AtlantiCare

A MEMBER OF GEISINGER HEALTH SYSTEM

Dear Prospective Junior Volunteer:

Thank you for your interest in volunteering at AtlantiCare. Student volunteers ages fourteen through seventeen are an important part of our team. Volunteers provide support in the Medical Centers and satellite offices to help deliver exceptional service to the communities we serve. We are grateful that you will share your talents with us, and want your experience as a volunteer to be a rewarding one. **ALL JUNIORS ARE REQUIRED TO COMPLETE WORKING PAPERS TO VOLUNTEER. PLEASE NOTE: Applications for the Summer Junior Volunteer Program are accepted between January 1 and April 15 only**. There are a maximum number of students accepted into the summer program and acceptance is based on the date the application is received in the Volunteer Services Department. For juniors interested in volunteering during the school year, applications are accepted between September 1 and December 15. Acceptance of juniors for volunteering during the school year is at the discretion of the Volunteer Services Department.

Attached please find:

1) A Junior Volunteer application (2-pages)
2) Parental Permission Form and Criminal Background Clearance Form
3) Privacy/Confidentiality Agreement Form
4) Photo Release/Release of Information to the Media
5) New Jersey Working Papers – **complete Section A and bring with you to the group interview for our signature**
   - In addition we require the status of the following immunizations: MMR, Varicella, Dtap/Tdap, Influenza. All junior volunteers are required to have a 2-step PPD test for tuberculosis which AtlantiCare provides at no cost to you through our Occupational Medicine Department. At the Information Meeting/Group Interview (explained below) you will receive an Authorization for Services form to receive the TB testing and to have your immunization records reviewed. **You will need your immunization records with you when you attend the appointment.** PLEASE NOTE: If you had a PPD test done within the past year, please bring the proof of the testing results to your Occupational Medicine appointment.
6) Occupational Medicine Questionnaire for your TB testing – **complete and bring with you to the group interview**

When we receive your completed application, you will then be invited to an information meeting/group interview at which one of your parents must attend with you. **Only the junior applicant and their parent(s) may attend the meeting.** When your medical testing is complete, you will then be required to complete an orientation. The final step will be meeting with you at a mutually agreeable time to select the department in which you will volunteer, plan your schedule, and receive your ID badge and volunteer shirt. Applications may be sent to AtlantiCare Hospice, ATTN: Volunteer Services, P. O. Box 1626, Pleasantville, NJ 08232, or dropped off at the front desk at AtlantiCare Regional Medical Center Mainland Division, 65 W. Jimmie Leeds, Road, Pomona, NJ 08240, or e-mailed to Volunteer Services.

SUMMER JUNIOR VOLUNTEER PROGRAM

After April 15, any junior who has been accepted in the Summer Program will receive a letter with dates of the Information Meetings/Group Interviews. **You must register for one of the meetings and attend with one of your parents**. **Only the junior applicant and their parent(s) may attend the meeting.** At the meeting you will be photographed for your ID badge.

FOR YOUR CONVENIENCE – Nurses from Occupational Medicine will be at all the meetings for the TB testing and to review your immunization records. **Please complete the questionnaire attached and bring it with you to the meeting.**

INFORMATION ABOUT THE TB TESTING – Step 1 of the PPD test is the injection of a serum in a subdermal section of your forearm. Two days after the placement, you need to return to have the area of the injection looked at, and the nurse will sign and date a form noting the results. The second part of the 2-step PPD testing must be done between 1 and 3 weeks after the first placement. It is the same process as the Step 1. You are welcome to have the PPD testing performed by your personal physician, at your expense, and we would need a copy of the results of the readings of Steps 1 and 2. You are also welcome to have a physician or registered nurse document the results of the testing performed by Occupational Medicine; however, the documentation must be returned to Occupational Medicine.

Once you have completed your medical testing, you will meet with Volunteer Services at a mutually agreeable time to select the department in which you will volunteer, plan your schedule, and receive your ID badge and volunteer shirt.

Your contribution as a volunteer is invaluable and we look forward to the opportunity to work with you. Please call if you have any questions.

Thank you again for your interest in volunteering within AtlantiCare.

Sincerely,

Maureen Hope Kathleen Donadio

Maureen Hope Kathleen Donadio
Volunteer Services

Malcolm Baldrige National Quality Award 2009 Award Recipient

Volunteer Services Department – phone: 609-407-2030, fax: 609-407-2029
e-mail: Maureen.hope@atlanticare.org Kathleen.donadio@atlanticare.org

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JUNIOR VOLUNTEER APPLICATION (ages 14 through 17)

**** PLEASE NOTE: WORKING PAPERS ARE REQUIRED FOR ALL JUNIOR APPLICANTS**

Date:_____ Name:_____
First Middle Initial Last

Date of Birth:_____ E-Mail Address:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Preferred Phone Number:_____ Alternate Phone Number:_____

Name of School Currently Attending:_____

Street Address of School:_____

City of School::_____State:_____ Zip Code:_____

Parent/Guardian Name:_____

E-Mail Address for Parent/Guardian:_____

Preferred Phone Contact for Parent/Guardian:_____

How did you hear about volunteering at AtlantiCare?_____

Have you volunteered at AtlantiCare in the past? □ No □ Yes If yes, in which department(s)?_____

_____

Do you have any previous hospital or community volunteer experience? □ No □ Yes If yes, please list where :____

_____

_____

Do you speak another language? □ No □ Yes If yes, what languages?_____

_____

Please tell us why you would like to be an AtlantiCare volunteer?_____

_____

_____

_____

_____

_____

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How would you like to volunteer with AtlantiCare?
Role descriptions are available on the website

(**Volunteer opportunities are based on department needs and volunteer skills. Please check all areas of interest.)**

- ❑ Interacting with patients (e.g. visiting patient rooms, sitting with patients to offer companionship, hospitality cart)
- ❑ Interacting with the public (e.g. information desk, hospital greeter/guide, registration, accompanying musicians/pet visits throughout the hospital)
- ❑ Dietary (help in the kitchen, cafeteria, dining area, catering)
- ❑ Logistics (e.g. restocking, rotating inventory, delivering supplies)
- ❑ Clerical help (e.g. filing, computer data entry, assembling information packets, phone support, laminating, mailings)
- ❑ Creative Arts and Healing Program (e.g. musicians, licensed pet therapy, etc. to visit patients or perform in lobbies)
- ❑ Growing Green, AtlantiCare's Community Gardening Initiative: Volunteers help to sustain community gardens sponsored by AtlantiCare. Volunteers participate in planting activities, programming opportunities, and general maintenance of gardens. Volunteers to work as a team, but also opportunity for independent gardening. A green thumb is not required!
- ❑ Other interests for volunteering? Please explain:_____

_____

_____

Junior Volunteers are typically scheduled for a three hour shift, once or twice a week.
A letter of Acknowledgement of Volunteer Service is presented to students who volunteer a minimum of 30 hours.

JUNIOR VOLUNTEER PARENTAL PERMISSION FORM and CRIMINAL BACKGROUND CLEARANCE

I hereby grant permission for my son/daughter:_____
PLEASE PRINT NAME

to participate in the Junior Volunteer program at AtlantiCare. I understand that participants must be between the ages of 14 and 17. My son/daughter will attend an Information Meeting/Group Interview with one of his/her parents and complete an orientation. My son/daughter is expected to follow AtlantiCare's policies and procedures. I will assume full responsibility for my son/daughter and, thereby, release AtlantiCare from any obligation, which may be incurred by him/her performing volunteer work on behalf of AtlantiCare.

AtlantiCare requires a criminal background clearance prior to individuals becoming part of our volunteer team. In lieu of a criminal background clearance for a Junior Volunteer, I hereby attest that my child is a minor and has not been convicted of a crime.

Please print Junior Volunteer's name:_____

Signature of Junior Volunteer:_____

Please print parent or guardian name:_____

Signature of parent or signature:_____

Date:_____

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Information Security Privacy/Confidentiality Agreement to Abide By AtlantiCare's Notice of Private Practices and *AtlantiCare Notice and Privacy Practices and AtlantiCare Policy*

Important

Read all sections carefully before signing. AtlantiCare will retain a copy of this agreement.

Agreement to Abide by AtlantiCare's Notice of Privacy Practices:

During the normal course of my junior volunteer assignment within AtlantiCare, I may come in contact with information that is private and confidential and is proprietary to patient(s) and/or AtlantiCare's Health System. Information is defined as all patient, employee, physician, healthcare provider and/or other data concerning AtlantiCare Health System and its related entities which appear in verbal, written, or electronic form.

I understand that AtlantiCare will utilize one Notice of Privacy Practices for all of AtlantiCare's business entities which will include members of AtlantiCare's junior volunteer staff. Junior volunteers must abide by AtlantiCare's Notice of Privacy Practices and AtlantiCare policy while on the premise of any AtlantiCare business entity.

I acknowledge that disclosure of confidential protected health and/or proprietary AtlantiCare Health System information may violate regulatory requirements, state, or federal laws and accreditation standards.

I understand that AtlantiCare Notice of Privacy Practices is essential in maintaining patient protected health information, as outlined within the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I will comply with AtlantiCare's policies protecting information security and the privacy/confidentiality of patient information.

I hereby acknowledge that I have review, understand, and will follow AtlantiCare's Notice of Privacy Practices and AtlantiCare's Information Security Policies and Procedures while a junior volunteer at any AtlantiCare business entity.

Date:_____

Print Volunteer's Name:_____

Volunteer's Signature:_____

Print Parent/Guardian Name:_____

Parent/Guardian Signature:_____

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Photo Release/Release of Information to the Media

I hereby grant permission to AtlantiCare, its employees and assigns and/or outside media to photograph, videotape or interview me and/or my dependent(s) on various dates throughout Junior Volunteer Career/Service. The specific information to be released to the media or AtlantiCare includes:

□ Photos □ Videos □ Interview □ Other, describe:

_Junior Volunteer Program Activities_____

I understand that the photographs, videotape or interview shall become the property of AtlantiCare and/or the outside media and that I shall not have any rights to the same. I also understand that I will not be compensated for participating in the taking of photographs, videotaping or interviewing and that I will not be entitled to compensation as a result of the broadcast or publication of the photographs, videotape or interview.

I understand that the photographs, videotape or interview may be used and redisclosed as a press release and shared with media for possible publication or broadcast. I also understand that the photographs, videotape or interview might be publicized or broadcast, or used in promotional materials that include, but are not limited to, brochures, billboards, advertisements, the AtlantiCare Internet site and the AtlantiCare Intranet site. I understand that the photographs, videotape or interview might be edited and I agree that AtlantiCare, its employees and/or agents shall have the right to, at any time, add to, edit, arrange, rearrange and/or revise such photographs, videotape or interview. I understand that AtlantiCare maintains the right to reuse the photograph, videotape, or interview for future purposes without additional authorization or release.

I release AtlantiCare, its employees and agents from any and all claims and from all liability including, without limitation, claims for libel, invasion of privacy and/or misappropriation of likeness arising out of the interviewing, photographing or videotaping and subsequent publication or broadcasting of this material. I understand that I am not required to sign this authorization and that AtlantiCare will not condition treatment on my execution of this authorization. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with the request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations and that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA. This authorization will expire _September 1, 2072.

Volunteer's Name (please print): _____

Signature:_____

IF SUBJECT IS A MINOR:

Name of Parent/Guardian (please print):_____

Signature OF Parent/Guardian: _____

Office Use Only - Description:

NEW JERSEY DEPARTMENT OF EDUCATION

Date Printed: _____

A300 Combined Certification Form

Date(s) of previously issued certificates *(if applicable)*: _____

☐ Cooperative Education Experience (CEE) - Hazardous Occupation ☐ CEE - Non-Hazardous Occupation ☐ Paid Structured Learning Experience

A. Minor's Personal Information

First Name M.I. Last Name	Social Security No.
Street Address *(Line 1)* Floor/Apt. No. *(Line 2)*	Date of Birth Age City of Birth
City State Zip Code	County of Birth State/Country of Birth
Telephone No. Cell/Alternate No.	☐ Male ☐ Female Height _____ Weight _____ Hair Color _____ Eye Color _____
Parent/Guardian First Name Parent/Guardian Last Name	Distinguishing Facial Marks *(if applicable)*
Parent/Guardian Address *(if different than minor's address)* Floor/Apt. No. *(Line 2)*	I hereby authorize the employment of my child as specified below under Employment Information.
City State Zip Code	
Parent/Guardian Telephone No. Alternate Telephone No.	_____ *Signature of Parent/Guardian* *Date*

B. Employment Information

Employer Business Name: AtlantiCare	Type of Business/Industry: Healthcare
Street Address *(where minor will be employed)*: 6550 Delilah Road Floor/Suite *(Line 2)*	Minor's Job Title *(Be specific)*: Junior Volunteers
City: Egg Harbor Township State: NJ Zip Code: 08234	Is liquor sold on the premises? ☐ Yes ☒ No
Contact Person Name: Maureen Hope	If Yes, are the entire premises licensed? ☐ Yes ☐ No
Telephone No.: (609) 407-2030 Alternate Telephone No.	If No, describe what areas of the premises are licensed, including any outside grounds: N/A
Minor's Hours of Work *(Provide daily hours and/or start and end times)* _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri Sat _____ Sun _____ Total Hours for Week: 16 Wages: Per Hour _____ Weekly _____ Other - _____	**Promise of Employment:** I have offered employment to the above named minor for the hours stated. I understand that these hours may be flexible but may not exceed the number of hours permitted by law according to the age of the minor. _____ *Signature of Employer* *Date*

C. Physician's Certification *(to be completed by licensed physician)*: I hereby certify that I have examined the above named minor on _____ *(Date)* and I designate the minor's physical qualifications regarding the above promise of employment as:

☐ Physically Qualified ☐ Physically Qualified with the following limitations _____

_____

Signature of Doctor *Date* Address

D. Proof of Age *(for Issuing Officer)*: I have examined the proof of age submitted by the above named minor which was in the form of *(select one)*:

☐ Birth Certificate ☐ Baptismal Certificate ☐ Passport ☐ Other documentary proof in existence for at least one year *(specify)*: _____

☐ Affidavit of Parent/Guardian together with 1) physician's statement of opinion as to age of minor, and 2) school record of age and the above date of birth

E. School Record *(to be completed by school that the minor attends)*

School District County

Name of School

School Address

Last Grade Completed _____

The above named minor attends school in this district and has completed the work of the above grade. To the best of my knowledge the minor can do the work proposed without impairment of progress in school.

_____

Signature of Principal *Date*

F. Issuing Officer Certification

School District County

School District Address

Telephone No.

☐ Regular Employment Certificate

☐ Vacation Employment Certificate *(summer & other school vacations)*

☐ Age Certificate (*issued to persons 18 to 21 years of age)* Age: _____

_____

Signature of Minor *Date*

_____

Signature of Issuing Officer **Date of Issue** **Certificate No.**

INSTRUCTIONS FOR A300 COMBINED CERTIFICATION FORM

1. **Employment Information** (section B) – After you have completed your personal information (section A), bring your certification form to the employer. The employer completes the Employment Information and signs and dates the Promise of Employment. If any of the employment details have been pre-filled and are incorrect, the employer must cross out the incorrect information and enter, initial and date the corrections.

2. **Physician's Certification** (section C) – The school district is responsible for performing the physical examination at no cost to you or your parents. A school physical (including a sports physical) performed during freshman year is good for all four years of high school (unless the school district policy specifies more frequent physicals).

   If your parent/guardian prefers that you be examined by a doctor other than the one employed by the school district, you may do so at your parent/guardian's expense. A minor is not required to obtain a physical if the parent/guardian objects (in writing) based on their religious beliefs and practices.

3. **Proof of Age** (section D) – If the school does not have a copy on file, you may be asked to provide a birth certificate, passport, baptismal certificate or other identification documentation to the School Issuing Officer.

4. **Parent/Guardian Authorization** (section A) – Your parent/guardian must indicate his/her authorization of your employment as specified in the Employment Information by signing and dating the Parent/Guardian authorization.

5. **School Record/Issuing Officer Certification** (sections E & F) - **Bring the completed certification form to your school district.** A designated school official will review the form and issue the working papers only after being satisfied that the working conditions and hours will not interfere with your education or damage your health. The official may refuse to issue working papers if such refusal would be in your best interest.

IMPORTANT INFORMATION

Hours of Work – 14 & 15 Year Olds

- no more than 3 hours a day on a school day
- no more than 18 hours a week during a school week
- may not work before 7:00 am or after 7:00 pm during the school year
- summer vacation: may work up to 8 hours a day, 40 hours a week, and may work up to 9:00 pm with written parental permission (which must be on file with the employer)

Hours of Work – 16 & 17 Year Olds

- no more than 8 hours a day
- no more than 40 hours a week
- may not work before 6:00 am or after 11:00 pm
  Exception: may work after 11:00 pm (up to 3 am provided work begins before 11 pm) during regular school vacation and when there is no school the next day with written parental permission (which must be on file with the employer)

Hours of Work – All Minors

- no more than 6 consecutive days
- may not work more than 5 continuous hours without at least a 30-minute meal break

Hours of Work - School-Sponsored Cooperative Education Experiences, Apprenticeships and Paid Structured Learning Experiences - Training site experiences may not exceed five hours on any day that school is in session nor may the combination of school and work exceed eight hours on any day that school is in session.

Prohibited Work– Certain potentially hazardous jobs are prohibited for minors based on the age of the minor. For a complete list of prohibited occupations, visit the Department of Labor and Workforce Development's website at *www.nj.gov/labor* and click on *Wage & Hour.*

www.nj.gov/education - New Jersey Department of Education
*www.nj.gov/labor (*click on *Wage & Hour)* – New Jersey Department of Labor and Workforce

OCCUPATIONAL HEALTH
AtlantiCare
Physician Group
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ATLANTICARE JR. VOLUNTEER

TUBERCULOSIS SKIN TESTING ADMINISTRATION RECORD

Name _____ **Date of Birth**_____

****

PPD Skin Test Administration

Initial Mantoux:
Date tested _____
Site: R_____ L _____forearm
Administered by _____
Lot# _____Exp. Date_____

PPD Skin Test Reading

Date to be read _____
Date read _____
Results _____mm
Read by _____

2 Step:
Date tested _____
Site: R_____ L _____ forearm
Administered by _____
Lot# _____Exp. Date _____

Date to be read _____
Date read _____
Results _____mm
Read by _____

OCCUPATIONAL HEALTH

AtlantiCare

Physician Group

TUBERCULOSIS SKIN TESTING CONSENT

I, _____, am presenting myself for Tuberculosis skin testing by AtlantiCare Occupational Medicine. I voluntarily consent to this procedure and understand the purpose of such procedure.

_____ _____

Date Jr. Volunteer Signature

_____ _____

Date Parent/Guardian Signature

Acknowledgment of Privacy Notice:

I understand and have been provided with AtlantiCare's ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

_____ _____

Date Jr. Volunteer Signature

_____ _____

Date Parent/Guardian Signature

TUBERCULOUS SKIN TESTING PRESCREEN – HISTORY

1. Have you ever had an allergy to tuberculin or the components derivative (PPD)?

   [ ] Yes [ ] No

2. Have you had a live viral vaccine or taken systemic steroids within the past 4 weeks?

   [ ] Yes [ ] No

3. Do you have a history of the following?
   [ ] A BCG vaccine
   [ ] A positive PPD skin test
   [ ] Active tuberculosis
   [ ]Treatment with preventative therapy (prophylaxis) for active tuberculosis

4. When was your last PPD done? _____