

Teen Volunteer Application

Contact Information		Please Print
Name		
Street Address		
City		
State / Zip		
Home Phone	Date of Birth: / /	
Cell Phone	Age at application:	
E-Mail Address		
School Attending		
Class Supervisor		
Supervisor Address		
Supervisor Phone		
E-Mail Address		
School Work Papers: No Applied YES		Parental Consent Form: NO YES
Emergency Contacts		
Name:	Relationship	Phone Number
	Parent/Guardian	
	Parent/Guardian	
	Doctor	
Availability		
During which hours are you available for volunteer assignments?		
	AM	PM
	Evenings	
Sunday		
Monday		
Tuesday		
Wednesday		
	AM	PM
	Evenings	
Thursday		
Friday		
Saturday		
Personal References		
Full Name	How Known	Phone Number
School or Volunteer References		
Full Name	Agency/Company	Phone Number

Our Policy		
It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual orientation, age, or disability.		
Special Skills or Qualifications		
Please summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.		
Previous Volunteer Experience		
Please summarize your previous volunteer experience along with dates of your volunteer activity.		
Background Information / Authorizations		
1. Have you ever been convicted of abuse, neglect, and/or exploitation of any person or have you been convicted of misappropriation of funds or property?	YES	NO
2. Have you ever been convicted of a crime that has not been annulled by a court? Note: A criminal conviction will not necessarily disqualify you from volunteering, depending upon the position for which you are applying	YES	NO
3. Do you have any relatives working at AGCHC or on our Board of Directors?	YES	NO
3a. Are you, or have you ever been, a patient at AGCHC?	YES	NO
3b. If you have answered YES to 3a. It is AGCHC policy that we must verify all patients, existing or past, with an AGCHC provider for any volunteer position. May we do this?		
4. In order that Avis Goodwin Community Health Center (AGCHC) may process my application for volunteership, I hereby authorized AGCHC and its directors, board members, employees, representatives, and agents (hereinafter collectively referred to as AGCHC) to conduct a complete investigation into my background including, but not limited to, my entire employment history, including my fitness for duty at all prior employment; education history; criminal record and military record, if any' to obtain opinions and references regarding my moral character and reputation and to solicit and obtain any other information AGCHC, in its sole discretion, deems as necessary to determine my eligibility for volunteership or for the purposes of confirming the accuracy or completeness of any information I have provided to AGCHC	YES	NO
5. In consideration for the processing of my application for volunteership with AGCHC, I hereby RELEASE, INDEMNIFY, AND HOLD HARMLESS AGCHC and all previous employers and other persons and organizations furnishing information in connection with AGCHC's investigation into my background from any and all liability based on their authorized receipt, disclosure, and use of the information gathered in processing my application for volunteerism with AGCHC.	YES	NO
6. I understand that, if I am extended an offer for volunteership, any offer is contingent upon a satisfactory criminal background records check and, depending on the position I am offered, my submission to a medical examination to determine my ability to perform the essential functions of the position offered. I also understand that if offered a position I will be a volunteer-at-will.	YES	NO

					Applicant Initials
7. By initialing this box and each of the following boxes, I acknowledge I have received a copy of the AGCHC Volunteer Handbook and have read, understand, and agree to abide by the policies, procedures, and protocols as stated in my AGCHC handbook and I have reviewed, understand and signed the following documents which will be kept in my file.					
Gray areas for agency use only	Specifics	To Do	Done	Filed	
School Work Papers					
Parental Permission Form					
Agency and Volunteer Agreement					
Audio/Video Consent Form					
Confidentiality Policy					
Criminal Records Check					
Handbook Receipt					
Identification Badge					
Parking Permit (Rochester Only)	#				
Permission to Verify Documents					
Time Sheet					
I certify that all the above information is true and complete. I understand that any misrepresentation or omission may result in my disqualification from further consideration for volunteer opportunities and/or my termination from such.				YES	NO
<hr/>					
Signature of Volunteer (Age 13-18)				Date	
<hr/>					
Printed Name of Volunteer					
<hr/>					
Signature of Parent/Guardian				Date	
<hr/>					
Printed Name of Parent/Guardian					
<hr/>					
Interviewed by:				Date:	
<hr/>					



Parental/Guardian Informed Consent and Injury Waiver

I am the parent or guardian of _____ (Participant's Name). I hereby give him/her permission to attend and participate in volunteer work at or on behalf of, Avis Goodwin Community Health Center. The activities will take place on _____ (date) at _____

I understand that such permission means that I assume on my son/daughter's behalf all risks and hazards incidental to his/her participation in activities undertaken in connection with volunteer projects, including, but not limited to, physical injury. I recognize that it shall be the responsibility of my son/daughter to comply with the rules and regulations set forth by Avis Goodwin Community Health Center.

I agree to release and hold harmless from liability Avis Goodwin Community Health Center for any injury sustained by my child while he/she is attending or traveling to and from this volunteer project, whether the result of negligence or any other cause. I understand that activities of the Avis Goodwin Community Health Center project will include, but not be limited to,

In case of an emergency, please contact:

Name: _____

Address: _____

Phone (Home): _____ (Business): _____

Relationship: _____

If the above person is not available, contact:

Name: _____

Address: _____

Phone (Home): _____ (Business): _____

Relationship: _____

Does your son/daughter have any medical conditions, e.g. diabetes, asthma, etc., that may limit his/her participation? If so, please list: _____

Is your son/daughter allergic to any medication(s)? If so, please list: _____

Is your son/daughter currently taking any medication(s)? If so, please list: _____

In case of illness or injury, please provide your group/individual health plan or major medical number as well as the name and phone number of your family physician:

Plan Name

Subscriber Number

Physician

Phone Number

If I am not available during an emergency, I authorize medical consultation or treatment for my son/daughter as may be necessary.

I am the parent or legal guardian of _____, who is in my custody, and I understand that I have the authority to sign this agreement.

Signature of Parent or Guardian

Date

Please Print/Type Name

For Participant:

I have read this agreement and agree to comply with the rules and regulations set forth by the AGCHC organizers and chaperones.

Signature of Participant

Date

Please Print/Type Name



ACCESS TO CONFIDENTIAL INFORMATION

As an employee, volunteer, consultant, student, contractor, or other individual affiliated with Avis Goodwin Community Health Center (AGCHC), you may have access to what this policy refers to as "confidential information." The purpose of this agreement is to help you understand your duty regarding confidential information. Confidential information includes patient/member information, employee/volunteer/student information, financial information, other information relating to AGCHC and information proprietary to other companies or persons. Confidential information is any medical or demographic information that pertains to patients, colleagues, co-workers or other individuals associated with AGCHC which is stored and maintained, whether paper-based or computerized. Medical information is deemed confidential and should not be released to third parties unless authorized by the patient or legal representative or otherwise permitted by law. You may learn of or have access to some or all of this confidential information through a computer system or through your activities with AGCHC.

Confidential information is valuable and sensitive and is protected by law and by strict AGCHC policies. The intent of these laws and policies is to assure that confidential information will remain confidential - that is, that it will be used only as necessary to accomplish the Center's mission. You are required to conduct yourself in strict conformance to applicable laws and AGCHC policies governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties will subject you to discipline, which might include, but is not limited to, termination of employment and legal liability.

You will have access to confidential information which may include, but is not limited to, information relating to:

- ☞ Patients/members (such as records, conversations, registration information, patient/member financial information, etc.)
- ☞ Employees (such as salaries, employment records, disciplinary actions, etc.)
- ☞ AGCHC information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.)
- ☞ Third party information (such as computer programs, client and vendor proprietary information, source code, proprietary technology, etc.).

Accordingly, as a condition of and in consideration of your access to confidential information, you promise that you will use confidential information only as needed to perform my legitimate duties as an individual affiliated with AGCHC. This means, among other things, that:

ACCESS TO CONFIDENTIAL INFORMATION

Page 2

- ☞ You will only access confidential information for which you have a need to know;
- ☞ You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of your professional activities affiliated with AGCHC
- ☞ You will not remove any paper-based record, or copy, any report from the office unless otherwise permitted. Computerized health information should not be removed except in the performance of your duties and per security policies
- ☞ You will not misuse confidential information or carelessly care for confidential information
- ☞ You will safeguard and will not disclose your User ID, password or any other authorization you have that allows you to access confidential information
- ☞ You accept responsibility for all activities undertaken using your User ID, password or other authorization
- ☞ You will report activities by any individual or entity that you suspect may compromise the confidentiality of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities
- ☞ You understand that your obligations under this policy will continue after termination of your employment or agreed upon terms of service with AGCHC
- ☞ You understand that your privileges hereunder are subject to periodic review, revision and if appropriate, renewal
- ☞ You understand that you have no right or ownership interest in any confidential information referred to in this policy. AGCHC may at any time revoke your access code, other authorization, or access to confidential information. At all times during your employment or affiliation with AGCHC you will safeguard and retain the confidentiality of all confidential information
- ☞ You will be responsible for your misuse or wrongful disclosure of confidential information and for your failure to safeguard my access code or other authorization access to confidential information. You understand that your failure to comply with this policy may also result in your loss of employment or affiliation with AGCHC.

I acknowledge reading this policy and agree to adhere to it.

Individual's Signature

Date

Name Printed