



Leesburg Regional Medical Center, 600 East Dixie Avenue, Leesburg, FL 34748 (Phone: 352.323.5060)
Please return completed application to the hospital or email to: jwoods@centflhealth.org

TEENAGE VOLUNTEER (TAV) APPLICATION FORM

This application is for volunteer service purposes only and is not valid until received and reviewed by the Auxiliary Committee and Volunteer Coordinator. Central Florida Health is committed to providing a safe and healthy environment for everyone on campus. Prior to new volunteer orientation and assignment, applicants must pass all applicable background screenings.

Application Date:				
Last Name:		First	Middle	
Present Address:	Street	City	State	Zip
Home Telephone:		Cell Phone:		
Name of Father/Guardian & Phone:		Name of Mother/Guardian & Phone:		
Date of Birth:	Age:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Social Security Number:		Driver License #:		
Family Members working at LRMC?		Department:		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Email Address:				
VOLUNTEER EXPERIENCE/COMMUNITY AFFILIATIONS				
How did you hear about the Volunteer Services program with Central Florida Health? _____				
Do you have previous volunteer experience? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Where and When: _____ _____				

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Please return the following documents. We will call you for a personal interview.

- 1. Completed and Signed Application
- 2. Two letters of Personal Reference
- 3. Parental Permission Form Completed and Signed
- 4. Tuberculosis Permission Form Completed and Signed

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Application Received: _____ Interview Date: _____ Interviewed By: _____

Scheduled Orientation Date: _____ Start Date: _____

Assignment: _____

Comments: _____

****PARENTAL PERMISSION to VOLUNTEER****

I hereby agree to allow my son/daughter _____ to serve as a Teen Volunteer with Leesburg Regional Medical Center Auxiliary. I release Leesburg Regional Medical Center from any responsibility or liability for any unforeseen results or causes that may arise as a result of my teenager's service. Further I hereby agree to hold harmless Leesburg Regional Medical Center and the Auxiliary and agree to indemnify, defend and hold harmless Leesburg Regional Medical Center, the Auxiliary, its officers, directors, employees and representatives from any and all liabilities and claims resulting solely from or attributable to acts of omissions of my son/daughter in the performance of these services.

1. It is mutually understood and agrees that your son/daughter is not an employee of Leesburg Regional Medical Center. The sole interest and responsibility of Leesburg Regional Medical Center is to ensure that the services provided by your son/daughter shall be consistent with the standards of care provided by Leesburg Regional Medical Center and are consistent with the policies and procedures of Leesburg Regional Medical Center and that my son/daughter performs and renders service in a competent, efficient and satisfactory provision of medical care at Leesburg Regional Medical Center. _____ **Parent's Initials**

2. At Leesburg Regional Medical Center's sole discretion, Leesburg Regional Medical Center may provide written notice to you that your son/daughter's work with patients or personnel is not in accordance with acceptable procedures or standards of performance or otherwise could disrupt patient services of Leesburg Regional Medical Center and remove your son/daughter from Leesburg Regional Medical Center. _____ **Parent's Initials**

3. Upon request, your son/daughter may be requested and shall provide the following required documents to Leesburg Regional Medical Center or cooperate with Leesburg Regional Medical Center to obtain these documents prior to start or while volunteering:
 - a. Application of volunteer
 - b. Health screening including: TB skin test or chest x-ray, proof of MMR immunity or vaccination, Free of Communicable Disease statement.
 - c. Agreement to comply with the Security and Privacy Policy _____ **Parent's Initials**

4. I am responsible for the transportation of my teen to/from the hospital as well as the purchase of the required uniform. (Photo ID Badge will be provided by the hospital). _____ **Parent's Initials**

5. I understand that my teen must commit to a minimum of 4 hours per week and must attend a new Teenage Volunteer Orientation before beginning volunteer service. I also understand that volunteer service assignments may only be made by the Teen Volunteer Coordinator. My teen may only report for volunteer service as assigned. If your teen wishes to serve additional hours please consult with the Teenage Volunteer Coordinator. _____ **Parent's Initials**

6. In general, the Teenage Volunteer Program is only available during the summer months. However, teens may Continue to volunteer during the school year if the assignment(s) is requested to, and approved by the Teenage Volunteer Coordinator following the teen's initial Volunteer service. _____ **Parent's Initials**

Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian

Date



MINOR TUBERCULIN SKIN TEST PERMISSION SLIP

_____ will be required to have a tuberculin Skin Test (PPD) as part of his/her LRMC/TVRH School Internship or Volunteer requirements.

Tuberculosis is a communicable disease, transmitted through airborne droplets from an infected person. All healthcare facilities and many other public service industries are required by law to test their employees on a regular basis. The skin test, known as a PPD (purified protein derivative) is performed by placing an intradermal injection on the forearm. The small bubble or wheal will disappear. Keep the area clean and dry. Redness or bruising at the site may occur, but a red, raised or blistered area may indicate a positive reaction. A positive reaction does NOT indicate active disease, only that an exposure to tuberculosis has occurred at some point. If a positive reaction is confirmed a chest x-ray will be performed to determine the presence or absence of active disease. The team member health nurse will provide guidance as needed to arrange appropriate follow up. If you have not had a documented PPD within the last year, a two-step will be required. This means that a second PPD will be administered 7 – 10 days after the first to confirm a true negative result.

Has your child:

- 1. Had a TB test (Mantoux) within the last 12 months? [] Yes [] No
2. Lived outside the United States? [] Yes [] No
3. Had a BCG vaccine? [] Yes [] No
4. Had a past positive reaction to a TB skin test? (If yes, complete TAV Application Page 5) [] Yes [] No

***Anyone with a history of a positive reaction must submit a negative chest x-ray taken within the last six months

CONSENT: My child, _____, is not suffering from unexplained weight loss, loss of appetite, night sweats, fatigue, chills and fever, blood in urine, chest pain or a prolonged cough. Is not taking drugs or medications which lower their immunity, nor do they have a disease which lowers immunity. They have not had any recent vaccinations.

I, _____, have read the information on tuberculosis and give my permission for this test to be performed including PPD injection, Quantiferon Gold blood test, and possible chest x-ray.

Signature

Date

Relationship to Student

Home Phone

Cell Phone

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5TU (.1ml) of Tuberculin Purified Protein Derivative Intradermal

IF QUESTIONABLE OR >5MM INDURATION, MUST BE SEEN BY TEAM MEMBER HEALTH NURSE.

Table with 3 columns: Date, 1st Step, 2nd Step. Rows include Forearm (L/R), Lot #, Expiration Date, Signature, Date Read, Reading (mm), and Signature.



TB SCREEN FOR THOSE WITH A HISTORY OF POSITIVE PPD

Do you have any of the following?

- 1. Chronic Cough Yes No with Sputum, color of Sputum: _____
- 2. Persistent Night Sweats Yes No
- 3. Involuntary Weight Loss Yes No
- 4. Chronic Fatigue Yes No
- 5. Any serious Illness Yes No

If you answered YES to any of the above, please explain: _____

Parent Signature: _____

Date: _____

Teen Signature: _____

Date: _____

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Chest X-ray ordered: Yes No

Date Ordered: _____ Date Completed: _____ Results to parent: _____

Results: _____

Team Member Health Nurse Signature

Date



ANNUAL VOLUNTEER REQUIREMENTS

Name of Volunteer: _____ D.O.B: _____ SSN: _____

Home/Cell Phone: _____ Other Phone: _____

- 1. Annual Training Module, HIPPA Training, Corporate Compliance Training and Annual TB Surveillance Forms

Confirmation # *Date* *Signature of Auxiliary Tester*

- 2. Annual Vision Exam (for Drivers ONLY)

Date *Signature of Employee Health Nurse*

NEW VOLUNTEER REQUIREMENTS ONLY

- 1. HIPPA Training and Corporate Compliance Training completed

Date *Signature of Auxiliary Tester*

- 2. Orientation completed

Date *Signature of Auxiliary Records Coordinator*

EMPLOYEE HEALTH/HR REQUIREMENTS

- 1. First TB test completed

Date *Signature of Employee Health Nurse*

- 2. Second TB test completed

Date *Signature of Employee Health Nurse*

- 3. Vision exam (for drivers only)

Date *Signature of Employee Health Nurse*

- 4. Released to volunteer by Employee Health

Date *Signature of Employee Health Nurse*

LRMC Employee Health
550 E. Dixie Dr.
Leesburg, FL 34748
(352) 323-4117
Fax (352) 323-4189