guardian: \_\_\_\_\_

CIVISTA Medical Center is dedicated to equal opportunity and will not make discriminations on the basis of race, sex, age, national origin, color, religion, handicap, disability or marital status.

**2013 VOLUNTEEN PERMISSION SLIPS**

**PARENTS: BOTH PERMISSION BLOCKS MUST BE SIGNED**

1. I/We \_\_\_\_\_, the parents/guardians of \_\_\_\_\_ understand the requirements of the Volunteen Program at CIVISTA Medical Center. I/We give my/our permission for my/our son/daughter to serve in this program. I/We agree that areas of assignment for Volunteen hours will be determined based on the needs of the Medical Center.

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Volunteen: \_\_\_\_\_

Address - Street/P.O. Box: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Tel. No(s). Home: \_\_\_\_\_

Work: \_\_\_\_\_

2. **MEDICAL SCREENING REQUIREMENTS PERMISSION SLIP**

I give permission for \_\_\_\_\_ to receive a skin test for Tuberculosis (PPD) at CIVISTA Medical Center as required for all volunteers.

In the event my son/daughter's Tuberculosis (PPD) test is positive, I give permission for him/her to receive a chest x-ray (free of charge) to test for active disease through the Employee Health Service at CIVISTA Medical Center.

Signature of Parent/Guardian \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Address - Street/P.O. Box: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Numbers:

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_

Applicant's Date of Birth: \_\_\_\_\_



**2013 VOLUNTEEN PROGRAM**

**LETTER OF REFERENCE**

TO: Name: \_\_\_\_\_

Position: \_\_\_\_\_

Please help the Human Resources Department of CIVISTA Medical Center determine the eligibility of \_\_\_\_\_ to serve as Volunteer, by completing page 2 of this reference if you feel he/she will be successful in this program.

Please return your Letter of Reference by **May 31, 2013** either to the Volunteer Applicant or by mail to:

**Human Resources Department  
Civista Medical Center  
6 Garrett Ave  
P.O. Box 1070  
La Plata, MD 20646-1070  
ATTN: Nickeisha Hamilton**

Questions may be addressed to Nickeisha Hamilton at 301-609-4446.

**LETTER OF REFERENCE (PAGE 2)**

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Complete the following reference:

	Above Average	Average	Below Average	No Knowledge
Adaptability				
Appearance				
Attendance at Class				
Communication: Verbal & Written				
Dependability				
Honesty				
How Relates to Others				
Initiative				
Judgement				
Maturity				
Responsibility				
Self Expression				

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_



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Comments: \_\_\_\_\_  
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\_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_