COOLEY DICKINSON
HEALTH CARE
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

30 Locust St.
Northampton, MA 01061

Tel: 413-582-2000
cooley-dickinson.org

SUMMER HIGH SCHOOL VOLUNTEER PROGRAM

Program Requirements:

- **High School Sophomore or older preferred**
- **Must be age 15 by June 1, 2020**

Application Process

Before submitting an application you need to make sure you can volunteer for 3 shifts per week between **June 29 and August 21, 2020** for a period of 6 weeks. We cannot accept volunteers who cannot make at least a 6 week commitment to the program.

Step 1 – Complete the application. Have your parent(s)/guardian(s) read and sign the Parent Permission form. Make sure you sign the application. Please include **2 letters** of reference or copy and use the reference form provided.

Step 2 – Applications are due: Monday, May 4, 2020 by 5pm

Applications should be mailed to:
CDH Volunteer Department
30 Locust Street
Northampton, MA 01060
Attn: High School Volunteer Program

Step 3 – approximately 20 applicants will be invited to be interviewed. All interviews must be completed by May 31, 2020.

Bring to your interview

1. Photo ID (driver's license or student ID) if you are 18 or older
2. Vacation schedule for the summer
3. Complete Summer High School Volunteer Student Health Record
4. Documentation of a negative TB test within the past 6 months

Step 4 – If accepted into the Summer Program you will need to attend an Orientation and Training session on **Wednesday, June 24th , 2020 from 12:30pm – 5pm**.

Step 5 – The Summer Volunteer Program will start the week of June 29, 2020 and end on August 21, 2020. **You must be able to commit to 6 of the 8 weeks.**

Please note best days and times:

Mon Tues Wed Thurs Fri Sat Sun

COOLEY DICKINSON HEALTH CARE
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

30 Locust St.
Northampton, MA 01061

Tel: 413-582-2000
cooley-dickinson.org

SUMMER HIGH SCHOOL VOLUNTEER APPLICATION

It is the intent of the CDHCC to conform to Federal and State Laws pertaining to non-discrimination.

Mr. Miss. Last Name: First Middle	Home Phone:
	Business/Cell Phone:
Address: No. Street City State Zip	Date of Birth:
Email:	

In case of emergency notify:

Name:	Address:
Relationship:	**Phone:**

Extracurricular, Personal and Volunteer Activities		
Activity	Approximate Time Spent (Hours per week and how long)	Position Held, Honors won

8am-12	☐	☐	☐	☐	☐	☐	☐
12-4pm	☐	☐	☐	☐	☐	☐	☐
4-7:30pm	☐	☐	☐	☐	☐	☐	☐

Please rate your **TOP FOUR** interests on this form by putting a number, 1-4, in the box.

PATIENT CONTACT

☐ **Information Desk (CDH and off-site)**
Escort visitors to appointments, give directions, create a warm and welcoming environment. Looking for friendly, out-going, active workers.

☐ **Rehabilitation—Northampton, Hadley or Southampton (All locations are off-site)**
Stock shelves, collate packets, prepare rooms, clean equipment. Observe some treatments with permission. Looking for mature students interested in healthcare

☐ **Surgical Day Care or Endoscopy**
Stock shelves, collate packets, prepare rooms, escort patients, and give comfort measures. Looking for mature students interested in healthcare.

☐ **Patient Support**
Assist on Patient Units by serving meals, answer call bells, provide comfort measures and help with clerical tasks.

SUPPORT SERVICES

☐ **Coffee Shop**
Work with other hospital volunteers and have fun. Serve drinks, sandwiches and desserts to patients, family members and staff. Volunteers are trained in food handling requirements. Looking for people who enjoy meeting people and who like to work in a busy environment.

☐ **Nutrition Department**
Work with a great team that serves over 300 meals daily. Load trays, clean dishes, equipment. Looking for active, enthusiastic helpers.

☐ **Central Sterile Supply**
Learn about and assist with the sterilization process for equipment used for surgeries and other procedures.

Personal Statement:

What interests you about volunteering at Cooley Dickinson Hospital? What characteristics and skills would you bring to your experience here? In your response, please reflect on any past

volunteer experience you have had.

Previous Employment: List most recent first.

Name & Address:	Position & Duties:	Dates:
1.		From To
2.		From To
3.		From To

Name of School	Level (Sophomore, Junior, etc.)	Year of graduation
High School:		

Have you ever volunteered at CDH before? ☐ Yes
If yes, when? ☐ No

References

Please provide **2 letters of reference**. These can be from supervisors, teachers, neighbors, or others who know you well. They can't be from people related to you.

Vacation Dates

I plan to be out for Vacation the following dates:
(NOTE: Only 2 weeks absence is allowed. Volunteers MUST commit to a minimum of 6 of the 8 weeks.)

_____

_____

Have you ever been sanctioned or excluded or been the subject of a sanction or exclusion proceeding by Medicare, Medicaid or other federal health care program? ☐ Yes ☐ No

Please Read Carefully

All of the above statements are true to the best of my knowledge. Any misstatements are sufficient cause for my dismissal.

I authorize The Cooley Dickinson Health Care Corporation to verify any information presented in this form and to request statements from references. In the event of my volunteering for the Cooley Dickinson Health Care Corporation, I agree to comply with all of The Cooley Dickinson Health Care Corporation's rules and regulations as they may be changed from time to time.

Signature: _____

Date: _____

<u>Please Remember to SIGN your form.</u>

COOLEY DICKINSON HEALTH CARE
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

Volunteer Immunization Documentation Form

Please Print:
First Name _____ Last Name_____

Date of Birth / / Assigned Department: _____Volunteer Services_____

Dear Medical Provider,
Cooley Dickinson Hospital (CDH) is committed to providing a safe environment for its patients from communicable illnesses. Your patient, identified above, is going to be working at CDH and must meet the following requirements.
Please provide/verify the dates as requested below.

1. TB screening within 6 months: Date Planted _____ Date Read _____
   Result in mm _____
   OR
   Date of TSpot/Quantiferon test: _____
   a. If hx of positive TB test: Date of positive test: _____
   b. Date of last Chest x ray: _____ and Result: _____
   c. Does the above patient have any current symptoms of active TB? Yes _____ No _____
2. Measles, Mumps, Rubella: MMR Vaccine #1 date _____ MMR Vaccine #2 date _____
   OR
   Date of Positive Titer for Measles IgG _____
   Date of Positive Titer for Mumps IgG _____
   Date of Positive Titer for Rubella IgG _____
3. Varicella: Varicella Vaccine #1 date _____ Varicella Vaccine #2 date _____
   OR
   Date of Positive Titer for Varicella IgG _____
   OR
   Verbal History of Varicella – must be sure of history Yes _____ No _____
4. Influenza Vaccine covering current flu season Date of Last Flu Vaccine _____

Provider Signature: _____ Date: / /
MUST BE RN, NP, PA, or Physician Provider
Provider Printed Name or Office Stamp:
_____
Work Address:
_____

COOLEY DICKINSON HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

30 Locust St.
Northampton, MA 01060

Tel: 413-582-2000
cooley-dickinson.org

Summer High School Volunteer Program Parent/Guardian Permission

Your son or daughter has applied to become a Cooley Dickinson hospital Volunteer. We are looking for teen volunteers, age 15 or older, who will honor the commitments they make, who will treat information about patients as strictly confidential, who are enthusiastic, pleasant, considerate and honest.

In return we can provide:

- The opportunity to learn work skills
- An environment with interesting people
- A chance to support their community and learn responsibility
- A chance to learn more about health care

For many of our High School Volunteers, the commitment they make to us is also a commitment for you. They count on their parents/guardians to:

- **Provide transportation to and from the hospital**
- **Help ensure their timely arrival**
- **Expect them to do their best in jobs assigned**
- **Not schedule family events or duties at the time they are scheduled to work**

We understand there will be times they can't come, due to illness, emergencies or vacations. We ask that volunteers call their supervisor when they are ill or have an emergency and that they give us as much notice as possible for vacations. High School Volunteers in the summer program are required to attend 6 of the 8 weeks of the program.

- I hereby give permission for my child,

  _____,

  to perform volunteer services at Cooley Dickinson Hospital.

_____
Name of family physician:

_____ _____
Located at: Phone

I grant the hospital permission to provide emergency treatment to my child in the event he/she becomes ill or sustains an injury while serving as a High School Volunteer.

_____ _____
Parent/Guardian Signature Phone

_____
Parent/Guardian – Print Name