SOUTHEAST GEORGIA HEALTH SYSTEM

Teen Volunteer Program Application Packet

For high school/college students ages 16 – 18 years old interested in a career in healthcare

While we continue to navigate the COVID-19 pandemic we are still committed to helping students in our community safely obtain volunteer service hours while making a difference in a healthcare environment. **We will not be providing on-campus volunteer opportunities this summer but instead we have created service kits that students can complete at home to earn 20 hours of volunteer service. Space is limited in the program**. Applicants must be in good academic standing, reliable, responsible and trustworthy.

Service Kits Will Include Basic Supplies & Instructions To:

- Design greeting cards to cheer our hospitalized patients, residents of our Senior Care Centers, etc.
- Cut, loop and insert pins in 200 awareness ribbons for breast cancer, heart health, etc. that healthcare staff will wear during various months throughout the year.
- Assemble 24 holiday ornaments for our Senior Care Center residents.
- Color 24 sun catchers with markers for our Senior Care Center residents.
- Create a hand-hygiene educational poster to be displayed in one of our departments reminding everyone to wash their hands, preventing the spread of infection.
- Search the Southeast Georgia Health System website for answers to questions that will enhance your knowledge of our programs and services. (*Contact Volunteer Services for assistance if you do not have access to our website through a computer, tablet or smart phone.)

Teen Volunteer Program Requirements

- Complete the application forms and attach a photocopy of your Driver's License or valid school I.D. along with a 200 word essay that answers the following questions: Why are you interested in healthcare? Why should we select you to participate in the program?
- Commit to completing the at home service projects during June and July.
- Have parental consent
- Provide 1 reference from a teacher or a guidance counselor to be submitted with application (reference form attached)
- Meet individually with the Volunteer Services staff if you are selected to participate. You will receive your service kit at that time.
- Meet individually with the Volunteer Services staff upon completion of your service kit.

To apply: Complete all portions of this application and return it to us by Friday, May 14th. You will be contacted by phone and/or email by Friday, May 21 if you have been selected to participate. **If your application is missing pieces or is incomplete when received, it will not be considered.**

Graduating high school seniors who have successfully served at least 20 hours of volunteer service through the Teen Volunteer Program and who are going on to pursue careers in healthcare can apply for one of the Volunteer Services scholarships offered at both campuses.

Questions? Contact Volunteer Services at (912) 466-3157 or via email at kdoll@sghs.org or chowser@sghs.org.

SOUTHEAST GEORGIA HEALTH SYSTEM

Teen Volunteer Program Application 2021

The Teen Volunteer Program at Southeast Georgia Health System is for high school/college students ages 16-18. Applicants must be in good academic standing, reliable, responsible and trustworthy. Space in the program is limited. ***Applications are due by May 14.*** Questions? Contact the Volunteer Services office at 912-466-3157.

PERSONAL INFORMATION

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

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

I am applying to participate at the following campus: Brunswick ____ Camden ____

EMERGENCY INFORMATION

In case of an emergency, who should we notify? _____

Relationship: _____ Phone: (____)_____

EDUCATION/COMMUNITY INVOLVEMENT

School: _____ Grade: _____

List any healthcare courses, school activities, clubs, honors, sports, etc. you currently participate in

_____

Do you have plans to continue your education after high school? If yes, what course of study do you want to pursue? _____

List any community affiliations (church, civic groups, etc.) _____

_____

If you are seeking to volunteer as a requirement for any of the above activities/groups, please explain. Include the number of hours required and the date you must have them done by if necessary.

_____

_____

Have you ever volunteered before (school, civic group)? If yes, please explain. _____

_____

OTHER

How did you hear about the Teen Volunteer Program? _____

_____

Do you have any friends, relatives, acquaintances employed by or volunteering at Southeast Georgia Health System? If yes, please list:

Name Position Relationship

_____

_____

☐ I have attached a copy of my driver's license or valid student I.D.

☐ I have attached my 200 word essay detailing why I am interested in healthcare and why I should be selected to participate in the summer teen program.

If selected as a member of the Teen Volunteer Program at Southeast Georgia Health System, I agree to observe the Health System's confidentiality requirements, maintain a high standard of conduct, and observe all Health System rules and regulations. I pledge that I will represent myself, and my school, to the best of my ability. I understand that failure to abide by these requirements will result in my termination from the Teen Volunteer Program.

Student's signature: _____ Date: _____

Please mail your completed application to:

Brunswick Campus:
Southeast Georgia Health System
Attn: Volunteer Services
2415 Parkwood Drive
Brunswick, GA 31520

Camden Campus:
Southeast Georgia Health System
Attn: Volunteer Services
2000 Dan Proctor Drive
St. Marys, GA 31558

SOUTHEAST GEORGIA
HEALTH SYSTEM

Consent to Volunteer Form

As the parent/legal guardian of _____, I do hereby give my permission
Name of student

for him/her to participate in the Teen Volunteer Program at Southeast Georgia Health System.
As a member of the Teen Volunteer Program, I understand that my child will be required to:

1. Submit a completed application packet by May 14, 2021.
2. Meet individually with Volunteer Services staff prior to participating if selected and upon completion of their service kit.
3. Complete all components of the service kit by July 30, 2021 to receive 20 hours of volunteer service. All components of the service kits must be returned to Volunteer Services, even if they were not all completed.

I understand that my child's failure to abide by any of the above Teen Volunteer Program rules and regulations will disqualify him/her from further participation in the program. I further understand that participation in the Teen Volunteer Program is strictly voluntary. No certification or degree of any kind is implied or awarded to its participants upon completion of the program.

_____ _____

Signature of parent or legal guardian Date

SOUTHEAST GEORGIA
HEALTH SYSTEM

CONFIDENTIALITY STATEMENT

As a Volunteer or Teen Volunteer at Southeast Georgia Health System, I do hereby certify that I will respect the confidentiality rights of every guest, patient, and visitor who interacts with any department or unit within the Health System. I understand that the confidentiality of guest, visitor, and patient information is strictly maintained to protect the privacy rights of the individual. I pledge that I will not discuss or otherwise communicate any form of information concerning the care, condition, or treatment of any person(s) within the Health System.

I understand that failure to abide by the confidentiality requirements will result in my immediate termination from the Teen Volunteer Program.

Print Name: _____ Date: _____

Signature: _____

AGREEMENT AND RELEASE OF LIABILITY

In consideration of my minor child being allowed to participate in the activities and programs of Southeast Georgia Health System Teen Volunteer Program and to volunteer at its facilities, I do hereby waive, release and forever discharge Southeast Georgia Health System and its directors, officers, agents, employees, representatives, successors, executors, and all other form and all responsibilities or liability for injuries or damages resulting from my child's participation in any volunteer activities. This includes occasions when my child may be transferred or transported by Health System personnel to various sites owned or operated by the Health System or its strategic affiliates. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility of liability for any injury or damage to my child, including those caused by the negligent act or omission of any others not released under this Agreement in any way arising out of or connected with my child's participation in any activities of Southeast Georgia Health System.

Name of Minor Child: _____

Signature of parent or legal guardian: _____ Date: _____

Print Name: _____ Relationship to Minor Child: _____

Witness Signature: _____ Date: _____

Print Name: _____

SOUTHEAST GEORGIA HEALTH SYSTEM

Authorization For Disclosure of Images / Testimonials for Commerical Marketing Purposes

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Full Name: _____Date: _____

Address: _____

Contact Telephone #: _____ Email: _____

If Patient, Date of Birth: _____Date of Service: _____

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:

_____

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

☒ Southeast Georgia Health System Marketing & Public Relations Department
☒ Other: Southeast Georgia Health System Volunteer Services Department

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, 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.

Expiration of this Authorization:

☒ This Authorization will expire on the following date or event: December 31, 2025.
☐ 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 Patient Representative Date

_____

Relationship to Patient / Basis of Legal Authority

SOUTHEAST GEORGIA
HEALTH SYSTEM

Guidance Counselor/Teacher Reference Form For Teen Volunteer Program 2021

Thank you for encouraging young people to volunteer in order to explore various careers. Students aged 16-18 who show a strong interest in healthcare are encouraged to apply. **We will not be providing on-campus volunteer opportunities this summer but instead we have created service kits that students can complete at home to earn 20 hours of volunteer service.**

Your recommendation will help us to determine the qualifications of the applicant. **PLEASE RETURN THIS FORM TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE ACROSS THE FLAP.**

Applicant's Name: _____

Counselor/Teacher Name: _____ Email:_____

School Name: _____

Students will be working independently from home to complete various components of a volunteer services kit that will impact patients and team members at the Health System as well as enhance their knowledge of our organization. Please rate the applicant on the following qualities.

1. What is the applicant's attendance/punctuality?
   Poor Average Excellent
   1 2 3 4 5

2. How would you rate the applicant's ability to follow instructions and ask questions for clarification when necessary?
   Poor Average Excellent
   1 2 3 4 5

3. How would you rate the applicant's ability to work independently to complete assigned projects?
   Poor Average Excellent
   1 2 3 4 5

4. How would you rate their completion of projects/assignments?
   Poor Average Excellent
   1 2 3 4 5

5. To the best of your knowledge, is this applicant seriously interested in a career in healthcare?
   _____Yes ____No

6. If you have comments regarding the applicant's qualifications, please include as an attachment.

☐ I do recommend this applicant as a volunteer

☐ I do NOT recommend this applicant as a volunteer

Signature: _____ Date:_____

Questions or comments? Please contact Kristin Doll, Volunteer Services Director, kdoll@sghs.org or at 912-466-1071.