2022 Student Volunteer Program

Please complete the Online application by **May 16** to be considered
STUDENT ONLINE APPLICATION-CLICK HERE

Thank you for your interest in our Student Volunteer Program, we believe this is a great opportunity for students to grow and develop professionally. We make every attempt to place student volunteers in their first camp choice, however, this cannot be guaranteed. Please complete all applicable forms in this packet and return to Volunteer Services by mail or e-mail **no later than May 16** (address below).

Commitment
The summer program will consist of 4 camps – students will volunteer during one camp, Monday-Thursday from 8:00am-4:30pm. They will have the opportunity to experience and assist in 8 different clinical and non-clinical departments and will earn 40 hours of volunteer service. Students will have the option to select their camp week in Form 1 and can sign up for more than one camp if space permits.

Consent (Form 1 - return with packet)

User Agreement and Confidentiality Statement (Form 2 – return with packet)

Criminal Record Check (Form 3 – return with packet if 16 years or older)

Occupational Health (Form 4 – return with packet if under 18 years old)
Please provide a copy of your immunization records with your packet. Required immunizations include; **1.** Covid vaccine Two Pfizer, Two Moderna, or One J&J, (2), **2.** Two MMR vaccines, **3.** Two Varicella (Chicken Pox) vaccines, and **4.** One TDAP vaccine. Positive blood titers are acceptable for the MMR and Varicella. Three Hepatitis vaccines are recommended, but not required. Documentation of a TB skin test if completed within the last year.

TB Screening
All volunteers are required to receive their first TB test on one of the walk-in dates listed below. If you are under 18 years old a parent/guardian must accompany you to this appointment. This is a walk-in service.

- Monday, May 23, 3:30-5:00pm, Outer Banks Hospital Lobby (reading 48-72 hours later)
- Tuesday, May 24, 3:30-5:00pm, Outer Banks Hospital Lobby (reading 48-72 hours later)

We require two TB skin tests, one must be provided by our Occupational Health nurse at a date listed above and the other must be completed within 7-21 days from a provider of your choice.
We are offering a second TB screening on the following date:

- Monday, June 6, 3:30-5:00pm, Outer Banks Hospital Lobby, (reading 48-72 hours later)

Orientation – Tuesday, June 14, 3:30-5:30pm
All student volunteers are required to attend orientation. Dress code is business casual. Enter the hospital at Main Entrance and we will meet in the Main Lobby.

Return packet to:
Volunteer Services
4800 S. Croatan Hwy, Nags Head, NC 27959
OBHVolunteers@theobh.com
252-449-4550

2022 Student Volunteer Program

THE OUTER BANKS HOSPITAL

Student Information	
First Name	
Last Name	
Preferred Name	

Camp Week	Preference (1=first choice)
June 11-14	
June 18-21	
June 25-28	
Aug. 1-4	

Camp Information:
Students will volunteer from 8:00am-4:30pm, Monday-Thursday during their assigned week. The volunteer should be able to commit to the entire camp as this is an immersive experience and we have a limited number of openings available. Please rate your preference 1-4 (1 being your first choice). Please N/A next to any weeks you are not available. If there is space and you are interested in volunteering in more than one camp, check the box below.

☐ Check if you may be interested in an additional camp.

☐ Check here if you are unable to attend the camp and are interested in a regular, 4 hour shift a week from June 11-Aug 4. We have a very limited number of these shifts and cannot guarantee placement into the program. Please provide reason here: _____

Parent/Legal Guardian Consent to Participate:

I, _____, give permission for _____
(Parent/Legal Guardian) (Student Volunteer)
To participate in The Outer Banks Hospital 2022 Student Volunteer Program.

Student volunteers are required to comply with all policies, procedures, and behavioral standards – failure to remain compliant can result in dismissal from the program. In addition, student volunteers should consider the program level of commitment and dedication required. I understand that letters of recommendation will only be provided to students in good standing at the conclusion of the program.

Signature:

Parent/Legal Guardian: _____ Date: _____

2022 Student Volunteer Program

Student Information	
First Name	
Last Name	
Preferred Name	

Conduct Expectation:

_____ (initial) DRESS REQUIREMENTS I understand that appropriate attire for the experience includes at a minimum; slacks, skirts, with the provided volunteer polo. Wear clean closed toe shoes, no open toe or open heel shoes will be allowed. Clothing should not be excessively tight or excessively baggy. Ripped, torn and dirty clothing is not appropriate. No scrubs. (NOTE – some units may issue sterile scrubs to be worn once on-site). If I am deemed to be dressed inappropriately, I understand that I will be asked to leave the premises.
_____ (initial) PROMPTNESS AND RELIABILITY I understand that it is important to arrive at the agreed upon time. Staff is anticipating my arrival, and I am expected to allow myself plenty of time for parking, walking time, and location of the unit. If I am going to be late or unable to come on the designated date, I need to contact Volunteer Services.
_____ (initial) PROFESSIONALISM I understand that I must behave in a courteous manner at all times. Cell phone usage is not allowed during the experience. I will turn the device off while on campus. If at any time my behavior is considered inappropriate or not in compliance with Vidant Health rules and regulations, I will be asked to leave. I understand that Vidant Health expects that I exhibit a positive and engaged attitude.
_____ (initial) INFECTION CONTROL I agree that I do not, to the best of my knowledge, have an infectious disease or a contagious health problem that might or could risk a patient's or team member's health at a Vidant Health entity. I agree to immediately notify the entity and do so before coming on site if I contract or become aware that I have a health problem that might put at risk the health of a Vidant Health patient or team member. I agree to follow all Personal Protective Equipment/Safety guidelines (masking, screening, safe distancing) while on Vidant Health premises.
_____ (initial) CONFIDENTIALITY I agree to not repeat or otherwise share confidential patient information as required by related state and federal laws. I understand that this includes patient names, health related information or any patient-specific information I come in contact with during my experience. I will only make known this information as allowed by law after contacting Volunteer Services.

THE OUTER BANKS HOSPITAL

RELEASE AND WAIVER FROM LIABILITY:

I voluntarily release Vidant Health, its successors, assigns, affiliates, subsidiaries, directors, officers, agents, and team members ("Vidant Health") from all liability for any claim or cause of action, I, my heirs, or assigns, might now or hereafter have for injury, loss, damage, or death arising out of, or incident to, my shadow experience. I agree to hold Vidant Health harmless from all claims, losses, liability, and demands that may be realized due to my negligence, gross negligence, willful misconduct, or violation of this Agreement. I understand that the privilege of being allowed to observe depends on my executing and complying with the Agreement. I understand that this privilege may be revoked or modified at any time without cause or prior notice at the entity's sole discretion. I have read and understand this Agreement as well as the Release and Waiver from Liability.

PARTICIPANTS MUST COMPLETE and SIGN BELOW:

I hereby consent to follow all of the rules set forth in this Agreement. I realize I must act responsibly and professionally in this role, and I also understand that I am to act as a volunteer only and am not permitted to act in any role other than what has been approved by Volunteer Services.

Student Name:	
Student Signature:	
Date:	

PARENT/GUARDIAN MUST ALSO COMPLETE and SIGN BELOW:

I, the undersigned, herewith consent that my daughter/son may participate with Vidant Health for the Student Volunteer Program, and I expressly release that entity from any and all claims which arise out of the volunteer experience as noted above.

Parent/Guardian Name:	
Parent/Guardian Signature:	
Date:	

Insurance Company Name:	
Policy Number:	
Contact Number:	

The Outer Banks Hospital

Vidant Health

User Agreement and Confidentiality Statement

I understand and will treat all patient information (i.e. medical, personal, social, financial and emotional) and the Outer Banks Hospital business information (collectively, "Confidential Information") acquired during the course of my work/affiliation as strictly confidential. I will only discuss Confidential Information in private and only with authorized individuals who have a medical and/or business-related need to know, whether on duty or off. I am legally responsible for my electronic and written signature and for the accuracy of the information I input into The Outer Banks Hospital medical or business records.

I will access Confidential Information only to the extent necessary to do my job. I understand that retrieving/viewing/printing or otherwise accessing information (electronic or paper), on patients (such as friends, relatives, neighbors, celebrities, co-workers, or myself) is a breach of confidentiality and can result in immediate termination and legal action against me.

I accept complete responsibility for my actions, and I understand that any violation of this Confidentiality Agreement may result in immediate revocation of my access to confidential information, removal from The Outer Banks Hospital premises, disciplinary action up to and including termination of employment, ability to provide services, and/or revocation of my ability to practice at The Outer Banks Hospital. (A member of the medical staff is subject to disciplinary action in accordance with Medical Staff Bylaws.)

My signature attests to the fact that I have read, understand and agree to abide by the terms if this confidentiality Agreement.

Date: _____

Signature: _____

The Outer Banks Hospital Employee

Name: (print) N/A

Employee #: N/A

Department: Volunteer Services

Work Phone: 252-449-4550

Non-The Outer Banks Hospital Employee

Name: (print) _____

Employer: Volunteer

Employer Address: TOBH Volunteer

Approved 7/13/98
Revised 10/22/2003, 9/1/2008, 2/8/2012

Form 3

Only complete if you are 16 years or older

DISCLOSURE/AUTHORIZATION STATEMENT

Vidant Health and its subsidiaries hereby disclose to you that a consumer report may be obtained for employment purposes as part of a pre-employment background investigation and at any time during your employment.

I understand that this document authorizes Vidant Health and its subsidiaries to procure a consumer report as part of a pre-employment investigation of my background. If hired, this authorization shall remain on file and shall serve as an ongoing authorization for any Vidant Health entity by which I am employed to procure consumer reports at any time during my employment period.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, motor vehicle bureaus, military services, government agencies, and persons to release information that they may have about me to Vidant Health or any of its subsidiary, or any agent acting on behalf of Vidant Health or any of its subsidiaries. I hereby release all parties providing such information from any claims, liability, damages and responsibility for doing so.

This authorization, in original or copy form, shall be valid for pre-employment reports and any future reports or updates that may be requested.

I understand that I have the right to request additional disclosure as to the nature and scope of the investigation of my background upon written request to Vidant Health within a reasonable period of time from the date hereof.

I authorize the National Records Center, St. Louis, Missouri, or other custodian of my military records, to release to Vidant Health and its subsidiaries, or any agent acting on their behalf, information or photocopies of my military personnel and related medical records or only the following information/records:

_____	_____	_____
Applicant's Signature	Print Full Name	Date
_____	_____	
Name at Birth	Social Security Number	
_____	_____	_____
Date of Birth	Driver License Number	State

Military Service #:_____ Branch of Service_____ From_____To_____

Form 3

VIDANT HEALTH

Only complete if you are 16 years or older

Criminal Record Check Form

Background checks will be performed on every applicant hired at Vidant Health or its subsidiaries. If the information you furnish on this form is found to be false, you may be disqualified/dismissed, and you may not be considered for future employment/service for up to 18 months.

Please answer the following questions (Check all that apply):

1. **Have you <u>EVER</u> been:**
   a. Convicted of, or pled 'no contest' to, a misdemeanor other than a minor traffic violation? ❑Yes ❑No
   b. Convicted of, or pled 'no contest; to, any felony? ❑Yes ❑No
   c. Excluded from participating in any federal healthcare program by the OIG? ❑Yes ❑No
   d. Subject to having your professional license suspended, revoked, limited or placed on probationary or monitored status? ❑Yes ❑No

IF THE ANSWER TO ANY OF THE FOREGOING QUESTIONS IS 'YES', PLEASE EXPLAIN EACH CONVICTION ON THE NEXT PAGE, INCLUDING DATE, COUNTY AND STATE OR NATION OF CONVICTION. IF NEEDED, ADDITIONAL SHEETS ARE AVAILABLE UPON REQUEST.

2. Please list all names you have ever been known by, including any birth name, previous marital name(s), legally changed name(s), nickname(s) or alias(es).
   (1)_____ (2)_____
   (3)_____ (4)_____
3. Please list street, city and state where you have lived for the **<u>last ten (10) years</u>** including military and school addresses (use additional sheets if more space is needed)

_____ Street	_____ Street	_____ Street
_____ City County	_____ City County	_____ City County
_____ State Zip	_____ State Zip	_____ State Zip
Dates: From_____To_____	Dates From_____To_____	Dates From_____To_____

I hereby certify that the answers on this application and any addendum are true and correct, and that any misrepresentation or false information on my part may disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination. In connection with this request, I authorize all law enforcement agencies, city, state, county, and federal courts to release information they may have about me to Vidant Health and its subsidiaries, or any agent acting on their behalf.

_____ Signature of Applicant	_____ Print Full Name	_____ Date
_____ Date of Birth*	_____ Social Security Number	_____ Valid Driver's License #
_____ Current Address City State Zip		_____ State where license was issue
Dates From_____ To_____		

* Date of Birth is required solely for purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

Only complete if you are 16 years or older

VIDANT HEALTH™

Please use this sheet to explain your conviction(s)

Date of conviction:_____
County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

Date of conviction:_____

County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

Date of conviction:_____

County & State of conviction:_____
Crime for which you were convicted:_____
_____
Explain: (Optional)

CONFIDENTIAL RECORD
Vidant Occupational Health
Demographic Information Sheet for Volunteers

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ **Social Security #** _____

Address: _____
Street/Apartment/P.O. Box

_____ _____ _____
City State Zip

Contact Phone #: (_____) _____-_____

_____ _____
Personal Physician's Name and Address Phone #

_____ _____ _____
Name of Emergency Contact Relationship To You Phone #

Allergies: (Food, Medication, Latex, Etc.) _____

Current Medications: _____

ACKNOWLEDGEMENT OF INSTRUCTION REGARDING ACCIDENTAL INJURY
If you sustain an injury while on duty at Vidant Health, please seek care as needed and contact Vidant Risk Management.

ACKNOWLEDGMENT OF INSTRUCTION REGARDING BLOOD EXPOSURES
All blood exposures are to be **immediately** reported to the Manager/Supervisor/Charge Person **and** Vidant Occupational Health Department where the volunteer will be instructed on the process. If Occupational Health is closed, the Manager/Supervisor/Charge Person will contact the Patient Care Coordinator/Nursing Supervisor **immediately**. The Patient Care Coordinator/Nursing Supervisor will instruct the volunteer on the process.

I have read the above information, and have had an opportunity to ask questions which have been answered. I understand that it is my responsibility to contact Vidant Occupational Health at any time I have a job-related exposure to any communicable disease.

_____ _____
Signature of Volunteer (or parent/guardian if under 18) **Date Signed**

Vidant Occupational Health Clinic

VIDANT HEALTH™

VIDANT MEDICAL CENTER AUTHORIZATION FOR TREATMENT OF MINORS

Hospital Infection Control policy requires documentation of immunization for measles, mumps, rubella, varicella, and tetanus/diphtheria/pertussis, as well as tuberculin skin testing and flu vaccination (during flu season). If adequate documentation is not provided, immunizations and/or lab testing will be required for your child.

Drug screening may be a part of the pre-employment process. It may also be done during employment if there is "reasonable cause."

I, the undersigned parent/guardian of _____, a minor, authorize Vidant Occupational Health Clinic, through its physicians or nurses, to perform required medical screening, drug screening, and/or immunizations in order to comply with hospital policy for employees and volunteers of Vidant Medical Center as outlined above.

Should my child need to be treated for minor illnesses and/or work-related injuries while employed or volunteering at Vidant Medical Center, I give permission for treatment to be administered by the physicians or nurses of Vidant Occupational Health Clinic or the Vidant Emergency Department.

I understand that my authorization lasts until I take back my authorization, which must be done in writing.

_____ _____

Parent or Legal Guardian Date

_____ _____

Minor Minor's Date of Birth

*****RETURN THIS COMPLETED FORM AND IMMUNIZATION RECORDS IF AVAILABLE BY THE END OF YOUR SCHEDULED INTERVIEW/APPOINTMENT****