



8118 Good Luck Road
Lanham, MD 20640
301-552-8060

Dear Youth Volunteer Candidate:

Thank you for your interest in the Volunteer Program at Doctors Community Hospital! Our hospital enjoys working with dependable and friendly volunteers who complement the quality care provided to patients, families, visitors and the community by our existing hospital staff.

The Youth Volunteer Program is open to all persons age 16 years of age and over. You must be able to donate a total of **60 hours** (at least 4 hours of service each week for a minimum of 15 weeks) to participate.

There is a set of **Guidelines for Youth Volunteers** which are included in this packet. Please review these guidelines before you complete the application process.

If you are ready to volunteer, please complete each of the following:

- ◆ Fill out the **Volunteer Service Application** and return it to Volunteer Services.
- ◆ Fill out the **Getting To Know You** and **Health History Forms** and return it to Volunteer Services.
- ◆ You must include **TWO letters of personal reference**.
- ◆ You should also include a copy of your most **current school grades**.
- ◆ Then you must register to attend **ONE** of the required **Volunteer Orientation Sessions**.

Youth & Evening Orientations are held periodically, please call 301-552-8602 to register; you can simply leave a message. The next Orientation is:

Orientation: Wednesday, October 6, 2010 6:00 pm -8:00 pm

All classes will be held in the 5th Floor, DSE Room /North Building, behind the hospital.

We look forward to you being a part of the Doctors Community Hospital Team!

Sincerely,

Mary Dudley
Director, Community Relations/Volunteers

Doctors Community Hospital

GUIDELINES FOR YOUTH VOLUNTEERS

MISSION: The Volunteer Service Department of Doctors Community Hospital has been established to provide an efficient and competent volunteer program which will supplement and complement the quality care provided to patients, families, visitors and the community by our existing hospital staff.

REQUIREMENTS AND GENERAL GUIDELINES:

1. This program is open to all persons 16 years of age and over*. ***You must be able to donate at least 4 hours of service each week for a minimum of 15 weeks (total 60 hours) before a Service Learning Verification Form will be completed and signed by the Volunteer Services Department.***
2. Volunteers are required to return the completed application with **two letters of reference**, from either counselors, teachers, church members, neighbors, etc. and **a copy of your most current school grades**. Volunteers are also required to attend an Orientation session.
3. Youth volunteers are required to have a PPD (T.B.) test prior to starting their volunteer service. This test is given at no cost to the volunteer by our Employee Health Department. **NOTE:** You must be able to return to the hospital 48-72 hours after the test to have it read. Instructions for the PPD will be provided at the Volunteer Orientation session.
4. A uniform is required and must be purchased prior to starting volunteer service. The uniform for all Youth Volunteers includes: Gray Collared Shirt with Doctors Community Hospital Emblem worn with white, navy blue or black slacks (**NO BLUE JEANS**). A name badge will be provided only upon completion of the Orientation program. Name badges and uniforms are to be worn at all times while on duty. Your uniform is to be kept clean at all times. Check should be made payable to EVA.
5. Volunteers must strongly adhere to the **confidentiality and privacy** of patients and staff.

COURTESIES PROVIDED:

1. Volunteers who serve 4 or more hours are entitled to a free meal.
2. Volunteers are welcome to attend any employee social function or training workshop i.e., the Holiday programs, the Employee Cookouts and picnic, etc.
3. Volunteers will receive service awards after 100 hours of service. The service awards will be given annually for 500, 1000, and 2000 hours, etc.
4. Student Service Learning verification forms will be completed and mailed to your home at the completion of your commitment.

* There is a Summer Youth Volunteer Program open to persons 14-18 years of age. The application process for the Summer program begins in April 2011

Doctors Community Hospital Youth Volunteer Service Program Application September – May 2011

◆ Name (Last, First, MI) _____ ◆ Circle one: Mr Miss Ms

◆ Nickname _____ ◆ Social Security No. _____

◆ Street Address _____

◆ City, State & Zip _____

◆ Home Phone _____ ◆ Cell Phone _____ ◆ Other _____

◆ E-Mail _____

◆ Date of Birth _____ ◆ License Plate _____ ◆ State _____

◆ How did you hear about this Volunteer Program? (circle): **1** P.G. Volunteer Center

2 Phoned Hospital **3** Newspaper **4** Word of Mouth **5** School **6** Human Resources

7 Visiting Hospital **8** Website **9** other: _____

◆ Work Status (circle): Employed Unemployed Student

◆ Previous Volunteer and/or Work Experience _____

◆ Are you a returning DCH Volunteer? No _____ Yes _____

◆ Why have you chosen to volunteer? _____

◆ Commitment to Service with DCH: Indefinitely _____ Months _____ Years _____

◆ Availability: (Indicate preferred shift below M=Morning A=Afternoon E=Evening)

 Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____ Sun _____

◆ Do you speak/understand a language other than English (Specify): _____

◆ Are there any limitations to your activities: No_____ Yes (explain)_____

◆ Skills/Interests (*Circle*): 1 Clerical 2 Patient Care 3 Telephone 4 Word Processing
5 Typing 6 Cashiering 7 Verbal Skills 8 other_____

Mother's Name: _____ Work Phone: _____ Other phone _____

Father's Name: _____ Work Phone: _____ Other phone: _____

◆ Person(s) to call in an Emergency if other than the above parents:

Name_____ Relationship _____

Telephone: Home_____ Work _____ Other_____

Name_____ Relationship _____

Telephone: Home_____ Work _____ Other_____

◆ Family Physician Name_____ Telephone_____

I authorize the use of any information in this application to enable the hospital to verify my statements, and I authorize my present employer and any other persons to answer all questions asked by the hospital concerning my ability, character and reputation.

◆ Applicant's Name (print) _____

◆ Applicant's Signature_____ ◆ Date_____

PARENTAL CONSENT

I understand that my child has applied to be a volunteer at Doctors Community Hospital. I have discussed the services to be performed and the responsibilities involved, and have given my permission for her/him to be a volunteer for the hospital.

Parent Signature_____ Date_____

Relationship_____

NOTE: **Be sure to attach – The TWO letters of reference and a copy of your latest grades. Also, call to register for one of the Orientation Sessions.**

Return To: Volunteer Services
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706

Phone: 301-552-8602

**Doctors Community Hospital
Youth Volunteer Program**

Getting To Know You

Name_____ Age_____

School_____ Grade_____

E-mail_____ Phone_____

Current Career Goals: Non-Healthcare Career Healthcare Career
(circle one)

Have you completed your Service Learning hours: No Yes
If yes, how many?_____

Describe your specific career interests:_____

List Hobbies / Sports Activities / Clubs / Other Volunteer Work, etc.

Why did you choose to do your volunteer service at Doctors Community Hospital?

List TWO things you will like to learn by doing volunteer service in a hospital:

1)_____

2)_____

Doctors Community Hospital Volunteer Health History Form

Volunteers & Parents:

In order to protect both ourselves and our patients, it is necessary to have on a file a complete immunization record of all volunteers. The information below has become a mandatory requirement for all volunteers. The completed form with dates noted must be submitted on Orientation Day.

Name: _____

Date of Birth: _____

Have you had the following?

Chickenpox:	No	Yes
Mumps:	No	Yes
Measles:	No	Yes
Rubella:	No	Yes

Have you been vaccinated against the following?

Chickenpox	No	Yes	Date:	Booster Date:
Mumps:	No	Yes	Date:	Booster Date:
Measles:	No	Yes	Date:	Booster Date:
Rubella:	No	Yes	Date:	Booster Date:
DPT:	No	Yes	Date:	Booster Date:
Polio:	No	Yes	Date:	Booster Date:

Date of Last Tetanus: _____

Parent's Signature: _____