2014-2015 School Year Jr.Volunteer Program

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

TO BE CONSIDERED FOR ACCEPTANCE, THE FOLLOWING ITEMS ON THE CHECKLIST BELOW MUST BE TURNED IN BY JUNE 9, 2014:

- ☐ Application
- ☐ Personal Essay
- ☐ Recommendation Form completed by a teacher and returned to you in a sealed envelope
- ☐ Letter of Recommendation written by someone outside of school, excluding family members or guardians
- ☐ Completed Medical Requirement Form

The deadline to submit your packet is MONDAY, JUNE 9th at 4PM!

Ways to submit your application:

*Mail to:
Cincinnati Children's Liberty Campus
Volunteer Services, MLC 16052
7777 Yankee Road
Liberty Township, OH 45044

*Hand Deliver to: Volunteer Services at the Liberty Campus

Important Information:

All volunteers must volunteer the same day, same time, each week for at least 50 hours throughout the year.

Cincinnati Children's

****APPLICANTS WILL BE NOTIFIED ON THE STATUS OF THEIR APPLICATION VIA EMAIL****

Cincinnati Children's

change the outcome®

March 7, 2014

Dear Applicant,

Thank you for your interest in the **2014-2015 School Year Junior Volunteer Program** at Cincinnati Children's Hospital Medical Center. There is a tremendous interest in volunteering at this time of year therefore we receive more applicants than we can accept. Our goal is to provide the most qualified candidates with a placement that is satisfying to them as a volunteer, while being helpful to our patients, families and staff.

We work diligently to provide a safe, nurturing environment for the child and family because being hospitalized can be a stressful experience. We endeavor to find volunteers of the highest possible character. With this in mind, please consider the following guidelines.

As a prospective **2014-2015 School Year Junior Volunteer**, are you able to:

1. Volunteer the same time/day each week for a 2- to 3-hour shift? If you have athletics, clubs, travel, or a work schedule that would prevent you from regular, weekly attendance, please consider another facility.
2. Volunteer for at least 50 hours?
3. Be respectful of the unique needs of the children and families and regard as confidential all information/experiences relating to them?
4. If invited, attend a volunteer interview?
5. If invited to schedule an interview you must bring the following information documented by your physician to your scheduled interview:
   - Results of a 2 Two Step TB test within the past 6 months (you will receive more information about this when invited to schedule an interview).
6. Complete the Volunteer Online orientation (you will receive more information about this at the time of your interview).

If so, we look forward to receiving your application. Please return your completed application packet as soon as possible**. If your packet is only partially complete, it will not be considered for acceptance.**

Thank you,
Cincinnati Children's Volunteer Services

Received_____
Interview_____

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER
2014-2015
Junior Volunteer Application

Date: _____

Name:_____ Soc. Sec. #:_____
*(mandatory)

Address:_____
(House #) (Street) (City) (State) (Zip)

Applicant's Phone Number: _____ _____
(Cell) (Home)

I am at least 15 years old, and have completed the 9th grade. Yes ___ No___ Birthdate:_____
(Mo. Day Year)

Applicant's e-mail address*(mandatory):_____

Person to call in event of emergency:

_____
(Name) (Phone #) (Relationship)

Present school attending:_____

Hobbies & interests:_____

_____

Volunteer experience:_____

_____

Preferred location to volunteer:
Please number in order of preference all that may apply (ex. 1 = most desired).

__ Anderson

___ Drake

___ Eastgate

___ Green Twp

___ Hopple Street

___ Fairfield

___Liberty

___Main Campus (Burnet Avenue)

___ Mason

___ Northern Kentucky

Volunteer Commitment

As a candidate for the 2014-2015 School Year Junior Volunteer Program at Cincinnati Children's Hospital Medical Center:

1. I understand if interviewed and accepted, I must complete the Volunteer Online Orientation.

2. I am committing to volunteering the same day, same time, each week for at least 50 hours.

3. I will be punctual and conscientious in the fulfillment of my duties and if for any reason I cannot come in at the assigned time, I will notify the Volunteer Office and my direct supervisor.

4. I understand that on the day of my scheduled interview I need to bring my completed TB Medical Requirement form that I will receive if contacted for an interview.

5. I will consider as **CONFIDENTIAL** all information that I may hear directly or indirectly concerning the patients & their families.

6. I will conduct myself with dignity, courtesy, and consideration for others.

7. I will endeavor to make my work of the highest quality.

8. I understand that Cincinnati Children's Hospital Medical Center maintains a drug free workplace as required by the Drug -Free Workplace Act of 1988. I understand that the unlawful manufacture, distribution, sale, possession, or use of controlled substance or illegal drugs by Cincinnati Children's Hospital volunteers is prohibited on CCHMC time and in or on Cincinnati Children's Hospital Medical Center's owned or controlled property.

9. I understand that in consideration of patients, Cincinnati Children's maintains a smoke-free workplace. While volunteering, my entire person, including clothing, must be free of smoke.

10. I certify that the facts and information provided by me on this application, and in my volunteer interview, are true and complete and I agree that if accepted as a volunteer, incorrect, incomplete, or falsified information will be grounds for dismissal regardless of when discovered.

11. I agree to observe all Cincinnati Children's Hospital Medical Center's policies and procedures for volunteering at all times.

_____	_____
(date)	(student signature)
_____	_____
(date)	(parent/guardian signature)

For the parent or guardian of 15- to 17-year-old applicants:

I give my permission for _____ to serve as a volunteer at Cincinnati Children's Hospital Medical Center.

Signature:_____ Date:_____
(Parent or Guardian)

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Volunteer Services Staff

Amy Biersack, Manager
Jess Obert, Senior Volunteer Coordinator, Main Campus
Megan Schmutte, Senior Volunteer Coordinator, Liberty Campus
Erika Bussard, Volunteer Coordinator

Cincinnati Children's Hospital Medical Center
Volunteer Services Department
Main Campus 513-636-4096
Liberty Campus 513-803-9302

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Ways to submit your application:

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  Volunteer Services, MLC 16052
  7777 Yankee Road
  Liberty Township, OH 45044

- Hand Deliver to: Volunteer Services at the Liberty Campus

Teacher Recommendation Form

DATE _____

Dear Teacher:

_____ has applied for membership in the Junior Volunteer Program at Cincinnati Children's Hospital Medical Center. Thank you for taking your valuable time to complete this evaluation. Your observations are an important part of this student's application and will be kept completely confidential. Would you please comment on this student's record in the following areas:

Personal Qualities: (Please circle best answer)

Attitude toward school	Excellent	Good	Fair	Poor
Cooperation	Always cooperates	Cooperates	Sometimes cooperates	Poor
Emotional Maturity	Very mature	Age appropriate	Sometimes immature	Very immature
Integrity	Highly trustworthy	Trustworthy	Usually trustworthy	Questionable
Leadership Potential	Leader	Can follow or lead	Leads on occasion	Rarely leads
Reaction to criticism	Excellent	Good	Fair	Poor
Responsible	Very responsible	Usually responsible	Sometimes responsible	Rarely
Self-confidence	Healthy self-image	Needs some support	Seems overconfident	Poor self-image
Self-control	Excellent	Good	Fair	Poor
Sense of humor	Highly developed	Good	Fair humor	Poorly developed
Warmth of personality	Always friendly	Usually friendly	Occasionally friendly	Rarely friendly

Work Skills:

Class participation	Joins in readily	Contributes some	Wants to dominate	Rarely contributes
Ability to work in a group	Always works well	Sometimes	Has difficulty	Has great difficulty
Ability to work independently	Always works well	Needs some help	Needs help frequently	Needs constant help
Completes assignments on time	Consistently completes	Usually completes	Needs additional time	Has difficulty
Follows directions	Easily & accurately	Needs some help	Needs	Rarely
Takes initiative	Always	Usually	Sometimes	Rarely
Attention span	Actively engaged	Attentive	Variable attention	Require frequent redirection

Social Skills:

Peer relations	Role model	Healthy relationship	Occasional problems	Relates poorly
Relationships w/ adults	Courteous	Usually positive	Occasional problems	Shows little respect
Concern for others	Very considerate	Considerate	Usually considerate	Rarely considerate
Attitude toward school	Excellent	Good	Fair	Poor

Classroom Conduct: Please comment on the student's behavior/attitude:

_____

_____

Areas of greatest strengths and greatest needs:

_____

_____

Would you recommend this student for the CCHMC Junior Volunteer Program? Y / N

Evaluator's Name (please print):_____Phone:_____

Evaluator's Signature_____Date:_____Title:_____

Letter of Recommendation

For your application to be considered, you must include a letter of recommendation written by someone outside of school excluding family members or guardians.
Example of people to ask: Employer, Scout leader, Dance instructor, etc.

Personal Essay

For your application to be considered, you must complete a personal essay. The essay must be two full pages typed, double-spaced and written in size 12 Times New Roman Font.

Essay Topic: Please tell us about yourself and why you should be considered for a volunteer position at Cincinnati Children's Hospital Medical Center. Topics to discuss might include extra-curricular activities, academic achievements, community service experiences, future goals, etc.

*****MUST RETURN COMPLETED WITH YOUR APPLICATION*****

CCHMC Volunteer
Medical Requirement Form

(Print) Volunteer Full Name:_____ **D.O.B.**_____

I consent to allow CCHMC Employee Health nurse to speak to my MD regarding medical information received. _____(signature)

The medical Information below must be filled out by your Medical Provider

Physician Name and Address _____
_____
_____

Physician Phone Number _____-_____-_____

_____
Signature of RN or MD completing form

Rubeola #1 ____/_____/_____ (date vaccinated) Rubeola #2 _____/_____/_____ (date vaccinated) or Antibody Titer IGg _____

Mumps #1 ____/_____/_____ (date vaccinated) Mumps #2 _____/_____/_____ (date vaccinated) or Antibody Titer IGg _____

Rubella #1 ____/_____/_____ (date vaccinated) Rubella #2 ____/_____/_____ (date vaccinated) or Antibody Titer IGg _____

*** History of disease is not accepted- Two vaccines or positive titers required- attach copy of titer results to form**

Healthcare Provider Signature _____
(credentials)

Varicella (Chickenpox): List year of disease _____

If no history of chicken pox disease, please list dates for **TWO varicella** vaccinations or a titer

VZV # 1 ____/_____/_____ (date) VZV # 2 _____/_____/_____ (date) or Antibody Titer IGg _____

*** attach copy of titer results to form**

Healthcare Providers Signature _____
(credentials)