

Dear Student Volunteer Applicant:

Rome Memorial Hospital has openings for a limited number of student volunteers. If you are at least 15 years old and are interested, please:

1. Complete the enclosed application
2. Send it along with a copy of:
 - ❖ Your immunization record, showing that you have had 2 Rubella (3-day measles) and 2 Rubeola (measles) shots.
 - ❖ Your working papers. (These may be obtained from your school nurse)
 - ❖ A physical done within 1 year or a statement from your doctor saying you are free of communicable disease and volunteering will not harm your health.
 - ❖ Signed permission slip for you to volunteer (signed by a parent or guardian).
 - ❖ Proof and result of TB Mantoux test done within 1 year.

*** Please be aware that Rome Memorial Hospital is a tobacco-free campus. Smoking is prohibited in all areas owned, leased and operated by Rome Memorial Hospital, including parking lots.**

Please mail or bring all of the above to:

Rome Memorial Hospital
1500 North James Street
Rome, New York 13440
Attn: Julie Chrysler

If you have any questions or concerns, please feel free to contact me at (315) 338-7134 or by email at jchrysler@romehospital.org. Once the information is complete, I will contact you to set up an appointment for an interview. Thank you again for your interest and I hope to hear from you soon.

Sincerely,

Juliana H. Chrysler, M. Ed.

STUDENT VOLUNTEER PROGRAM

WELCOME TO ROME MEMORIAL Hospital's Student Volunteer Program.

As a hospital volunteer you are a vital part of the healthcare team. You will have one to one contact with our patients, and therefore, be seen as a representative of this hospital. In order that you may have a positive experience, there are some things you should know about the hospital and the areas in which you will be working. There are also ethics, rules, and regulations you must follow as a student volunteer in the hospital.

The hospital is a private, not for profit hospital. As such, it is open to everyone; no one is turned away. Our motto is "THE DOOR THAT NEVER CLOSES".

The requirements for a student volunteer are as follows:

1. You must be 15 years of age.
2. Must hold valid New York State Employment Certificate (Working Papers).
3. Both young men and women are accepted into the program.

DRESS CODE

1. Student volunteers may wear street clothes (shorts/jeans are not permitted).
2. All clothing must be clean and neat.
3. Shoes should be clean with soft soles.

GROOMING

1. Hair is to be neat and clean and away from your face. Long hair must be pulled back or pinned up.
2. Jewelry should be kept to a minimum. No bracelets, necklaces, etc.; earrings are acceptable as long as they do not dangle. OTHER PIERCINGS ARE UNACCEPTABLE. No more than one ring on each hand.
3. Makeup must be kept to a minimum. Heavy eye shadow and eyeliner is not appropriate.
4. Fingernails may have pale or clear polish; must ALWAYS be clean. Artificial nails are NOT allowed.
5. Fragrance, if any, must be light.
6. Clothes must be clean, neat and pressed at all times.



Student Volunteer Application

Name _____

Date of Birth _____

Address _____

Telephone # _____

Email address: _____

Cell phone # _____

Person to notify in case of an emergency

Name: _____ Relationship _____

Telephone # _____

Type of work you are volunteering for?

- Patient care (visiting, delivering meals, transporting by wheelchair / stretcher)
- Assisting in the Residential Health Care Facility (RHCF)
- Student volunteer hours (specify below, IE Gov't class, PHP, New Ventures, BOCES)
- Other _____

Special skills or interest you have (e.g. clerical, patient care, computer, crafts etc.):

Do you have a preference as to the department / area of assignment Yes _____ No _____

If yes, please give preference(s): _____

Please circle the days you wish to volunteer: Mon Tues Wed Thurs Fri Sat Sun

Hours of the day you wish to volunteer: _____

Why do you want to volunteer at Rome Memorial Hospital? _____

Have you volunteered before? YES NO If yes, where? _____

Have you ever been convicted of a felony?

Were you referred to us by?

An Individual? _____ Agency? _____

Do you have any special needs we should be aware of in order to accommodate you in your volunteer status?

Yes _____ No _____ If yes, please explain _____

Please list 2 people to be contacted as a reference, i.e. Teacher, employer, friend, co-worker, an adult other than a parent, spouse or other relative.

References:

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

Signature

Date

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PERMISSION FOR VOLUNTEERING
(Necessary for all volunteers less than 18 years of age)

I give my permission for

(Print student volunteer's name)

to volunteer at Rome Memorial Hospital.

DATE

SIGNATURE OF PARENT OR GUARDIAN

Rome Memorial Hospital

Physical Examination Report for Volunteers

Name: _____

Date of Birth: _____ Date of Examination: _____

Ht. _____ Wt: _____ B/P: _____

Vision: _____ Left: _____ Right: _____

Immunizations: MMR: 1 _____ 2 _____

_____ Mantoux _____ Results _____

Influenza Vaccine date: _____ H1N1 vaccine date: _____

Review of Systems:

Eyes _____ Ears _____ Nose _____ Throat _____

Teeth/Gums _____ Cardiac _____ Lungs _____

GI _____ GU _____ Skin _____

Musculoskeletal _____ Nutrition _____ Nervous System _____

Other: _____

Medications: _____

Limitations: _____

Diagnosis: _____

Summary: I have examined the patient and found him/her ___able ___unable to participate in volunteer activities at Rome Memorial Hospital. He/she is free of communicable diseases and addictions to drugs/alcohol.

Signature _____

Date _____