



Lakewood Ranch Medical Center

www.lwrmc.com/volunteers

Thank you for your interest in participating in the VolunTEEN Program at Lakewood Ranch Medical Center.

Volunteering requires a sincere interest in people and helping others, a sense of responsibility and dependability and a professional and positive attitude about your commitment to the hospital, its patients and visitors.

To become a VolunTEEN at Lakewood Ranch Medical Center, you need to complete a **Four-Step** process. There is limited space available, and acceptance into the program will be determined upon successful completion of the requirements listed below.

Please note that the VolunTEEN program is an 8 week program, starting Monday, June 15th and ending on Friday, August 7th. We ask that all Teens are able to commit to the full 8 week program. If you have a planned vacation, and will need to miss a shift, you will be required to complete an extra shift the week BEFORE your scheduled time out.

Step One: Application Packet- complete packet submitted to HR by March 31st
NO LATE APPLICATIONS WILL BE CONSIDERED.

1. Complete the enclosed application.
2. Have the VolunTEEN's physician complete the Medical Release Form.
3. Complete the TB Test Form and bring with VolunTEEN on June 15th.
4. Send out the enclosed reference forms to be completed (2 references required).
5. Submit a copy of your school immunization records with your application.

Step Two: Interview scheduled between April 1 -8th.

Step Three: Notification of Acceptance into the Program will take place by April 30th

Step Four: Mandatory VolunTeen Hospital Orientation

Monday, June 15th, 9AM-1:00PM, Conference Room 1, Main Entrance

ALL students must get a TB Test between 8:00-9:00AM on Monday, June 15th.

1. VolunTEEN assignments will be given.
2. VolunTEEN will receive your photo ID and volunteer t-shirt on this day.
3. VolunTEEN will do their PPD Test between **8:00am-9:00am.**

**** Parents must accompany all teens for the TB Test.**

Please call Theresa Elconin at (941) 782-2147 with any questions prior to June 15th.

Employee Health office hours:

Monday 7:30am-4:00pm, Tuesday 7:30am-4:00pm, Wednesday 7:30am-11:30am

After all of STEP ONE and TWO requirements are met, you will be notified and an invitation sent for Orientation.

Thank you for your interest in our VolunTEEN Program at Lakewood Ranch Medical Center.

Christina Soderberg
Volunteer Coordinator
941-782-2131

Welcome to Lakewood Ranch Medical Center

Because you have chosen to work in a hospital as a teen volunteer there are some rules and requirements that must be observed in consideration of our patients and staff. Please read them carefully. We know that you will learn many things and provide valuable assistance to our patients and our staff and we want you to enjoy your time here with us. Adherence to these rules will help to assure that your experience as a LWRMC VolunTEEN is a rewarding one.

Lakewood Ranch Medical Center feels a community service responsibility to provide students the opportunity to observe and actively participate in a variety of volunteer service areas in the hospital.

I. Eligibility Requirements:

- 1) Maintain a 2.5 (C+) grade point average and be at least 15 years of age and going into high school or under 18 years of age. Students 18 and older would qualify for the adult volunteer program.
- 2) Must maintain patient confidentiality.
- 3) Must successfully complete the orientation and training programs.
- 4) Must function satisfactorily in the assigned area.
- 5) Must be available to actively volunteer during the assigned time period.

II. Code of conduct: As a VolunTEEN I realize that I am subject to a code of conduct similar to that which binds the professionals in the fields in which I work. The Human Resources Policy and Procedure Manual that outlines this code of conduct can be found in the Volunteer Department Office. I assume certain responsibilities and expect to account for my actions without constant supervision.

III. Supervision and Training:

- 1) Will be under the direction of the Department Supervisor.
- 2) Will agree to training by hospital personnel.
- 3) Will conform to all department and hospital regulations.
- 4) Will stay in the assigned area unless other arrangements have been made by my supervisor or the Coordinator of Volunteer Services.

IV. Work Hours:

- 1) Each VolunTEEN is required to volunteer a minimum of 4 hours per week. Additional days can be added as hospital requirements and the teen's schedule permit. VolunTEEN should be available to commit to the full 8 week program (June 15th, 2016 – August 7th, 2016). **Please see Attendance Requirements.**
- 2) The program is set up to function on a five day week. The program begins each summer after school is out. Upon completion of this program, year-round volunteering is permitted and encouraged.
- 3) A shift consists of a 4 hour block of time. The usual shifts are Monday through Friday, 8 am – noon OR noon- 4 pm. Afternoon shifts from 4 pm – 7 pm and weekend shifts to assist with coverage of the main reception desk may be available as well.

* For those of you that are unable to commit to the 8 week requirement, we have additional opportunities for VolunTEENS to get involved by writing letters or making drawings to send to the troops overseas. One hour will be awarded for every two letters or drawings submitted. Please contact HR for additional information about Operation Gratitude.

V. Meal Vouchers (Tickets) and Breaks:

- 1) VolunTEENs are eligible for one meal ticket for every four (4) hours worked.
- 2) Meal vouchers must be used on the day the teen works.
- 3) Meals may be eaten in the cafeteria or taken home.
- 4) Breaks and lunch or dinner should be taken at the instruction and convenience of your supervisor.
- 5) A fifteen minute break may be taken for every four hours worked.
- 6) Eat or drink only in designated areas. Never eat or drink in the presence of patients or visitors.

VI. Sign In and Report for Duty Procedure: VolunTEENs sign in on the computer at the main reception desk in the lobby and report to their assigned service areas. If unable to report to work or if reporting late, notify the supervisor in your assigned service area. Learn your supervisor's telephone number.

VII. Attendance Requirements: The successful operation of the VolunTEEN Program depends largely on the attendance of the teens. Departments that have requested a teen volunteer expect that teen to be present at the mutually agreed upon time. Failure to notify your service areas supervisor of an absence is considered a No Show.

- 1) One No Show- preventative counseling
- 2) Two No Shows- verbal warning
- 3) Three No Shows- dismissal from the VolunTEEN Program

VIII. Pins: VolunTEENs will receive achievement pins after completing 100 hours of service.

IX. Uniform Standards:

- 1) Uniform: VolunTEEN shirt or smock (furnished by the Volunteer Department) with khaki slacks (no jeans, shorts, Capris, baggies or tights). Always have a clean uniform. If you are not in the proper attire, you will be sent home.
- 2) Shoes: low-heeled, clean white or neutral shoes or sneakers, toes and heels must be covered. Sandals and open toed shoes are not permitted.
- 3) Name badges are to be worn anytime the teen is in the hospital. They should be worn high enough to be read easily, and always above the waist. Name tags must be returned to the Volunteer Office at the end of the summer or if resigning your Volunteer position before the end of the summer session.
- 4) Perfumes and colognes are not to be worn. This is a courtesy to those patients or staff that may have allergies.
- 5) Hair must be neat and well kept.
- 6) Jewelry: Earrings and necklaces are permitted.

Lakewood Ranch Medical Center
Volunteer Services Department
VolunTEEN Program Policy Statement

FOR OFFICE USE ONLY

Received: _____

STAFF VOLUNTEER AGREEMENT LETTER

Lakewood Ranch Medical Center, LP, its subsidiaries and affiliates, utilizes docents and volunteers to further enhance the vital link between the Facility and the Community. We rely on individuals, such as yourself, to enhance our programmatic efforts. I want to thank you for your participation, which ensures the continuity of our programs and helps us to continue to meet the challenges within the academic community.

In the event that an accident or injury occurs while providing volunteer services, IMMEDIATELY report to the supervisor and complete the required Employee Accident Report form within 24 hours of the injury. In the event of an injury which requires medical care, volunteers are authorized to seek medical care as follows: Lakewood Ranch Medical Center Emergency Department, Lakewood Ranch Medical Center First Care Walk-in Clinic, or Manatee Memorial Hospital Emergency Department.

ELECTION OF REMEDY

As a condition of my participation in Lakewood Ranch Medical Center’s volunteer service and in consideration for my use of Lakewood Ranch Medical Center facilities and equipment, I, the below named volunteer, hereby understand and agree that in the event I am injured or contract an illness or disease either during my Lakewood Ranch Medical Center’s volunteer service, or subsequent thereto as a result of such service, that I am hereby electing to be covered under the Lakewood Ranch Medical Center’s Workers Compensation Insurance Program as a volunteer for Lakewood Ranch Medical Center, and that the benefits provided by the Labor Code of the State of Florida shall be my **SOLE AND EXCLUSIVE REMEDY FOR ANY AND ALL SUCH INJURIES, ILLNESSES, OR DISEASES**. This election of remedy shall be binding on myself, my heirs, administrators, executors and assigns.

WAIVER, RELEASE & INDEMNITY

In consideration of my use of Lakewood Ranch Medical Center’s facilities and equipment and of my coverage under the Lakewood Ranch Medical Center’s Workers Compensation Insurance Program, I, the below named volunteer, hereby for myself, my heirs, executor, administrators, and assigns voluntarily release, forever discharge, waive, and relinquish any and all actions, claims, or causes of action for bodily injury, personal injury, property damage, or wrongful death occurring or arising out of the course and scope of my volunteer service against Lakewood Ranch Medical Center, LP, its subsidiaries, affiliates, officers, agents, volunteers, and/or employees, whether the same shall arise by contract, the negligence of any said persons, or otherwise. **IT IS MY INTENTION BY THIS INSTRUMENT TO EXEMPT AND RELIEVE THE FACILITY FROM ANY AND ALL LIABILITY TO ME, MY HEIRS, ADMINISTRATORS, EXECUTORS AND ASSIGNS FOR BODILY INJURY, PROPERTY DAMAGE, AND WRONGFUL DEATH CAUSED BY NEGLIGENCE.**

I, the below named Volunteer, for myself, my heirs, my administrators, executors and assigns do hereby agree, in the event any claim for bodily injury, property damage, or wrongful death arising out of my volunteer services shall be prosecuted against Lakewood Ranch Medical Center, LP, to defend, indemnify, and hold harmless Lakewood Ranch Medical Center, LP, from and against any and all such claims or causes of action by whomever or wherever made or presented, except for such claims as may arise from or be caused by the willful misconduct of Lakewood Ranch Medical Center, LP.

Please sign and date the lower portion of this form indicating that you have read and understand your responsibilities as a volunteer. As a member of the Lakewood Ranch Medical Center, you are expected to comply with all policies, procedures and health and safety regulations that the Facility enforces. At the discretion of the Facility, the services of a volunteer may be terminated at any time. Again, your contribution is sincerely appreciated.

Volunteer’s Name (please print) _____

Address _____
Street City State Zip code

Home Phone Number (_____) _____ Daytime Phone Number (_____) _____

Date of Birth _____ Last four digits of Social Security Number _____

Volunteer appointment begins _____ and ends _____
(mo/day/yr) (mo/day/yr) cannot be blank or indefinite

Volunteer’s Signature _____ Date _____

Volunteer Coordinator: **Christina Soderberg** Department: **Volunteer Services** Extension: **22131**

Volunteer Coordinator Signature _____ Date _____



Lakewood Ranch Medical Center

Medical Release Form VolunTEEN Services Volunteer

Name: _____

Physicians Name: _____

Physician's Phone: _____

This individual would like to begin or continue doing volunteer work at the Lakewood Ranch Medical Center. They will require a full recommendation from you, their physician. Please circle "Yes" or "No" for each question below.

Yes No He/she is capable of considerable walking or standing.

Yes No He/she is capable of carrying/lifting 10 pounds.

Yes No He/she is capable of pushing a patient in a wheelchair.

Yes No His/ her physical and emotional health is acceptable for working around patients.

Please list any physical limitations: _____

Date

Signature of Physician

I understand that it is my responsibility to seek medical testing if I am exposed to a communicable disease and to report it to Volunteer Services.

Date

Signature of VolunTEEN

Please fax the completed form to the Human Resource Department at (941) 782 -3471

LAKWOOD RANCH MEDICAL CENTER
EMPLOYEE HEALTH SERVICES

CONSENT --- TUBERCULIN SKIN TEST (PPD)

I voluntarily consent to be tested for tuberculosis. I understand that this will be administered just under the skin on either forearm. I am not aware of ever having a positive reaction in the past.

I acknowledge that I do not have a current or chronic infection at this time.

I have been informed that a localized reaction does not necessarily mean that I have tuberculosis; it could be a reaction to the ingredients of the test.

I understand that the most common side effect is a local reaction, which includes erythema, swelling, warmth, or induration. (These signs and symptoms of local inflammation are generally tolerated well and usually subside within a week or so of having the test).

I understand that there is a very small chance that a local infection could occur.

I agree to have this test read by the health care provider administering the test or a designee of said person within 48 to 72 hours after receiving the test. In the event that I am found to have a positive reaction, I will agree to have a chest x-ray within 24 hours. If I have had a positive reaction in the past, I will be required to receive a chest x-ray rather than the skin test.

I agree to annual PPD testing in accordance with hospital policy.

If I have received the BCG vaccine I will be required to have a blood test or a Chest X-Ray instead of the TB Test.

I acknowledge I have read and understand the above.

Note: A parent or legal guardian must be present for the PPD if the volunteer is a minor.

Printed Name

Signature

Date

(If volunteer is a minor, parent or legal guardian must sign)

**MANATEE MEMORIAL HOSPITAL & HEALTH SYSTEMS
LAKEWOOD RANCH MEDICAL CENTER
EMPLOYEE HEALTH SERVICES**

**TUBERCULOSIS SCREENING (MANTOUX)
COMPLETION IS MANDATORY FOR PROCESSING OF ANNUAL MERIT REVIEW**

Name (Print): _____ Department: _____

Date of Birth: _____

Circle One: Employee Volunteer Physician/Allied Health Sodexo Master Plan (Bio Med)
Circle One: Annual Pre-Employment HHS Exposure Follow-Up

The Center for Disease Control (CDC) states that pregnancy should not exclude a female from being skin tested. If, however, you wish to defer testing until after delivery, you may do so. Date you will return for testing: _____

Check the appropriate response for the following symptoms.

- 1. Unexplained weight loss () Yes () No
- 2. Anorexia (Loss of appetite) () Yes () No
- 3. Fever (Usually at night) () Yes () No
- 4. Night Sweats (Drenching) () Yes () No
- 5. Cough (> 2 weeks) () Yes () No
- 6. Hemoptysis (Spitting up blood) () Yes () No

If you answered yes to any of the above listed symptoms, please explain below.

- BCG is a vaccine given in some countries outside of the United States. (It is not the tuberculosis skin test). Have you ever had a vaccine for tuberculosis (BCG)? () Yes () No If yes, what year: _____
- Have you ever had a "positive" T.B. skin test? () Yes () No If yes, what year: _____
- Have you ever been treated for a positive skin test? () Yes () No If yes, what year: _____ Medication: _____
- Have you ever been treated for active T.B.? () Yes () No If yes, what year: _____ Medication: _____

*If you answered yes to any questions on this form, please discuss with Employee Health Nurse before receiving a TST.

TB Respirator (N95 Mask) Wearers only, please answer the following additional questions:

- Are there any changes in your medical condition that may affect your ability to wear the TB mask?.....() Yes () No
(If yes, a more thorough exam may be indicated.)
- Have you lost or gained 20 pounds or more in the last year?.....() Yes () No
- Have you had any difficulties in obtaining a good seal / fit with your mask?.....() Yes () No

I understand that upon receiving the Tuberculin Skin Test (TST), I must return in 48 to 72 hours for this test to be read. Should the test positive, I must be cleared with a negative chest x-ray and follow up with the appropriate medical evaluation. The Test must be repeated not read.

I also understand that all pre-employment screening requires two step testing. If Mantoux intra dermal T.B. test is more than 1 year old second test 1-3 weeks after the first test is required. My last test was _____ (Date).

I agree to the administration of a T.B. skin test (TST) and / or chest x-ray performed by Lakewood Ranch Medical Center and release by from any liability for any complications, which may possibly arise due to such screenings.

Signature: _____ Date: _____

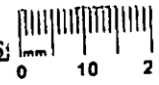
If Minor, Parent / Legal Guardian: _____ Date: _____

Date of test _____ Time _____ Site: (circle) L or R Forearm Given By: _____ Lot _____ Exp.Date _____
Dates due to be read: _____ or _____ >>>>>>>>Date Read _____ Time _____ Result _____ mm Read By: _____
after before

Second test required () Yes () No Manufacturer: _____

Date of test _____ Time _____ Site: (circle) L or R Forearm Given By: _____ Lot _____ Exp.Date _____
Dates due to be read: _____ or _____ >>>>>>>>Date Read _____ Time _____ Result _____ mm Read By: _____
after before

*****To reach Employee Health Nurse please call 782-2147 at LWR or 745-7353 at MMH*****
EMPLOYEE: PLEASE RETURN THIS FORM TO EMPLOYEE HEALTH SERVICES;
MAKE A COPY TO SHOW TO YOUR SUPERVISOR



TUBERCULOSIS

WHAT IS TUBERCULOSIS?

Tuberculosis (TB) is a disease which usually affects the lungs, but can affect other body parts as well. Long ago it was called “consumption”. It can be spread from one person to another.

Some people just become infected. Some who are infected will develop the disease.

THE SKIN TEST:

The purpose of a tuberculin skin test is to tell whether you have become infected with the germs (bacteria) that cause tuberculosis (TB).

WHO SHOULD BE TESTED?

Everyone should have at least one skin test. Persons at high risk of exposure to tuberculosis should be retested at regular intervals. Persons who have been in contact with someone who has active tuberculosis should be tested as soon as possible. Anyone who might be or is infected with the HIV virus should be tested also.

HOW IS THE TEST DONE?

A small amount of harmless tuberculin protein is injected into the surface layers of the skin, usually on the forearm.

WHAT IT SHOWS:

The test site is examined 48 to 72 hours after the test is given. If NEGATIVE or not significant, it usually means you are not infected with tuberculosis germs. However, certain medicines or medical conditions which affect the body’s immunity may cause a false negative test result. Before having the skin test, discuss this with the person doing the test.

If POSITIVE or significant (test site shows swelling, possible redness and/or blistering), it means you have been infected with tuberculosis and you now have the germs in your body that cause tuberculosis disease. It may not mean that you have tuberculosis disease or that you can give it to other people. A chest x-ray, and perhaps other tests, should be done to see if you have tuberculosis.

Occasionally a test will be read as “doubtful”. A repeat test will probably be necessary. The tester will explain why this is needed.

VolunTeen Program Application
Reference Form

Volunteer Department
Lakewood Ranch Medical Center
8330 Lakewood Ranch Boulevard
Lakewood Ranch, Fl 34202

TO BE COMPLETED BY SCHOOL COUNSELOR, TEACHER, OR SUPERVISOR

The student listed below has applied to volunteer at Lakewood Ranch Medical Center. Please assist us by answering the questions below and add any additional comments you consider to be helpful. The permission for the release of confidential information signed by the student and a parent is on the bottom of this form. Thank you for your cooperation by completing this form and returning to the student or mailing directly to our office.

Student's Name: _____

- 1. Is the Student a Responsible Individual: Yes or No
- 2. Scholastic GPA: _____
- 3. To your knowledge has the applicant had any physical or emotional problems that would affect working with patients or visitors at the hospital? Yes or No

If yes, please explain: _____

Additional Comments: _____

Signature: _____ Date: _____

Phone Number: _____

I give permission for the release of any information and /or records requested by the Volunteer Program at Lakewood Ranch Medical Center.

Name of School: _____

Signature of Student

Signature of Parent or Guardian

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Reference Form

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Lakewood Ranch Medical Center
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Signature of Student

Signature of Parent or Guardian