CONTRA COSTA
VOLUNTEER SERVICES
A Department of Contra Costa Health Services

CONTRA COSTA REGIONAL MEDICAL CENTER
STUDENT VOLUNTEER APPLICATION

Today's Date: _____ Date of Birth: _____

First Name: _____ Middle Initial: _____ Last Name:_____

Address:_____
(Number and Street, No Post Office Box Accepted) (Apt. #) (City) (Zip Code)

Home Phone ( ) _____Cell Phone ( ) _____

Email: _____Driver's License/State ID #_____

How did you hear about the CCRMC volunteer program? ☐Current/Former volunteer ☐Former Patient ☐Staff Member ☐CCRMC Website ☐Contra Costa County Volunteer Center ☐Other

Please list any language you speak fluently, besides English:_____

Name of School:_____ Grade _____
Current GPA_____

Days and Times Available: (Please Be Specific)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Clubs/Organizations in which you have taken part of/office held:

Hobbies/Interests/Skills: (Please describe)

PARENTAL CONSENT

(Name of Child) _____, a minor, desires to perform volunteer services for Contra Costa County in accordance with the attached application form.

As Parent/Guardian of this minor, permission is hereby granted for him/her to participate in the Volunteer Program.

Signature of Parent/Guardian: _____ Date _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT OF A MINOR

Do you have a health problem we should be aware of in case of emergency? □YES □NO
If yes, please describe---such as history of back trouble, heart, epilepsy, diabetes, fainting, etc.)
_____

Is there a medication you must take? □YES □NO If yes, please describe:
_____
_____
_____

EMERGENCY CONTACT INFORMATION

1) Emergency Contact (Name):_____

Relationship:_____Phone:_____

2) Emergency Contact (Name):_____

Relationship:_____Phone:_____

I hereby give my consent for all emergency medical treatment prescribed by a licensed physician (M.D.) for (Name of Child)_____ as his or her legal guardian. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent while on duty as a volunteer of the Contra Costa County Health Services Department.

Known allergies _____

Other important medical information _____

Signature of Parent/Guardian: _____ Date: _____

VOLUNTEER COMMITMENT AGREEMENT

IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE TO THE FOLLOWING:

1. To assist patients and visitors in a warm and helpful manner, and for the time that I am here, put their needs ahead of my own.
2. To make a one year commitment of at least **200 hours** of service.
3. Work at least 1 shift a week (4 consecutive hours).
4. To limit my unexcused absences to three (3) during my commitment.
5. To be punctual and conscientious and endeavor to make my work professional in quality.
6. To conform to all uniform requirements as outlined in the Orientation Packet.
7. Respect patient, family and staff confidentiality; which I understand is both a patient right and the Hospital's legal responsibility. To refrain from discussing confidential information concerning patients with anyone.
8. To notify the department in which I am working of any absence, planned or unexpected, at least one day in advance, if possible.
9. To notify the Coordinator of Volunteer Services, if for some circumstances beyond my control, I must discontinue my volunteer service commitment.
10. Decline to perform any task for which I feel I have not been adequately trained or which would put me or others at risk
11. Abide by the rules and regulations of the Contra Costa Regional Medical Center and the Volunteer Department, which includes wearing the name badge and volunteer uniform (when required), and recording hours with the volunteer office.
12. To return the Photo-Identification Badge and keys (if applicable) upon completion of volunteer service.
13. To return the uniform (and receive back ½ of initial investment if minimum of 200 hours are completed and all initial requirements (Post Test, HIPPA Test, Injections etc.)
14. To sign-in and sign-out on the computer monitor (located in the volunteer office lobby) upon arrival and departure. To be honest with documented hours.

15. Complete service in the hospital by 8:00 p.m. each day. Neither the hospital or Volunteer Services are responsible for the student volunteer when assigned hours are completed.
16. Adhere to the personal conduct, dress code, and appropriate behavior. Failure to comply, may result in immediate dismissal from the Volunteer Program.

I HAVE READ EACH OF THE ABOVE CONDITIONS AND I AGREE TO BE BOUND BY THEM.

_____ _____

Volunteer Signature **Date**

I HAVE READ EACH OF THE ABOVE CONDITIONS AND I AGREE TO BE BOUND BY THEM ALONG WITH MY MINOR CHILD.

_____ _____

Parent's Signature **Date**

CONFIDENTIAL INFORMATION

I have been advised against, and accept any responsibility for any breach on my part respecting confidential information. I have read the solution adopted by the Contra Costa County Board of Supervisors on volunteer programs. In return for the benefits provided by Contra Costa County in case of my illness, injury, death, or third party liability, while providing or resulting from acts or occurrences within the scope of my authorized volunteer services, and for my right to authorize expense reimbursements, I waive any claim on my behalf and on behalf of my heirs, representatives and assigns against the County of Contra Costa or any of its agents, servants or employees for illness, injury, debts, or other harm arising from my volunteer services, whether or not authorized.

Volunteer Signature: _____ Date: _____

Signature of Parent/Guardian:_____ Date: _____

* *

Disclaimer: Applicants will be required to submit an application, participate in a face-to- face interview, provide references for checking, complete a background check, and attend a training program prior to placement. Applicants who provide false information shall be disqualified for, or terminated from service.

TB Testing and Flu Vaccine

It is a requirement of the hospital that all volunteers as well as employees are vaccinated each year against the flu. In addition, all volunteer and employees must pass a tuberculosis screening. This is a simple skin test that will indicate that you are free of tuberculosis. Both of these screenings must be completed in order to be a volunteer at the Contra Costa Regional Medical Center. Minors must have a parent or guardian sign below giving permission for the student to receive the flu vaccine and tuberculosis screening annually.

I give permission for my child _____to receive a flu shot as well as participate in the tuberculosis screening on an annual basis.

_____ _____

Parent Name (please print) Parent Signature

_____

Date

VOLUNTEER QUESTIONNAIRE

Have you had any previous experience as a volunteer? If so, with what organizations, and what kind of work did you do?

Please tell us why you would like to volunteer at Contra Costa Regional Medical Center?

What do you hope to gain from being a volunteer?

CONTRA COSTA
HEALTH SERVICES

STUDENT VOLUNTEER RECOMMENDATION FORM

Name of Student: _____

Scale: 1=Below Average 2=Fair 3=Average 4=Good 5=Excellent 6=Outstanding U=Unknown

Oral Communication Skills	1	2	3	4	5	6	U
Punctuality	1	2	3	4	5	6	U
Dependability	1	2	3	4	5	6	U
Sense of Responsibility	1	2	3	4	5	6	U
Self-Motivation	1	2	3	4	5	6	U
Perseverance	1	2	3	4	5	6	U
Ability to Work Independently	1	2	3	4	5	6	U
Reaction to Criticism	1	2	3	4	5	6	U
Regard for Authority	1	2	3	4	5	6	U
Regard for Rules	1	2	3	4	5	6	U
Cooperation	1	2	3	4	5	6	U
Flexibility	1	2	3	4	5	6	U
Sensitivity to Feelings of Others	1	2	3	4	5	6	U
Behavior in a Group	1	2	3	4	5	6	U
Ability to Follow Directions	1	2	3	4	5	6	U
Problem Solving Skills	1	2	3	4	5	6	U
Ability to Work in a Team	1	2	3	4	5	6	U
Initiative	1	2	3	4	5	6	U
Respectful of differences	1	2	3	4	5	6	U
Friendliness towards coworkers/students	1	2	3	4	5	6	U

Note: This form should be completed by a personal/professional reference and submitted with your volunteer application. The person completing this should not be a parent/guardian. A teacher, coach, employer, or someone else who knows you well would be appropriate.

I recommend this student to the Contra Costa Regional Medical Center for the Volunteer Program:

___With great enthusiasm ___With Confidence ____With some confidence ____With reservation ___I do not recommend

Comment(s):

Signature: _____Title:_____ Date_____

Please place the completed recommendation form into a sealed envelope and sign and date across the envelope closure. Students should hand in a sealed recommendation with a completed volunteer packet. Should you require additional information or have further questions please contact the Volunteer Coordinator at 925-370-5440. To learn more about the CCRMC Volunteer Program please visit http://cchealth.org/medicalcenter/volunteer.php.

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