SOUTHEAST GEORGIA HEALTH SYSTEM

Real-World Career Experiences Exploring®

What are you going to do after you get out of High School?

Are Health Services a possible career path for you?

Southeast Georgia Health System has a Health Services Post. This post concentrates on all aspects of medical-related services, including:

- Maternity Care Center
- Radiology
- Facilities Management
- Laboratory/Pathology/Morgue
- Emergency Care Center
- Surgical Services
- Rehabilitation Services
- Center for Educational Development

- Post meets monthly September thru May and cost $25 for the school year.

- Must be a sophomore or above.

- GPA of 3.0 required along with a reference from your advisor, teacher or school administrator.

- Invitations to the Open House are limited to the first 35 qualifying students who submit a fully complete application packet by the due date.

To receive an invite to the open house, please submit the completed packet by **September 18, 2018** via email to **tdunnig@sghs.org**

SOUTHEAST GEORGIA HEALTH SYSTEM

Personal Reference Form

Name of Applicant: _____

I am submitting an application for participation in the Health Careers Explorer Post. I understand that I cannot be considered for participation until my references have been checked and are on file.

Name of Person Providing Reference: _____
**Reference should be from a school administrator, teacher or guidance counselor, not a family member.*

Street Address: _____

City/State/Zip Code: _____

Telephone: _____ Email: _____

	Outstanding	Above Average	Average	Below Average	Unsatisfactory
Enthusiasm					
Willingness to assist others					
Ability to maintain strict confidentiality					
Ability to work as part of a team					

GPA of 3.0 or Greater: ☐Yes ☐No (3.0 minimum GPA required for Health Careers Explorer Post)

Additional comments regarding applicant (continue on back or add additional pages if needed):
_____
_____
_____

Signature: _____ Date: _____

Applicant please check the campus where you will be participating:

☐ **Brunswick Campus**:
Southeast Georgia Health System
2415 Parkwood Drive
Brunswick, GA 31520
(912) 466-7000

☐ **Camden Campus**:
Southeast Georgia Health System
2000 Dan Proctor Drive
St. Marys, GA 31558
(912) 576-6200

Scrub Top Size (please circle)

S M L XL 2XL 3XL

Explorer Club

For Sixth-, Seventh-, and Eighth-Graders

The Explorer Club Learning for Life career education program is for young men and women who are in the sixth, seventh, and eighth grades.

The Explorer Club's purpose is to provide experiences to help young people learn about different careers.

Real-World Career Experiences

Exploring®

The Exploring Learning for Life career education program is for young men and women who are at least 14 (and have completed the eighth grade) or 15 years of age but not yet 21 years old.

Exploring's purpose is to provide experiences to help young people mature and become responsible and caring adults. Explorers are ready to explore the meaning of interdependence in their personal relationships.

YOUTH APPLICATION

Exploring is based on a unique and dynamic relationship between youth and the organizations in their communities. Local community organizations initiate a specific Explorer post or club by matching their people and program resources to the interests of young people in the community. The result is a program of activities that helps youth pursue their special interests, grow, and develop.

Explorer posts/clubs can specialize in a variety of career skills. Exploring programs are based upon five areas of emphasis: career opportunities, life skills, citizenship, character education, and leadership experience.

LEARNING FOR LIFE®
PreK-12 Programs Career Exploring

524-009
2014 Printing

Tips for completing the Application for Exploring Youth Participant:

- ➢Print—do not use cursive.
- ➢Use black or dark blue ink.
- ➢Press firmly when printing.
- ➢Print one letter only in each box.
- ➢Use uppercase letters and stay within the blue boxes for legibility.
- ➢Fill in circles; do not use check marks.
- ➢Make sure you have all needed signatures on application.
- ➢Don't alter the application—it could affect the quality of the scan.

Mailing address example:

7	0	3		F	I	R	S	T		S	T	

Participant Chart

Term per month	Youth/adult participant fee
1	2.00
2	4.00
3	6.00
4	8.00
5	10.00
6	12.00
7	14.00
8	16.00
9	18.00
10	20.00
11	22.00
12	24.00
13	26.00
14	28.00
15	30.00
16	32.00
17	34.00
18	36.00

Cut along dotted line.

TEMPORARY PARTICIPANT CERTIFICATE
(Good for 60 days)
This certifies that

_____

is a member of _____

_____
Post or club leader signature

_____
Date

Explorer Club Exploring (Real-World Career Experiences)

USE BLACK OR DARK BLUE INK ONLY.

- Print—do not use cursive.
- Print one letter or number only in each box.
- Use uppercase letters and stay within the blue boxes for legibility.

- Fill in radio buttons completely.

○ Exploring Post ○ Explorer Club Number:

Na **…nt one letter in each space—press hard, you are making a copy.)**

Firs… | Middle name: JANE | Last name: SMITH | Suffix

First name: KATHLEEN

Country: US | Mailing address: 1234 ANY STREET | City: ANYTOWN | State: NY | Zip code: 12345

Phone: 555-123-4567 | Date of birth (mm/dd/yyyy): 01/01/1998 | Grade: 10

Ethnic background:
○ Black/African American ● Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School: OAK TREE HIGH SCHOOL

Gender: ○ Male ● Female

Email address (Post youth participant only): KATHYJS@MYMAIL.COM

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ● Grandparent ○ Other (specify)

First name **(No initials or nicknames)**: DEBORAH | Middle name: SUE | Last name: SMITH | Suffix

Country: US | Mailing address: 1234 ANY STREET | City: ANYTOWN | State: NY | Zip code: 12345

Home phone: 555-123-4567 | Date of birth (mm/dd/yyyy): 01/01/1972 | Occupation: VP OPERATION | Employer: RGK INTL

Gender: ○ M ● F

Business phone: 555-765-4321 x | Ext. | Previous Exploring experience: FIRE EXPLORER | Cell phone: 555-253-6118

Parent/guardian email address: DEBORAH.SMITH@

- Make sure you have all needed signatures on application.

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Bill Taylor
Signature of post or club leader

05 / 13 / 2013
Date

Deborah Sue Smith
Signature of parent/guardian

Kathy Smith
Signature of Explorer

Participation fee $. Paid: ☐ Cash ☐ Check No. _____ ☐ Credit card

524-009

Retain on file for three years.

YOUTH PARTICIPANT

○ Exploring Post ○ Explorer Club Number:

If applicant has an unexpired participant certificate, participation may be accomplished at no charge by transferring the registration. Mark and attach a copy of the certificate.

○ Transfer application Transfer from council no.:

○ Exploring Post ○ Explorer Club Number:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

U S

Phone - - | Date of birth (mm/dd/yyyy) / / | Grade

Ethnic background:

○ Black/African American ○ Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School

Gender: ○ Male ○ Female

Email address (Post youth participant only) @

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

U S

Home phone - - | Date of birth (mm/dd/yyyy) / / | Occupation | Employer | Gender: ○ M ○ F

Business phone - - X | Ext. | Previous Exploring experience | Cell phone - -

Parent/guardian email address @

Signature of post or club leader

Date / /

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of parent/guardian

Signature of Explorer

Participation fee $. Paid: ☐ Cash ☐ Check No. _____ ☐ Credit card

LOCAL OFFICE COPY

Retain on file for three years. 524-009

SOUTHEAST GEORGIA HEALTH SYSTEM WAIVER AND RELEASE OF LIABILITY AND PARENTAL CONSENT

HEALTH CAREERS EXPLORER POST

In consideration of Southeast Georgia Health System (SGHS) permitting my son/daughter to participate in activities conducted at the SGHS Campuses in support of the Health Careers Explorer Program, I agree as follows:

- I fully understand and acknowledge that the activities scheduled for the Explorer Post may involve inherent risks, dangers, and hazards. The events my son/daughter may be participating in include but are not limited to: departmental tours and presentations where chemicals and bio-hazardous waste may be present or stored.

- I understand that the risks and dangers associated with these materials may be caused by the negligence of the participants, the negligence of others, or accidents, and that injury or harm may arise from foreseeable and unforeseeable causes including risks, hazards and dangers that are integral to these activities.

- By allowing my child/children to participate in these activities, I hereby assume all risks and dangers and all responsibility for any injury, harm, losses and/or damages.

I further waive, release, discharge, and agree to hold harmless Southeast Georgia Health System and its respective agents and employees from any claim that may arise from my son/daughter participating in the activities described above.

Name and age of my son/daughter participating in activities sponsored by the Southeast Georgia Health System Health Careers Explorer Post #466:

_____ _____

Participant Name (Print) Age

I have read the above Waiver and Release of Liability and Parental Consent and, by signing it, represent, warrant, and agree that it is my express intent to release, exempt and relieve Southeast Georgia Health System and its agents and employees from liability for claims that arise out of my child's participation in these activities.

_____ _____

*Signature of Parent or Guardian Date

***Signature of Custodial Parent(s) Required**

Southeast Georgia Health System
Health Careers Explorer Post

Consent For Medical Treatment Of A Minor

I, (We) are the natural parent(s) or guardian(s) of_____, a minor, who is participating in certain programs sponsored by the Southeast Georgia Health System Health Careers Explorer Post

In the event I (we) cannot be contacted and the above-referenced minor shall, by reason of accident, illness or injury, require medical treatment or surgery, including any and all diagnostic procedures or drugs related to such treatment, this Consent hereby authorizes representatives of Southeast Georgia Health System Health Careers Explorer Post to consent to the medical treatment of said minor and to do each and every act necessary to provide for said medical treatment.

Parent/Guardian name: _____

Parent/Guardian address: _____

_____

Parent/Guardian telephone _____

_____

Signature of Parent/Guardian Date

SOUTHEAST GEORGIA
HEALTH SYSTEM

Authorization For Disclosure of Images / Testimonials for Commerical Marketing Purposes

Full Name: _____ **Date:** _____

Address: _____

Contact Telephone #: _____ **Email:** _____

If Patient, Date of Birth: n/a **Date of Service:** n/a

I hereby authorize Southeast Georgia Health System ("Health System"), together with its team members, agents, and contractors, to use or disclose private information or images known as Protected Health Information ("PHI") about me or my treatment as described in this Authorization for marketing purposes. I understand that any interview, photograph, movie, video or audiotape taken will become and remain the sole property of the Health System or the authorized media organization named in this Authorization.

Information to be used or disclosed:

- ☒ My visual image, such as in a photograph, movie, video, etc.
- ☐ A movie, video or audio clip of me receiving healthcare services.
- ☐ A movie, video or audio clip of me giving a statement or being interviewed about treatment.
- ☒ A written quotation from me regarding the treatment or services I received.
- ☒ Other: Medical Explorer Post participation

Person(s) or *Class of Persons* authorized to use or disclose PHI for marketing purposes:

- ☒ Southeast Georgia Health System Marketing & Public Relations Department
- ☐ Other: _____

PHI may be used by, or disclosed to or by, the following person(s) or *Class of Persons*:

- ☒ To news media or print networks and the public at large via Internet, Facebook, TV, radio, billboard, letter or any other marketing correspondence or forum.
- ☐ Other: _____

Marketing purpose(s) regarding the use or disclosure of PHI:

I understand that my PHI will be used to encourage the use of Health System services, facilities and products by the general public and/or community, including use or disclosure for medical research, professional or patient education, audiovisuals or multimedia presentations, kiosk imaging, radio broadcasts, or any other news, public service, promotional or advertisement reason.

- The Health System will not receive direct or indirect payment in exchange for the use or disclosure of my PHI, but could indirectly benefit financially from sharing my image or statement by an increase in the use of its facilities or services or products.
- I also understand that the Health System will not pay me for the use of the information, images or videos to be used and disclosed.

Southeast Georgia Health System
Authorization For Disclosure of Images / Testimonials for Commerical Marketing Purposes

Expiration of this Authorization:

☒ This Authorization will expire on the following date or event: 09/20/2026.
☐ At the end of the marketing campaign ending: _____.

How to cancel this Authorization:

I understand that I may cancel this Authorization prior to its expiration to prevent the additional release of information and/or any photography, movie, video or audiotape.

- Cancellation requests must be sent, in writing, to Southeast Georgia Health System, Attention: Marketing Department, 2415 Parkwood Avenue, Brunswick, GA 31520.
- My cancellation shall not stop any use or disclosure made by the Health System prior to the date it received my written cancellation request.
- The Health System may not be able to stop an advertising campaign prior to the end of the campaign. I should not complete an Authorization for this use and disclosure of my PHI, if I am concerned that I may not wish to participate for the full marketing campaign.

This Authorization is not a condition to my receiving treatment at the Health System:

I am not required to participate in marketing projects. My decision to participate or not in this marketing project will not change my full access to treatment and services at the Health System.

Redisclosure of My PHI by Another Party:

I understand that the information/images disclosed by the Health System for marketing purposes might be redisclosed by the recipient of my PHI, in which case it will not be protected under the HIPAA Privacy Rule or Georgia law.

- I understand that I have a right to receive a copy of this signed Authorization.
- I have read and understand this Authorization and my questions have been answered.
- I certify that I am the patient listed above or the patient's authorized representative.
- I hereby release the Health System and its officers, trustees, affiliates, employees, agents and contractors from any liability arising from the use or disclosure of Protected Health Information or images pursuant to this Authorization.

_____ _____ _____
Signature Print Full Name Date

If a Patient Cannot Sign or if a Patient is a Minor Child, under age 18:

_____ _____ _____
Signature Print Full Name of Authorized Representative Date

_____
Relationship to Participant / Basis of Legal Authority

SOUTHEAST GEORGIA HEALTH SYSTEM

Real-World Career Experiences Exploring®

Medical Explorers Pledge

I understand that *attentiveness* and *punctuality* are factors to my success.

I agree to be respectful towards the volunteers who have given me this opportunity and towards my peers.

I understand that I represent my school and that my actions reflect on my school, my teachers and my classmates.

I agree to wear my scrub top, as means of identification and a symbol of the health care career that is before me.

I agree to have fun and to maximize this opportunity to learn, grow and develop professionally.

Explorer signature: _____ Date: _____

Exploring Mission Statement

It is the mission of Exploring to enable young people to become responsible individuals by teaching positive character traits, career development, leadership, and life skills so they can make informed, ethical choices and achieve their full potential.

Coastal Georgia Council- Boy Scouts of America, 11900 Abercorn St. Ext., Savannah, GA 31419
Office: (912) 927-7272 Mobile: (912) 308-7892. Email: barbara.foley@rocketmail.com