July 2017

Dear Student,

Thank you for your interest in Sinai Hospital’s Student Fall Volunteer Program! As a healthcare family dedicated to our community, we are excited to help facilitate your hands-on learning experience.

In 2017, Sinai Hospital’s Student Fall Volunteer Program will begin on September 18. Students are asked to complete at least 100 hours of service before May 2018. The deadline for applications is September 8th. Please request that your Service Learning Coordinator contact Volunteer Services at Sinai Hospital regarding deadline extensions. Note: students must be at least 15 years of age by September 18, 2017, and have completed the 9th grade to be eligible to participate.

The Sinai Hospital Volunteer Application includes an Information Sheet, Student Application Addendum, a Health Screen form, two Reference Check forms, Standards and Expectations Agreement, two Parental Consent Forms, and an Application Checklist. Please complete and return all forms to Volunteer Services at Sinai Hospital in order to be considered for placement.

Please feel free to contact me at (410) 601-5023 if you have any questions regarding your application. Thanks again for thinking of Sinai Hospital!

Sincerely,

Sarah J. Chrzanowski
Volunteer Manager
Sinai Hospital
Volunteer Services
Application Packet
Information Sheet

Please print all information clearly

Name ____________________________ Date of Application __________________
Address ____________________________ Primary Phone # __________________
                     ____________________________ Secondary Phone # __________________
                     ____________________________ Email address __________________
Date of Birth ____________________ Social Security # __________________

Primary Emergency Contact   Secondary Emergency Contact
Name ____________________ Name __________________
Relationship ____________________ Relationship __________________
Phone # ____________________ Phone # __________________

Are you currently a student? Yes/No

If you are a student, are you applying for a position that will count towards any type of service hours or official internship program? Yes/No

If yes, please complete internship application

Are you currently employed by LifeBridge Health? Yes/No

How did you hear about our program? If you were referred, who referred you?__________________

What are your areas of interest? (Check all that apply)

____ Patient Visits/Delivering Flowers  ____ Clerical or Reception Desks
____ Gift Shop or Gift Cart  ____ Special Projects and Mailings
____ Other: __________________________________________

What days and hours are you interested in volunteering?

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Signature: ____________________________ Date: __________________

To be completed by Volunteer Department: Date received:
Reference forms present? Y/N  Background check form present? Y/N  Health form present? Y/N
Sinai Hospital
Volunteer Services
Student Application Addendum

Name ____________________ Age ______ School _________________________

Education level (please circle highest level completed)

9th grade 10th grade 11th grade 12th grade Some college Bachelor’s Degree

Advisor/Contact _______________ Advisor’s phone number _______________

Is this a formal internship program?  Yes/No

Will you be receiving credit for this experience?  Yes/No

What documentation does your school require?

How many hours a week does your program require? _________________

Why are you interested in volunteering at Sinai Hospital? _______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever been convicted of a crime?  Yes/No
If yes, please explain when, where and disposition of case:

To be completed by parent or legal guardian

I authorize Sinai Hospital to give medical treatment to (please print name____________________ in the event of an emergency. I also consent for my child’s participation in the Student Volunteer Program.

Signature of parent or guardian: ______________________________   Date: ______________

To be completed by applicant

I agree that the above information is correct as of the date it has been filed. I also agree to the rules and regulations of the Volunteer Department. I understand that my relationship with the Volunteer Department may be terminated if any of the information I have provided above is found to be false, if I violate the standards and expectations of the hospital and/or if I fail to meet my school/program obligations.

Signature of applicant: ______________________________   Date: ______________
Name: ___________________________ Date of Birth: __________________________

Please give this form to your health care provider for completion, and return to Volunteer Services. The information below is required to volunteer at Sinai Hospital. Tuberculin skin tests can be administered free of charge at Sinai’s Employee Health Office if you do not have one on file within the last year. It is your personal and financial responsibility to provide documentation of immunity to Measles, Mumps, Rubella and Chicken Pox.

Dear Health Care Provider:

The above individual has applied to work as a volunteer at Sinai Hospital of Baltimore. In this role, they may have contact with newborns, children or patients with a compromised immune system. To ensure their safety, along with the safety of our patients, we thank you in advance for providing us with the following information:

1. Tuberculin skin test performed within last 12 months? ____ No ____ Yes
   Date: ________ Result:_________ If positive, last chest x-ray Date: ________ Result: ________

2. Immunization Status:
   Has this individual been vaccinated for:
   Measles, Mumps, Rubella ____ No ____ Yes Date: ____________________
   Chicken Pox ____ No ____ Yes Date: ____________________

3. Please stamp or print Health Care Provider name, including complete address

I have personally evaluated the above potential volunteer within the previous twelve (12) months and find him/her mentally and physically able to perform duties at Sinai Hospital.

Signature of Health Care Provider ___________________________ Phone Number ___________________________ Date ___________________________

I hereby authorize the release of this information to:

Volunteer Department
Sinai Hospital of Baltimore
2401 West Belvedere Ave.
Baltimore, Maryland 21215
Fax: 410-601-2180

Signature of Applicant ___________________________ Phone Number ___________________________ Date ___________________________
Reference Check

Please give this form to a personal or business reference. Once the form is completed and signed, please send it to Volunteer Services.

_____________________ has applied to be a volunteer at Sinai Hospital of Baltimore. Your name was provided as a personal/business reference. We would appreciate your taking a few minutes to answer the below questions about this individual. Any information you give us will be kept private. I have enclosed a return envelope for your convenience. You may also fax this form to the Volunteer Office at Sinai Hospital at 410-601-2180. Thank you in advance for your cooperation.

Length of time you have known this individual __________

How do you know this individual?
   _____ personal friend   _____ co-worker   _____ previous volunteer placement   _____ other: _____________

Do you feel this individual would be an appropriate volunteer in an acute care hospital?
   _____ yes   _____ no

Do you feel this individual has good customer service skills?
   _____ yes   _____ no

Do you feel this individual is trustworthy and reliable?
   _____ yes   _____ no

Comments: _______________________________________________________________________
                  _______________________________________________________________________

Your name (please print) ______________________________ Title ______________________
Signature ___________________________________________ Date ______________________
Phone ______________________________

I hereby authorize the above individual to provide information to Sinai Hospital of Baltimore Volunteer Department.

Applicant name ______________________________
Applicant signature ______________________________ Date ______________________
Please give this form to a personal or business reference. Once the form is completed and signed, please send it to Volunteer Services.

___________ has applied to be a volunteer at Sinai Hospital of Baltimore. Your name was provided as a personal/business reference. We would appreciate your taking a few minutes to answer the below questions about this individual. Any information you give us will be kept private. I have enclosed a return envelope for your convenience. You may also fax this form to the Volunteer Office at Sinai Hospital at 410-601-2180. Thank you in advance for your cooperation.

Length of time you have known this individual __________

How do you know this individual?
___ personal friend ___ co-worker ___ previous volunteer placement ___ other: _____________

Do you feel this individual would be an appropriate volunteer in an acute care hospital?
___ yes ___ no

Do you feel this individual has good customer service skills?
___ yes ___ no

Do you feel this individual is trustworthy and reliable?
___ yes ___ no

Comments: _______________________________________________________________________
________________________________________________________________________________

Your name (please print) ______________________________ Title ______________________
Signature ___________________________________________ Date ______________________
Phone ______________________________

I hereby authorize the above individual to provide information to Sinai Hospital of Baltimore Volunteer Department.

Applicant name ______________________________________
Applicant signature ______________________________ Date ______________________
Student Volunteer Standards and Expectations Agreement

By signing this form, I _____________________ agree to adhere to the following requirements of the Sinai Hospital Volunteer Program:

➢ Complete 100 hours of service during the program period
➢ Report to the Hospital at least two days a week, for four hours
➢ No use of profanity on hospital grounds
➢ Be quiet and respectful of Hospital staff, patients and adult volunteers
➢ Refrain from using all electronic devices and switch them to silent or vibrate at the Hospital
➢ Follow the volunteer dress code while at the hospital, detailed below:

Volunteer Dress Code:

• Wear khaki or black pants - no denim, shorts, or skirts above the knee
• Wear assigned polo shirt (volunteer or school uniform)
• No open toed shoes in clinical areas
• No exposed tattoos
• No large dangling earrings
• Minimal jewelry and makeup

Excessive call outs, tardiness, inappropriate dress or behavior or other violations of the standards and expectations of the program will be grounds for termination from the summer program. Termination may affect a volunteer’s ability to return to the Sinai Hospital Volunteer Program in the future.

__________________________________   _______________
Volunteer Signature      Date

__________________________________   _______________
Parent/Guardian Signature (under 18)   Date

__________________________________   _______________
Volunteer Office Signature     Date
PARENTAL CONSENT FORM

[  ] YES. I freely give my consent for Sinai Hospital to administer a Tuberculin skin test to my child.

[  ] NO. I do not wish for Sinai Hospital to administer a Tuberculin skin test to my child.

Date:______________

PARENTS SIGNATURE

________________________________

CHILD’S NAME

Please mail or fax to:

Sarah Chrzanowski
Volunteer Services
Sinai Hospital
2401 West Belvedere Ave.
Baltimore, MD 21215

Fax: (410) 601-2180
PARENTAL CONSENT FORM

Please note that Sinai Hospital staff and volunteers are required to receive the seasonal flu vaccine this fall, details to follow. The shot can be administered free of charge at Sinai, or documentation from a physician will be required.

[ ] YES. I have freely give my consent for Sinai Hospital to administer the seasonal flu vaccine to my child.

[ ] NO. I do not wish for Sinai Hospital to administer the seasonal flu vaccine to my child.

[ ] My child will receive the flu vaccine from another health care provider, and we will provide documentation.

Date: __________

PARENTS SIGNATURE

____________________________

CHILD’S NAME

Please mail or fax to:

Sarah Chrzanowski
Volunteer Services
Sinai Hospital
2401 West Belvedere Ave.
Baltimore, MD 21215

Fax: (410) 601-2180
The Sinai Hospital  
Department of Volunteer Services  
Application Checklist  

The following are the steps to become a volunteer at Sinai Hospital. Check each step once it has been completed. When all indicator boxes are checked you will then be a Sinai Volunteer!  

1. ☐ Complete and send in your Application Packet.  
   ☐ Application Form  
   ☐ Parental Consent Form (if under 18 yrs and/or attending high school)  
   ☐ Health Screen Form (or copy of vaccination records)  
   ☐ 2 Reference Checks (only 2 required if you are under 18)  
   ☐ TB & Flu Parental Consent Forms (if shots will be administered at Sinai)  

2. ☐ Screening Interview with Volunteer Manager  
   *Note:* The Volunteer Manager will contact you for your interview once your application is received.  

3. ☐ Interview with the supervisor from your potential assignment site. (You will need to schedule this interview.)  

4. ☐ Submit completed Placement Interview Form to Volunteer Services.  

5. ☐ Complete a mandatory online hospital orientation.  
   ☐ Volunteer Training Certificate of Completion  

6. ☐ Have TB screening.  
   *Note:* You may either submit written documentation of your TB screening taken at your wellness center or medical practitioner’s office within the past year or receive the TB screening free of charge at the Department of Occupational Health. This department is located on the fifth floor of the Hoffberger Building, suite 54. The office hours are 7:30 a.m. to 4:00 p.m., Monday through Friday. **Appointments are walk in. Please note there are no TB screenings on Thursdays. Remember, you must return in 48 to 72 hours to the Dept. of Occupational Health to have the TB screening evaluated. Failure to do so will result in a repeated screening. Once you have the TB screening evaluated, please bring a form stating that you qualify to be a volunteer to Volunteer Services.**  

7. ☐ Have picture taken for hospital identification badge.  
   *Note:* Badging must be scheduled with the Volunteer Manager. The Badge Office is located on the ground floor of the main hospital. The office hours are 8:00 a.m. to 3:30 p.m., Monday through Friday. The office is closed for lunch between 1pm and 2pm. You must present a valid picture identification to receive a Sinai Badge.  

8. ☐ Procedure for signing in and out:  
   A. Sign in AND out using the kiosk in Volunteer Services. To report off site hours, call (410) 601-5007, and select option 2.  

9. ☐ Volunteer Benefits: Free parking and 10 percent discount at the GreenSpring Café.  
   ☐ Parking will be assigned during orientation.  
   ☐ You must present your badge to receive a discount in the GreenSpring Café.