



Teen Volunteer Application Packet

Grady's Teen Volunteer Program is open to students ages 15-17, who are eager to make a difference in their community this summer! Teen Volunteers are placed in various areas throughout the hospital and under continual supervision by Grady staff, help with tasks ranging from administrative work to customer service. Volunteers will not shadow clinical staff or participate in direct patient care.

The 2020 program begins on Monday, June 1, 2020 and ends on Thursday, July 23, 2020. Make certain that the seven-week session does not conflict with any other summer plans (i.e. vacation, band, or camp). You must be available six out of the seven weeks. The program will break for one week during June 29 – July 3. We do not have any placements on Friday or on the weekends.

APPLICATION PROCESS:

Applicants must complete STEP 1 and STEP 2 by NOON on Wednesday, February 26, 2020 to be considered for an interview. We email all confirmations and communications, so please check your email regularly.

STEP 1: Complete the online application form at www.gradyhealth.org/teen

STEP 2: Complete the application packet, including the items listed below, and return to Grady Volunteer Services no later than NOON on February 26, 2020. *If you choose to mail these forms, please make sure they arrive in an envelope by the deadline.*

- ☐ Teacher/Counselor Recommendation Form
- ☐ Teen Volunteer Agreement (signed by teen and parent/guardian)
- ☐ Consent for Photography/Videography (signed by teen and parent/guardian)
- ☐ TB Consent Form (signed by teen and parent/guardian)
- ☐ TB Confidentiality Agreement
- ☐ Copy of MMR Records/Chickenpox Immunizations
- ☐ Copy of Photo I.D. (school I.D. or driver's license)

Scan and email completed information to Kimberly Wallace at kwallace@gmh.edu or send to Grady's Volunteer Office by mail or in-person:

Grady Health System
Volunteer Services
80 Jesse Hill Jr. Drive, SE
Atlanta, GA 30303

Those selected for interviews and subsequently those accepted into the program will be notified via email. Interviews are scheduled on a first come, first served basis.

Thanks for your interest in Grady's Teen Volunteer Program!



Teacher/Counselor Recommendation Form

Dear Teacher/Counselor:

_____ has applied to the Teen Volunteer Program at Grady Health System. Thank you for taking the time to complete this evaluation; your observations are an important part of this student's application. Please complete each field and choose from the following options:

Personal Qualities

Attitude toward school

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Cooperation

☐ Always cooperates

☐ Cooperates

☐ Sometimes Cooperates

☐ Poor

Emotional maturity

☐ Very mature

☐ Age appropriate

☐ Sometimes immature

☐ Very immature

Integrity

☐ Highly trustworthy

☐ Trustworthy

☐ Usually trustworthy

☐ Questionable

Leadership potential

☐ Leader

☐ Can follow or lead

☐ Leads on occasion

☐ Rarely leads

Reaction to criticism

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Responsible

☐ Very Responsible

☐ Usually responsible

☐ Sometimes responsible

☐ Rarely

Self-confidence

☐ Healthy Self-Image

☐ Needs some support

☐ Seems overconfident

☐ Poor self-image

Self-control

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Sense of humor

☐ Highly developed

☐ Good

☐ Fair humor

☐ Poorly developed

Warmth of personality

☐ Always Friendly

☐ Usually Friendly

☐ Occasionally friendly

☐ Rarely friendly

Ability to work independently

☐ Consistently works well

☐ Needs help occasionally

☐ Needs help frequently

☐ Needs help



Work Skills

Class participation

☐ Joins in readily

☐ Contributes some

☐ Wants to dominate

☐ Rarely contributes

Ability to work in a group

☐ Always works well

☐ Sometimes

☐ Has difficulty

☐ Has great difficulty

Ability to work independently

☐ Always works well

☐ Needs some help

☐ Needs help frequently

☐ Needs constant help

Completes assignments on time

☐ Consistently completes

☐ Usually completes

☐ Needs additional time

☐ Has difficulty

Follows directions

☐ Easily and accurately

☐ Needs some help

☐ Needs

☐ Rarely

Takes initiative

☐ Always

☐ Frequently

☐ Sometimes

☐ Rarely

Attention span

☐ Actively engaged

☐ Attentive

☐ Variable attention

☐ Requires redirection

Social Skills

Peer relations

☐ Role Model

☐ Healthy Relationship

☐ Occasional Problems

☐ Relates poorly

Adult relations

☐ Courteous

☐ Usually positive

☐ Occasional Problems

☐ Shows little respect

Concern for others

☐ Very considerate

☐ Considerate

☐ Usually considerate

☐ Rarely considerate

Attitude toward school

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Classroom Conduct: Please comment on the student's behavior/attitude:



Areas of greatest strengths:

Areas for improvement:

Would you recommend the student for the Teen Volunteer Program?

Evaluator's Name (please print): _____ **Phone:** _____

Evaluator's Signature: _____ **Date:** _____ **Title:** _____

PLEASE RETURN THIS FORM TO APPLICANT SO IT CAN BE INCLUDED IN THEIR APPLICATION PACKET.

THANK YOU!



Consent for Photography/Videography

I, _____, hereby grant permission for Grady Health System to permit a photographer to take photographs, video, or otherwise, of me on the premises of Grady Health System.

I hereby release Grady Memorial Hospital Corporation and its employees or agents from any liability arising out of the presence of photographing personnel on the premises of Grady Health System and any liability arising from the use of such photographs/videotape.

If the photographs/videotape are to be used for clinical or teaching purposes, I understand that the photographs/videotape shall be the property of Grady Health System. Unless I expressly consent otherwise, I understand that the videotape will be used only for the below listed designated purposes:

Signature of parent or guardian

Date

Witness

Date

Witness (second witness required only for telephone consent)

Date



TB Consent Form

Dear Teen Volunteer Parents/Guardians:

Due to requirements set forth by The Joint Commission, **all volunteers in a hospital environment must be tested for Tuberculosis (TB).**

The test for TB consists of a small injection of fluid under the skin on the forearm. The test is then “read” two to three days later by a Registered Nurse at Grady. The test must be read within that allotted time or your child will miss the opportunity to participate in Grady’s Teen Volunteer Program.

Grady Employee Health Nurses administer TB tests during the allotted walk-in hours after the interview, before volunteering begins. The TB tests are free of charge to all participating volunteers; any follow up needed will be the responsibility of the parent/legal guardian.

If your child tests positive for TB, it is the parent’s/guardian’s responsibility to have any follow-ups completed and to bring a letter from a physician outlining recommendations or treatment. Once that is completed and approved, your child may begin volunteering.

If you have any questions or concerns, contact the Volunteer Office at (404) 616-4360.

Please sign and date below to give us consent to administer the TB test to your child.
This form must be returned along with the required items needed to complete the Teen Volunteer Application.

Teen’s Name

Parent/Guardian Signature

Date



CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

I, _____, volunteer at Grady Health System, acknowledge that I have completed generic training on the Hospital's privacy policies and the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

- I understand that all patient information, including billing and financial data, is confidential.
- I agree to keep patient information confidential.
- I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action, up to and including termination of volunteer service.
- I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I shall ask my Supervisor, the Hospital Privacy Officer, or the Hospital Compliance Officer.
- I understand and agree that the Hospital Privacy Policies and Procedures will apply to any patient information even after I terminate my volunteer service or other relationship with the hospital.

Signature: _____ Date: _____

Name: _____ Department: _____
(Please Print)