

Thank you for your interest in the 2018 Caring Teen Summer Volunteer program at Houston Methodist Hospital in the Texas Medical Center. Houston Methodist volunteers play a key role in the healing of patients and assisting their families. The necessity for teen volunteers to conduct themselves with a high level of maturity and sensitivity in a hospital environment is vital. Due to the onboarding costs incurred by the hospital for each teen applicant, we have an extensive application screening process. Our program is extremely competitive. An application does not guarantee placement in the program. Incomplete applications will not be accepted nor considered. Please read all instructions and requirements and follow carefully. **This application is strictly for use at the Texas Medical Center location and will not be accepted at any other Houston Methodist locations**

Application Requirements for New Applicants:

- Must be between 15 and 18 years of age on June 4, 2018. Teen volunteers who are 15-years old are subject to shift restrictions outlined in Policy and Procedure VS25, which can be found in the Caring Teen Volunteer Handbook.
- Must complete the 2018 Summer Caring Teen application
- Must successfully complete volunteer onboarding (provided by the Houston Methodist Hospital upon acceptance):
 - Background check
 - Heath Screening
 - Drug test
 - TB screening
 - 2-part Orientation
 - Safety Exam

Application Requirements for Returning Caring Teen Summer Volunteers:

- Returning Volunteers must complete the 2018 Summer Caring Teen application, *if not an 'Active' volunteer*
- Returning volunteers must have completed 2017 program requirements with satisfactory evaluations
- Must successfully complete volunteer onboarding as outlined above

Application Checklist			
	Page #	New Volunteer	Returning Volunteer
		PROVIDED BY APPLICANT	
Copy of applicant's school or government-issued photo ID			
Most recent copy of report card, with B average or above			
		INCLUDED IN PACKET	
Application	2-6		
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Do not submit your application unless you have met all of the above requirements.

The Volunteer Services Department will only consider complete applications with all application requirements. Applicants will receive an email confirmation once **ALL** requirements are met. Most communication is done by email. **Please provide the email address of the teen only.** It is important that communications are handled by the teen directly, so we can have the opportunity to assess the teen's readiness for a volunteer position in our hospital.

The application deadline is **Friday, March 2nd at 5:00 pm.** Applications can be submitted by one of the methods listed below:

Hand Deliver
Houston Methodist Hospital,
6565 Fannin Street, F127
Houston, Texas 77030

Volunteer Services Department

Mail
Attention:
Caring Teen Summer 2018
Houston Methodist Hospital
6565 Fannin Street, F127
Houston, Texas 77030

Email
atoval@houstonmethodist.org

Subject: Caring Teen Summer 2018

Ask for written receipt.

Item must be postmarked before Friday, March 2nd

New Volunteer

Returning Volunteer

Office Use Only
Received By Staff:

Method: Hand
Delivery, Email, Mail

Date Received:

Deadline for Applications: Friday, March 2nd, at 5:00 pm

Name: _____ Telephone: _____

Address: _____ Email: _____

(Must be teen's email, not parents)

City: _____ State: _____ Zip Code: _____

DOB: _____ Age (on April 9, 2018): _____ Shirt Size (Circle One): SM M L XL XXL

Prior Volunteer Experience: _____

Why do you want to volunteer at Houston Methodist Hospital? _____

What do you want to gain or learn from your volunteer experience at Houston Methodist Hospital? _____

What are your areas of interest within Houston Methodist Hospital? _____

Do you know an employee at Houston Methodist Hospital? ____ Yes ____ No

If so, what is their name? _____ Relationship _____

Department: _____ Contact Number: _____

Special talents, hobbies, or interests: _____

What other activities will you be involved with this summer? Will these interfere with your volunteer schedule?

Tell us what good volunteer service means to you?

Please write/type a **150-200 word essay** describing how volunteering at Houston Methodist Hospital for the summer of 2018 will personally impact you. In addition, please explain why we should select you as a candidate to volunteer. Applicants will be assessed on originality, strength of ideas, and grammar.

Volunteer Availability:

Volunteer Shift Times:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<i>Are you available to start at 6:30am?</i>							
8am-12pm							
10am-2pm							
12pm-4pm							
2pm-6pm							
4pm-7pm							

The Caring Teen Program runs **June 4th to August 17th**. Please check the day(s) of the week and shift(s) that you are available to volunteer.

Please note: If accepted as a Caring Teen Volunteer, you are making a commitment to volunteer for a minimum of six (6) **CONSECUTIVE** weeks during this period and to complete a minimum of 60 volunteer hours. Volunteer assignments will be the same day/same time each week. Failure to meet this commitment will prevent participation in future Caring Teen Volunteer programs and your volunteer hours will not be verified.

Volunteers who complete all program requirements with a satisfactory evaluation will receive an hours report and program completion certificate. Those volunteers who complete 100 or more volunteer hours, with a satisfactory evaluation, will be eligible to receive a letter of recommendation.

If I am accepted as a Houston Methodist Caring Teen Volunteer, I understand that I am making a 60 hour and consecutive six (6) week commitment to volunteer during the 2018 summer session. I understand that I must complete my commitment to be invited back for future volunteer assignments and have my volunteer hours verified. I am also required to complete the onboarding process prior to start date including, but not limited to: a 2-step volunteer orientation, health screening, LMS Safety Exam, background check and new volunteer training.

Volunteer Signature

Parent/Guardian Name (If Volunteer Under Age 18)

Parent/Guardian Signature (If Volunteer Under the Age of 18)

Have you ever been convicted of or been on deferred adjudication for, or are you now either awaiting trial for or on deferred adjudication for, a felony or misdemeanor? Yes No

Convictions will not necessarily bar volunteer service. If yes, describe, including dates and locations:

Public Law 91-508 requires that we advise you that a routine inquiry may be made which will provide information concerning your character, reputation and personal characteristics, and mode of living. You may obtain a copy of this information upon written request.

I hereby certify that the information I supplied in this application is true, complete and correct to the best of my knowledge and I understand that any information I withheld or falsely provided in connection with the foregoing shall be cause for rejection of this application or termination of volunteer status. I hereby authorize the Houston Methodist Hospital, without liability, to contact prior employers (present employers if authorized) schools or references I have given and authorize said employers, schools, or references to make full response to any inquiries by the Houston Methodist Hospital in connection with this application for volunteer service.

I understand, and agree that as a condition of my acceptance in the Houston Methodist Hospital Volunteer Program, I will be required to pass scheduled physical examinations as they relate to my ability to discharge my duties. I HAVE READ AND UNDERSTAND, AND AGREE TO THE FOREGOING PARAGRAPHS.

Volunteer Signature

IF ACCEPTED AS A METHODIST VOLUNTEER, I AGREE THAT:

1. I will use confidential information, only as needed to perform my volunteer duties. I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to the Houston Methodist Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.
2. My services are donated to the hospital and given for humanitarian, religious, or charitable reasons.
3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off of hospital property, or act as a runner or capper for an attorney in the solicitation business. I shall report all known occurrences of solicitation for attorneys to the Director of Volunteer Services.
4. I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petition on hospital premises unless I receive the express authorization of the Director of Volunteer Services to engage in these activities.
5. I shall submit to the physical screenings, which may include chest X-rays, skin test, and appropriate laboratory test, as a condition of my acceptance into the volunteer program. I also authorize the person(s) performing tests or x-rays films to report the results to the hospital.
6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
7. I shall attempt to resolve any problems related to my volunteer activities with my unit/department supervisor, and, if unsuccessful, attempt to resolve any such problems with the Director of Volunteer Services.
8. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
9. I shall at all times uphold the mission of the hospital.
10. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) 3 absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the department Director, would make my continued service as a volunteer contrary to the best interests of the hospital.

I have read all of the above conditions and I agree to adhere to them.

 Volunteer Signature

 Parent/Guardian Name (If Volunteer Under Age 18)

 Parent/Guardian Signature (If Volunteer Under Age 18)

YOUR NAME _____

CONFIDENTIALITY AGREEMENT

I agree to use confidential information only as needed to perform my volunteer duties. This means I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to Houston Methodist Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.

Volunteer Signature _____

Today's Date _____

CONFIDENTIALITY

Houston Methodist Volunteer Acknowledgement Form

By signing this acknowledgement form, I am agreeing that I am volunteering my services to the Houston Methodist Hospital System for civic, charitable, and/or humanitarian reasons.

I have no expectation nor have I been promised compensation for these services, with the exception of de minimum benefits offered to all Houston Methodist volunteers such as free parking; hospital cafeteria discounts; free flu shots, TB screening, and CPR certification; letters of recommendation; and participation at special events for volunteers on Houston Methodist premises.

I am volunteering my services to Houston Methodist freely and without coercion.

I also fall in one of the following categories and have initialed it accordingly:

- I am not employed by any entity of the Houston Methodist Hospital. I understand that should I become employed by Houston Methodist at any entity my volunteer services must be reviewed by HR before I can continue.

- I am employed by the Houston Methodist Hospital but the services I am providing as a volunteer are not the same or similar to the services I provide in accordance with my job responsibilities as an employee. I understand that my volunteer services must be approved by HR before I may begin providing them.

Name of Volunteer (Printed)

Name of HMH Witness (Printed)

Signature of Volunteer

Signature of HMH Witness

Date Signed

Date Signed

Immigration and Export Control Compliance Questionnaire for Non-Employees (Unpaid Persons)

It is the policy of Houston Methodist Hospital System to comply with all Immigration and Export Control Laws and Regulations. Therefore all Visitors, Students, Observers, Volunteers and other *Unpaid Persons* providing services or participating in activities at Houston Methodist Hospital System must complete this questionnaire before being granted access to our facilities.

- Without specifying a particular category, do you fall into any one of the following U.S. citizenship/immigrant categories: (i) U.S. citizen or national; (ii) Lawful permanent resident (i.e. green card holder) of the U.S.; (iii) Person granted U.S. refugee or asylee status?

Circle the correct answer: Yes No

If you answered "Yes" to Question #1, **stop here** and return the form to the TMHS contact who gave it to you.

- If you answered "No" to Question #1, Please complete the attached FOREIGN NATIONAL INFORMATION FORM and also answer the question below (yes/no):**

Please indicate if you are a national, citizen, or permanent resident of one or more of the following countries: *Cuba, Iran, North Korea, Sudan, or Syria.*

Circle the correct answer: Yes No

 Printed Name

 Date

 Signature

 Passport #, ITIN, or Last 5 of SSN

FOR OFFICE USE ONLY:

- Will the individual be participating in an unpaid activity (i.e. observership, trainee program, volunteer assignment, internship, etc.) in any of the following areas: *TMHRI, IT-Security Biomedical Engineering or FMS?*

Circle the correct answer: Yes No

- Is the individual participating in a trainee program (as defined by HR 44) through Methodist International?

Circle the correct answer: Yes No

 Printed name of Houston Methodist employee
 completing questions 3 and 4 above

 Date

 Signature

 TMHS User Id.

Instructions: If the individual answered "Yes" to #1 please file in the department file ONLY and stop here. If the individual answered "No" to #1 and answered "Yes" to # 2, 3 OR 4, **scan & email to: exportcontrol@tmhs.org with a completed Foreign National Information Form (FNIF) attached.** If the individual answered "No" to #1 and answered "No" to #2, #3 AND 4, send Questionnaire and FNIF (a) by email to HR-Immigration@tmhs.org and (b) originals via interoffice mail to HR Immigration Services, Greenbriar GB162. Save a copy of this page ONLY (not the FNIF) in the department file.

Caring Teens Program Participation Parental Consent

The Houston Methodist Hospital Caring Teen Volunteer Program is intended to encourage students to explore a variety of career pathways. It is our desire that participation in the program inspires teen volunteers to expand their leadership skills, accountability, and self-dependence.

We expect teen volunteers to be interested and enthusiastic about what they are doing. It is important to be independent and comfortable talking to adults. There are many rules regarding infection control, confidentiality, and interacting with patients – it is of vital importance to pay attention to this information and follow regulations. Volunteer Services staff and department mentors expect teen volunteers to follow directions and demonstrate maturity and respect.

While we appreciate teens’ interest in specific areas, capacity is limited and we must respond to the needs of the hospital. We make every attempt to place teen volunteers in at least one of their areas of interest, but will also balance hospital need and assignment availability.

As a parent, you may facilitate your teen’s growth through participation in this program by:

- Allowing your teen to handle **ALL** communication with HMH staff regarding their Caring Teen Volunteer opportunity. Teens who are unable to handle communication without help from parents may not be best suited for our program, which may ultimately impact their final acceptance into the program.
- Refraining to visit your child while they are on duty, if there is a reason to do so please contact the Volunteer Services office first. You are not permitted to sit in on onboarding requirements or to enter hospital administrative, customer support, or clinical areas to supervise/visit your teen. You may, however, accompany your teen to the employee health clinic. Repeat issues of escorting or visiting teens’ assignments may result in their termination from the program.
- Encouraging them to indicate preference in areas that are of interest to them to broaden their knowledge of potential healthcare careers. The healthcare field is vast and career opportunities span greatly.

By allowing participation in this program you are agreeing to let your teen demonstrate maturity by acting independently in regard to program communications and requirements. Thank you for partnering with us to make this experience an enjoyable one.

Name of Child

Date

Name of Parent of Guardian

Signature of Parent or Guardian

CONSENT TO BE PHOTOGRAPHED OR VIDEOTAPED

I, _____ (print name) consent to have photographs or videotapes taken of me by Houston Methodist Hospital Volunteer Services employees or volunteers.

Signature (parent or guardian signature if minor)

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PHOTOGRAPHS OR VIDEO IMAGES

I, _____ (print name) authorize Houston Methodist Hospital to use and disclose photographs or video images taken of me by Houston Methodist Hospital Volunteer Services employees or volunteers for the purpose of publishing and republishing in newsletters, brochures or any other purpose which Houston Methodist Hospital may deem appropriate. I understand and agree that my identity may or may not be released. I agree to hold Houston Methodist Hospital, its employees and volunteers harmless from any and all liability arising from these activities.

This authorization is valid from the date of my signature, unless I specify otherwise. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so by sending or faxing a written revocation to Director of Volunteer Services. I understand that the revocation will not apply to information already released in response to this authorization.

I understand that if the recipient of this information is not covered by Federal or Texas privacy laws, this information will not be protected under these laws once it is disclosed and, therefore, may be subject to re-disclosure by the recipient. I understand that photographs or video images of me taken by the media may be used for any purpose in which the media may deem appropriate.

Signature (parent or guardian signature if minor)

Date

Employee Health Clinic
6550 Fannin Street, St. 555
Houston, Texas 77030
Clinic: 713.441.1391
Fax: 713.441.7200

Houston Methodist Employee Health Parental Consent Form

To whom it may concern:

Parental consent is granted to the Acting Physician of the Employee Health Clinic of Houston Methodist Hospital, and to other physicians from which he/she may request consultation, to accomplish physical examinations (to include drug screening), Diagnostic test, X-rays, Immunization procedures, and to prescribe treatment that is deemed necessary for

Name of Child

Date

Name of Parent of Guardian

Signature of Parent or Guardian

Houston Methodist Volunteers # 3114
VOLUNTEER INFORMATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ / _____ / _____ Date of Birth¹ _____

Email address: _____ (Provide if you prefer to receive information via email)

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

*Have you ever been convicted of a crime? Yes No (Please attach a separate sheet of paper to provide additional entries)

Offense _____ County _____ State _____ When _____

Offense _____ County _____ State _____ When _____

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.

(Please attach a separate sheet of paper to provide additional entries)

1. **City:** _____ **State:** _____ **Date From:** _____ **Date To:** _____

2. **City:** _____ **State:** _____ **Date From:** _____ **Date To:** _____

3. **City:** _____ **State:** _____ **Date From:** _____ **Date To:** _____

4. **City:** _____ **State:** _____ **Date From:** _____ **Date To:** _____

STATE LAW NOTICES

Minnesota or **Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING

BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law.

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature: _____ **Date** _____

Parent/Guardian Signature: _____ **Date** _____

¹ The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.
 Nevada Private Investigator License # 1618

**Houston Methodist Volunteers # 3114
VOLUNTEER DISCLOSURE & AUTHORIZATION**

APPLICANT'S FULL NAME _____
Any Other Names Used _____
Social Security No. _____ / _____ / _____ Date of Birth _____
Current Address _____
City _____ State _____ Zip _____
Driver's License State _____ D.L. Number _____
Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The prospective organization ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your volunteering with the Company to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my volunteering, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ **Date** _____

Parent/Guardian Signature: _____ **Date** _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

Ver0813

RECOMMENDATION FORM

Applicant Name: _____

Date: _____

Teacher or Counselor Recommendation (circle one)

His/her grade average is at least a "B" Yes or No

Please evaluate the applicant in the following categories:

Category	N/A	Excellent	Very Good	Average	Needs Improvement	Poor
Promptness						
Emotional Maturity						
Verbal Communication Skills						
Ability to work in a team						
Ability to work independently						
Ability to accept correction/criticism						
Ability to follow directions						
Level of commitment						
Level of responsibility						
Ability to manage stress						

Why would you recommend the above named applicant to serve within Houston Methodist Hospital as a Caring Teen Volunteer?

Teacher/Counselor: _____

Telephone: _____

Email address: _____

School: _____

 Teacher/Counselor Signature

 Date

Letters of recommendation are subject to verification

RECOMMENDATION FORM

Applicant Name: _____

Date: _____

Teacher or Counselor Recommendation (circle one)

His/her grade average is at least a "B" Yes or No

Please evaluate the applicant in the following categories:

Category	N/A	Excellent	Very Good	Average	Needs Improvement	Poor
Promptness						
Emotional Maturity						
Verbal Communication Skills						
Ability to work in a team						
Ability to work independently						
Ability to accept correction/criticism						
Ability to follow directions						
Level of commitment						
Level of responsibility						
Ability to manage stress						

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Email address: _____

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 Teacher/Counselor Signature

 Date

Letters of recommendation are subject to verification