VOLUNTEERS

1906 Blake Ave
Glenwood Springs, CO 81601
970.384.6653
email: volunteers@vvh.org

Dear Potential Junior Valley View Volunteer,

We are happy you are interested in becoming a volunteer at Valley View. Valley View is a great place to learn and give back. Junior volunteering is a wonderful experience for young people because it involves learning to work with others in a health care setting and making the needs of others a priority. If a junior volunteer is accepted, they will gain valuable skills in caring for others.

REQUIREMENTS FOR PARTICIPATION include:

- Must be 15 years of age
- Complete the enclosed application before June 7, 2023.
- Complete an interview with the Volunteer Coordinator, or the person designated by the Coordinator.
- Reading and signing the "Parent/Student Commitment" and "Professional Appearance Guidelines "
- Submit two references who are not relatives
- Provide a copy of your immunization records on the day of your TB test and drug screening. **All volunteers must have received two shots of the COVID vaccine.**

Please note that applications for junior volunteering are accepted from the beginning of March to the end of May each year. If you have any additional questions please call the volunteer office at 970.384.6653

We look forward to serving with you!

Sincerely,

Kati Ledall
Volunteer and PR Coordinator
Valley View Volunteer Services

Date Received: _____

VALLEY VIEW

Junior Volunteer Application

Contact Information

Name	
Guardians Name	
Street Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
E-Mail Address	
Do you meet the age required of at least 15 years old?	Yes NO Birthdate:

Availability

What days and hours are you available to volunteer?

	Monday	Tuesday	Wednesday	Thursday	Friday	Weekends
A.M.						
P.M.						

Interests

Why would you like to volunteer at Valley View and what are you hoping to gain from the experience?

Hobbies

What are some extra circular activities that you are involved in?

Date Received: _____

Interests

Where in the hospital would you like to volunteer?

- With Children
- Rehabilitation Services
- In a specialty clinic
- Laboratory
- In patient care areas
- In non-patient care areas
- Administrative tasks
- Customer services

Current summer plans or planned vacation dates:

References – individuals not related to you

Name	
Title	
Email address	
Phone number	
Name	
Title	
Email address	
Phone number	

Emergency Contact

Name	
Relation to Contact	
Home Phone	
Work Phone	
E-Mail Address	

Agreement and Signature

I certify that the above information is true and complete to the best of my knowledge. I realize this information is confidential and may be used to determine my eligibility to serve in patient areas. I understand that I will be required to complete a background check and a health screening including: drug/alcohol testing, TB screening and will be asked to provide immunization records.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

If you have any questions please contact Volunteer Services at 970.384.6653 or volunteers@vvh.org.

VOLUNTEERS

Date Received: _____

Volunteer Agreement

Parents, guardians, and students, please read the following statements and if you are in agreement with these commitments, please sign at the bottom.

1. It is extremely important that students be present for his/her shifts. Students who do not drive and depend on the family car or bus for transportation must have the full support of the family member who is providing their transportation. If transportation is a problem and cannot be assured, this is not the volunteer program for you.

2. An unexcused absence occurs when students fail to notify the director of volunteer services and their department supervisor, that he/she will be absent. Excused absences are those, which are unavoidable and have, been discussed with their department supervisor. One no-call/no-show puts a student volunteer on probation and two no-call/no-shows will result in dismissal from the program.

3. Because of extensive orientation and training, our student volunteers must commit to a minimum of 30 hours in our program, which includes this orientation (please be sure to sign-in).

4. Professional behavior is expected from our student volunteers at all times. Volunteering is a great opportunity for a young person, and is considered “pre-work” experience on a résumé. Professionalism is required, which includes no loud talking, running, inappropriate language, name-calling or dirty joking. A friendly, helpful attitude and the willingness to interact with our employees and patients are an absolute necessity.

5. Professional appearance guidelines must be followed at all times when the student volunteer is on duty. If a student comes to work out of uniform, or wrinkled, dirty clothing, he/she will be asked to correct the situation immediately. This may involve going home to change, or asking a family member to bring clothing to the hospital. Our dress requirements are outlined in the Professional Appearance Guidelines.

6. Respect of property and equipment is an expectation. Any deliberate damaged caused to property will be the responsibility of the guardians of those students who are minors.

We have read this Parent/Student commitment, and agree to its requirements:

Parent or Guardian:

_____

Student Volunteer:

_____

Date: _____

VOLUNTEERS

Date Received: _____

Volunteer Professional Appearance Guidelines

Volunteers are considered to be partners of Valley View. It is of great importance that volunteers dress and behave as a professional. The comfort and well-being of the people we serve must be a primary motivator for our presence here. In an organization that serves the community, our credibility does not come from what we say about ourselves, but from what others say about us.

Good personal hygiene is essential: clean hair, clean nails well-manicured, clean body, clean teeth, and fresh breath. Hair should be appropriately styled (tied back if long). Apply a good deodorant and do not wear excessive perfume, cologne, or make-up.

Student volunteers will all wear the same hospital provided t-shirt. It is your responsibility to have this shirt laundered and kept clean. Your name badge must be worn at all times. Jewelry and hair ornaments should be kept to a minimum and be conservative in nature.

Student volunteers will wear slacks, denim is not appropriate. Female volunteers may wear skirts, which are appropriate in length.

Shoes need to be comfortable. If wearing athletic shoes they must be clean and not look as if they just came from the soccer field. No open toes or sandals are allowed due to safety reasons. Socks or hose must always be worn.

Thank you in advance for presenting yourself in a professional manner.

I have read the guidelines and agree to its requirements:

Student Volunteer:

_____

Date: _____

Date Received: _____

Valley View Hospital

VALLEY VIEW HOSPITAL

Volunteer, Temp., Contract Health Questionnaire

Please fill out the following health questionnaire. These answers remain confidential and are not released from Employee Health without your consent. This information is meant to help us protect the safety and health of you, our patients and our employees.

Name:_____ Birthdate:_____
Mailing Address:_____
City:_____ Zip Code:_____
Home Phone:_____ Department:_____
Private Physician:_____
*If Junior Volunteer Parent's Name _____ Phone:_____

1. Are you allergic to any food or medications? _____Yes _____No
   If yes, please list your allergies:_____

   _____
2. Do you have any chronic conditions that have been diagnosed by a physician? _____

   _____
3. Do you have any physical conditions that would prevent you from volunteering?

   _____
4. Have you ever had a positive tuberculosis skin test? _____
5. Have you ever received the Hepatitis B series?_____ Date:_____
6. Have you had the chickenpox?_____
7. Have you been immunized for measles, mumps and rubella? _____

I verify that to the best of my knowledge the above answers are truthful.

Signature:_____ Date:_____

** ALL JUNIOR VOLUNTEERS MUST PROVIDE COPIES OF THEIR IMMUNIZATION RECORDS

Date Received: _____

Consent to treat form

Parents need to sign the following form to give permission for their son or daughter to have a TB test and drug screening.

CONDITIONS OF SERVICE

HEALTH AND MEDICAL CARE CONSENT: I voluntarily consent to such hospital care involving medical evaluation, psychiatric, diagnostic procedures, and medical treatment as may be ordered by my attending or consulting physicians their assistants or their designees. I understand that this hospital provides only general duty nursing care. If I desire or need special duty or continuous nursing care, I understand and agree that I must make independent arrangements for such care and pay the cost of such care separately. I release the hospital from any liability arising out of the absence of such additional care if needed.

I authorize this hospital and its designees to dispose of and/or preserve for medical diagnostic purposes any organ, product of conception, or other tissue removed during any procedures. I authorize the taking of pictures and their use for scientific, educational, or research purposes.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN: I understand that services provided in this hospital are under the control and direction of my attending physician. All physicians and surgeons furnishing services to the patient, including emergency room physicians, radiologists, pathologists, anesthesiologists and other hospital-based physicians, are independent practitioners and are not employees or agents of the hospital. These physicians are not under the direction, supervision, or control of the hospital and may bill separately for their services. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment and special diagnostic or therapeutic procedures.

RELEASE OF INFORMATION: I authorize Valley View Hospital, its designees, and/or other providers of professional care in the hospital, including emergency room physicians, radiologists, pathologists, anesthesiologists, and other hospital-based physicians, to release such patient and guarantor information from the patient's medical or financial records as may be necessary for the processing of insurance claims; for advance, concurrent, or retrospective review of services; for receipt of benefits; or for continuity of health care. The information may be released to third party payors and their agents and/or to health care providers involved in care rendered in the hospital or in continuing care. I also understand that such information may be released as permitted or required by law. If I receive a trackable medical device which is recalled, I understand and agree that my Social Security number may be released to the manufacturer or distributor as required by the Federal Drug Administration.

FINANCIAL RESPONSIBILITY: I understand and agree that I am totally responsible for payment of all hospital charges and the fees of other professional providers for care rendered to me in the hospital in accordance with the regular (published) rates and terms of the hospital, and that those charges and fees may be due and payable prior to discharge. All patients admitted to the hospital must have made arrangements for 100% coverage of the estimated hospital bill plus any outstanding balance for prior services. The coverage required may consist of estimated insurance coverage, cash, participating credit cards, checks and/or other financial arrangements acceptable to the hospital.

I further understand and agree that insurance deductibles, co-pays, coinsurance, and services that are not covered (or denied) by my insurance company (including Medicare and Medicaid) are payable by patients and may be included in my total balance due at discharge. Verified supplemental insurance is acceptable in lieu of payment.

INSURANCE BENEFITS: The hospital will file an initial claim with the insurance company, or other third-party payor, if I have provided necessary information and any required forms. I agree to cooperate in the processing of claims for insurance or other benefits. I understand that if the insurance company or other payor does not make payment on the claim within forty-five (45) days of submission, it is my responsibility to pay the hospital at that time or make other payment arrangements acceptable to the hospital. If any insurance payment results in a credit balance on this hospitalization, that credit will be applied first to any previous outstanding balance, and the remainder, if any, will be refunded to me.

I authorize direct payment of insurance benefits to Valley View Hospital and other providers of professional care in the hospital, including emergency room physicians, radiologists, pathologists, anesthesiologists, and other hospital-based physicians.

COSTS OF OUTSIDE COLLECTION: Interest on any unpaid balance will be computed at the rate of 10% per annum from the date due until paid. I agree to pay this charge and all other costs incurred by the hospital for collection of any sums due on my account, including any and all collection expenses, court costs, and attorneys' fees.

PERSONAL VALUABLES: The hospital maintains a safe for the safekeeping of money and valuables. I understand and agree that Valley View Hospital shall not be liable for loss of or damage to personal property not deposited in the hospital safe. The hospital reserves the right to inventory items placed in the safe, to refuse to accept items that are unsafe, illegal, or too bulky, and to dispose of items after my discharge if unclaimed thirty (30) days after written notice is mailed to my last known address.

I HAVE READ, UNDERSTAND AND BEEN GIVEN A COPY OF THE FOREGOING TERMS, CONDITIONS, AUTHORIZATIONS, AND CONTENTS AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS. MEDICARE PATIENTS: I ACKNOWLEDGE RECEIPT OF THE MEDICARE NOTICES.

I UNDERSTAND THAT THE PROVISION OF HEALTH CARE SERVICES IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN OR CAN BE MADE TO ME REGARDING THE RESULTS OF ANY EXAMINATION OR TREATMENT THAT MAY BE RENDERED TO ME DURING MY HOSPITALIZATION.

I CERTIFY THAT I AM THE PATIENT OR I AM AUTHORIZED BY THE PATIENT TO EXECUTE THIS DOCUMENT ON THE PATIENT'S BEHALF, AND I ACCEPT THE CONDITIONS OF SERVICE CONTAINED HEREIN.

Patient / Authorized Representative Signature

Date of Signing Time of Signing

Witness

Relationship to Patient

Reason Patient Unable to Sign

CONDITIONS OF SERVICE

BD: / / Age/Sex:?- DOS: / /

ADM.CONSRV

Valley View Hospital
Glenwood Springs, CO

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