Which hospital(s) are you volunteering for?

- Centennial Hills Hospital
- Desert Springs Hospital
- Spring Valley Hospital
- Summerlin Hospital
- Valley Hospital
VALLEY HEALTH SYSTEM – TEEN VOLUNTEER APPLICATION

PLEASE PRINT CLEARLY  Date: ___________________ Social Security #: ___________________ Mr.  Miss  (circle one)

Name: ____________________________________________________________________________       Last    First    Middle

Address: ____________________________________________________________________________________________________       Number & Street    City    State    Zip

Home Phone: _______________________ Cell Phone: _________________________________ Birth Date: ___________________

Email Address: _______________________________________________________________________________________________

Parent or Guardian’s Name and Cell Phone #: ______________________________________________________________________

Name of School: ______________________________    Graduation Year: __________     GPA: ___________     Grade: _______

Address of School: ____________________________________________________________________________________________       Number & Street    City    State    Zip

Career Planned: _________________________________________________________     Are you now employed?  ☐ Yes  ☐ No

Name of Employer: _________________________________     Phone: ____________________ Position: ________________

Extra curricular activities/hobbies: ________________________________________________

Why do you want to be a volunteer? ______________________________________________________________________________

What does customer service mean to you? _________________________________________________________________________

Previous/current volunteer experience: ________________________________________

Agency or Company Name    Position
____________________________________________________________________________________________________________

Agency or Company name    Position
____________________________________________________________________________________________________________

How much time can you give?  Days per week ________________________ Hours per day ________________________

Check the day that you are able to volunteer:  ☐ Monday  ☐ Tuesday  ☐ Wednesday  ☐ Thursday

☐ Friday  ☐ Saturday  ☐ Sunday

Times available:  ☐ Morning   8:00 a.m.-noon  ☐ Afternoon noon-4:00 p.m.  ☐ Evening   4:00-8:00 p.m.

Who encouraged you to volunteer: _____________________________________________

Have you ever been convicted of a crime?  ☐ Yes  ☐ No     When? ________________________________

If yes, describe: ________________________________________________________________

PERSON TO BE CONTACTED IN AN EMERGENCY:

Name: _______________________________ Relationship ____________________ Phone: ____________________

Address: ____________________________________________________________________________       Number & Street    City    State    Zip  Cell: ____________________
IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT:

1. I shall hold as absolutely confidential, all information that I obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information.

2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious or charitable reasons.

3. I shall submit to an annual tuberculin skin test and any other health examination which may be necessary as part of my volunteer service.

4. I understand that it is required I take safety and educational classes yearly.

5. I shall be punctual and conscientious, conduct myself with dignity, courtesy and with consideration of others, and endeavor to make my work professional in quality.

6. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

7. I shall at all times uphold the philosophy and standards of the hospital.

8. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work appearance; or (d) any other circumstances which, in the judgment of the department director, would make my continued services as a volunteer, contrary to the best interests of the hospital.

I have read each of the above conditions and I agree to be bound by them as well as all hospital policies and procedures with The Valley Health System.

_______________________________________________  ______________
Volunteer Signature        Date

INSTRUCTIONS: Please have your parent/guardian complete page 4. Your guidance counselor or a current teacher must complete page 5 and return entire application to the Volunteer Services Department.
PARENT OR GUARDIAN CONSENT FORM

CONSENT TO VOLUNTEER:

If accepted, I ______________________________________ (parent/guardian name) agree to cooperate with him/her in complying with the Volunteer Services rules and regulations which include providing transportation, wearing the prescribed uniform, and ensuring that he/she faithfully maintains his/her weekly volunteer schedule.

I further concur that while on duty he/she is to remain on hospital property unless otherwise instructed by me. I understand that if the Teen Volunteer does not comply with policy, this may be grounds for immediate releasing of the volunteer from hospital service.

I understand that he/she must have the two step tuberculin skin test prior to volunteering and that The Valley Health System will administer this test at no cost to me. I further understand that the Teen Volunteer must attend an orientation and have the tuberculin skin test annually in order to continue volunteering.

Parent/Legal Guardian Signature: ________________________________ Date: __________

Parent/Legal Guardian Name: ________________________________

Please Print

CONSENT TO RELEASE SCHOOL RECORDS:

Name of Student: _______________________________________________________________________

School: _____________________________ School Phone: ______________________________

I hereby:
• authorize a representative of the above school to complete the reverse side (School Guidance Counselor/Teacher Evaluation Form) in connection with the above student’s application to participate in the Teen Volunteer Program at The Valley Health System.

• I understand the purpose of the form is to aid The Valley Health System in selecting qualified Teen Volunteers. All information provided by the school would remain confidential.

Parent/Legal Guardian Signature: ________________________________ Date: __________

Parent/Legal Guardian Name: ________________________________

Please Print
SCHOOL GUIDANCE COUNSELOR or TEACHER
CONFIDENTIAL EVALUATION

Student Name: _______________________________________ Birthday: ___________________________

School: _____________________________________________ Grade: ______________________________

I would rate this student as follows:

1. Requires less more about the same amount of instruction as most students.
2. Requires minimal occasional considerable supervision or direction.
3. Does Does not follow through on assignments.
4. Gets along not well well very well with peers.
5. Gets along not well well very well with older persons.
6. Has Has not shown adequate emotional stability to work with hospital patients.
7. Does Does not exhibit general appearance of neatness.
8. Is Is not regular in school attendance.
   If not regular, what is the cause of absence/tardiness? _____________________________________

☐ I recommend this student be accepted as a Teen Volunteer with The Valley Health System.

☐ I DO NOT recommend this student be accepted as a Teen Volunteer with The Valley Health System.

Comments: ________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Signature: ___________________________________________________    Title: _______________________
Print Name: _________________________________________________    Date: _______________________

Please return evaluation to the student or mail/fax to the Volunteer Services Department at:

☐ Centennial Hills Hospital, 6900 North Durango Drive, Las Vegas, NV 89149  (702) 835-9861 (fax) 835-
☐ Desert Springs Hospital, 2075 E. Flamingo Road, Las Vegas, NV 89119  (702) 369-7782  (fax) 369-7836
☐ Spring Valley Hospital, 5400 Rainbow Boulevard, Las Vegas, NV 89118  (702) 853-3059 (fax) 853-8609
☐ Summerlin Hospital, 657 Town Center Drive, Las Vegas, NV 89144  (702) 233-7532 (fax) 233-7119
☐ Valley Hospital, 620 Shadow Lane, Las Vegas, NV 89106  (702) 388-4668 (fax) 388-7841
WANTED: HOSPITAL VOLUNTEERS

WHAT’S A HOSPITAL VOLUNTEER? They are a special, wonderful kind of person who offers his or her time, free of charge, to help others.

WHY ARE HOSPITAL VOLUNTEER IMPORTANT? Because they provide many EXTRA services that supplement the basic, essential functions of the staff…services that add to the comfort, care and happiness of the patient! Volunteer add to the quality of health care by helping the patients, their families, the staff and visitors.

BUT WHAT DOES THE VOLUNTEER GET OUT OF THIS? A chance to learn new skills, develop new interests, make new friends and most of all, a chance to enjoy that rare satisfaction that comes from helping others.

WHAT KIND OF PEOPLE ARE VOLUNTEERS? Men and women of all ages, all backgrounds, and all abilities. They may be students, housewives, working people or retired people.

WHAT QUALIFICATIONS ARE NEEDED? You need to be interested, have a good attitude, be dependable and be discreet.

PREPARATION FOR THE JOB? First we will interview you to match your interests, talents and schedule to the hospital’s needs. We will then orientate you to the hospital and its goals, uniform requirements, policies and procedures, and your benefits. Once you have completed all our requirements (including a two-step tuberculosis screening), you will be introduced to your assignment and contact person. Then you will be ready to begin volunteering!

And many thanks to you for volunteering at our hospital!

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<th>To be completed by the Volunteer Services Department</th>
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<td>Interviewed: ___________________________</td>
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