

CHILDREN'S HOSPITAL CENTRAL CALIFORNIA VOLUNTEER SERVICES

WORK EXPERIENCE PROGRAM

Work experience is for students who have a specific field of interest and have a required number of hours to fill to enter a program (i.e. Physical Therapy Program). Students will gain basic hands-on experience under direct supervision at all times.

All Work Experience volunteer placements must be pre-approved by the Volunteer Coordinator and the department where the work experience will take place. Students may volunteer in the Work Experience program for maximum of 6 months.

Requirements – Prior to meeting with the Volunteer Coordinator

- Completion of an Application
- Completion of Confidentiality Agreement
- Completion of an I-9 form
- Two forms of ID (*see I-9 form for acceptable forms of ID*)
- One PPD skin test administered and read within the last 12 months
- Proof of immunizations against Measles, Mumps & Rubella (MMR's) – 2 dates
- Proof of immunization against Chicken Pox (Varicella)

Please complete the following forms and obtain the necessary health records before calling to schedule an appointment with Jennifer Fain, Volunteer Coordinator, at (559) 353-5040.

This appointment will take approx. 2 hours, as it will include your orientation to Children's Hospital. You will also be required to provide two (2) proofs of identification. Please review the "List of Acceptable Documents" that is included with the I-9 form.

Thank you for your interest in the Work Experience Program at Children's Hospital Central California.



FOR OFFICE USE ONLY

WORK EXPERIENCE VOLUNTEER APPLICATION

Today's Date: _____

Mr. Mrs.

Miss. Ms.

(Please Check One)

Last

First

M.I.

Address: _____

Number

Street

Apt No.

Home Phone: (____) _____

Cell Phone: (____) _____

City

State

Zip Code

Provide other last names under which you have worked: _____

Are you bilingual? If so, please list the languages you speak: _____

How did you learn about this opportunity? Self CHCC Employee/Volunteer Student Teacher/Professor Other: _____

Name of employee referred by: _____

Are you at least 18 years of age? Yes No Are you under 15 years of age? Yes No

PLACEMENT

What school are you currently enrolled in? _____ Major? _____

For what program or class are you applying for work experience? _____

In which department will you be gaining work experience? _____

How many hours are you required to complete? _____ What is your anticipated start date? _____ What is your anticipated end date? _____

Why did you choose Children's Hospital Central California? _____

EMERGENCY INFORMATION

In case of an emergency, please notify:

Name	Relationship	Telephone Number
		()
		()

Is there any medical information that you would like to share with us in case of an emergency? _____

Work Experience Volunteers at Children's Hospital Central California may have regular access to patients. For this reason, the following information is required:

Have you ever been convicted of a felony? Yes No

If yes, please list the date(s) of the conviction(s) and any facts and circumstances surrounding the conviction. Conviction does not automatically exclude you from the participation in the work experience program. Children's Hospital Central California may consider the nature, date, and circumstances of the offense and whether relevant to the duties of the work experience you will be receiving. _____

Have you ever been arrested on charges of possession, sale, transport, cultivation or selling to a minor any controlled substance, or forging or altering prescriptions? Yes No If yes, please describe: _____

Have you ever been arrested on sex offense charges such as rape, assault with intent to rape, child molestation, or enticement or abduction of a minor for immoral purposes? Yes No If yes, please describe: _____

APPLICANT'S STATEMENT

I certify that answers by me to the foregoing questions and statements are true and correct. I agree to a health screening and understand that placement in the Work Experience Volunteer program at Children's Hospital Central California is contingent upon successfully passing the health screening. I also understand that falsification or material omission of facts on this application may result in the rejection of my application or my dismissal. I also agree that, if accepted, I will abide by the philosophy and all policies and procedures established by Children's Hospital Central California. I understand that either the hospital or I can terminate my role as a Work Experience Volunteer at any time for any reason. I further understand that a copy of this application will be provided to the assigned department should an emergency occur and above information be needed.

Signature

Date



CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES

I, the undersigned, acknowledge that during the course of my voluntary participation or performance of duties at Children's Hospital Central California that I may receive access to confidential information of Children's that is prohibited from disclosure to others.

“Confidential Information” means information provided by Children's that is not commonly available to the general public, or is required by law or regulation to be protected from disclosure to third parties not considered part of the Hospital's “workforce” as that term is defined by federal and state health information privacy regulations such as the Health Information Portability and Accountability Act and the California Confidentiality of Medical Information Act. Confidential Information includes information contained in patient medical records and any other health information which identifies a patient; quality assurance, research or peer review information; and information concerning Children's employees, services or business operations. Such information can be acquired by any means and in any form, written, spoken or electronic.

I agree not to share, disclose or discuss Confidential Information with anyone who does not have a legitimate interest in such information. I will abide by Children's policies and procedures concerning the use or disclosure of Confidential Information and I will contact a Children's representative if I have any questions regarding these policies and procedures.

I will maintain and protect the privacy of Children's employees, medical staff and patients in my use and disclosure of Confidential Information and I will not misuse or be careless with such information.

I understand that any violation of this Agreement or Children's policies related to access, use or disclosure of Confidential Information may result in significant legal ramifications for which I will be held solely responsible with respect to this Agreement.

I acknowledge that I have reviewed all of the information above. I understand that compliance with the principles, policies and procedures expressed above is a condition of my participation and continued presence at Children's Hospital Central California.

Name (please print)

Date

Signature