

Thank you for your interest in the Caring Teen Volunteer program, for the 2017-2018 school year, at the Houston Methodist Hospital in the Houston Medical Center. Due to the necessity for teen volunteers to conduct themselves with a high level of maturity and sensitivity in a hospital environment and the key roles that Houston Methodist volunteers play in the healing of patients and assisting their families, we have an extensive application screening process. Our program is extremely competitive. Houston Methodist will only accept complete applications that meet all requirements. Incomplete applications will not be 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. This application will not be accepted for the 2018 summer program.**

**Application Requirements for New Applicants:**

- Must be between 15 and 18 years of age
- Applicants under 18 years old must have parental consent
- Must successfully complete a background check, drug test, TB test, and 2-part orientation (all provided by the Houston Methodist Hospital upon acceptance)
- Must provide a copy of most recent report card, with B average or above (can be from previous academic year, if no report card has been issued for current year)
- Must provide two copies of applicant's school or state issued ID, or passport
- Must provide two forms of recommendation from teacher or counselors (forms included in packet)
- Must complete Pre-Employment Disclosure & Authorization Form (forms included in packet)
- Must complete Volunteer Acknowledgment Form (form included in packet)
- Must complete Immigration and Export Control Compliance Questionnaire (form included in packet)
- Must complete Houston Methodist – Employee Health – Parental Consent Form (form included in packet)
- Must complete the Consent to be Photographed or Videotaped Form (form included in packet)
- Must complete the Background Release Form-Houston Methodist Volunteers #3114 (form included in packet)

**Please do not submit your application unless you have met all of the above requirements.**

Applications may be submitted until December 1, 2017 with applicants being admitted on a rolling basis. 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.** To assess the teen's readiness for a volunteer position at our hospital, it is important that communications are handled by the teen directly.

Please complete the Volunteer Services application packet including all requirements and submit by one of the methods listed below. Please only deliver your application once.

**Hand Deliver**

Houston Methodist Hospital,  
6565 Fannin Street  
Houston, Texas 77030  
Volunteer Services Dept.  
Suite Fondren 127

**Mail**

Attention:  
Caring Teen 2017/2018  
Houston Methodist Hospital,  
6565 Fannin Street, F127  
Houston, Texas 77030

**Email**

[atoval@houstonmethodist.org](mailto:atoval@houstonmethodist.org)  
Subject: Caring Teen 2017/2018

*Ask for written receipt.*

New Volunteer  
 Returning Volunteer

Caring Teen Year-Round Program:  
November 1, 2017-April 27, 2018

**Office Use Only**  
Received By Staff: \_\_\_\_\_  
Method: Hand  
Delivery, Email, Mail  
Date Received: \_\_\_\_\_

**Deadline for applications: Friday, December 1<sup>st</sup>, at 5:00p.m.**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
(must be teen's email, not parents)  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Unisex Shirt Size: SM  M  L  XL  XXL

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Prior Volunteer Experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why do you want to volunteer at Houston Methodist Hospital? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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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: \_\_\_\_\_

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Special talents, hobbies, or interests: \_\_\_\_\_  
\_\_\_\_\_

What other activities will you be involved with this school year? Will these interfere with volunteering here?



If I am accepted as a Houston Methodist Caring Teen Volunteer, I understand that I am making a commitment to volunteer and I am required to volunteer weekly or bi-weekly and complete 40 hours before April 28, 2017. I understand that I must complete 40 hours of service in order for my hours to be verified or to be considered for any future programs.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Parent/Guardian Signature (If Volunteer Under Age 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 Signature (If Volunteer Under Age 18)

**CONFIDENTIALITY AGREEMENT**

**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 \_\_\_\_\_





**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.

1. 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.

2. **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

\_\_\_\_\_ Date

\_\_\_\_\_ Signature    Passport #, ITIN, or Last 5 of SSN

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 \*\*\*\*\*

**FOR OFFICE USE ONLY:**

3. 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

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

**Circle the correct answer:**                      Yes                      No

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

\_\_\_\_\_ 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](mailto: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](mailto: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.

## 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 minimus 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 TMHS Witness (Printed)

\_\_\_\_\_  
Signature of Volunteer

\_\_\_\_\_  
Signature of TMHS Witness

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Signed





**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

### Parental Consent Form

To who 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 Birth<sup>1</sup> \_\_\_\_\_

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** \_\_\_\_\_

<sup>1</sup> 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](http://www.PreCheck.com) [info@precheck.com](mailto:info@precheck.com)  
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

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