

Dear Student Applicant:

Thank you for your interest in becoming a high school student volunteer at Northwest Community Healthcare (NCH). We are especially proud of our Volunteer Program - involving nearly 800 people of all ages, interests and abilities who are all passionate about giving back to the community. Volunteers are an integral part of our organization contributing to a variety of areas throughout the hospital. Students consistently remark that their volunteer experience is meaningful and provides them with a lot of real-life experiences.

Requirements:

- **Commitment to volunteer 50 hours minimum**, approximately 4 hours per week.
- Placed in one position in a department.
- Maintain the same shift day of the week and volunteer time for the duration.
- Student volunteer positions are generally available Monday-Friday from 4-8pm; weekends 8am-8pm. More shifts are available in the summer.

Enclosed:

1. **Volunteer Application** - Please complete both sides.
2. **Medical Release Form** - Completed and signed by family physician. Form can be included with the application or faxed by the physician to (847) 618-4499. (If you have immunization records available, please also submit with the application.)
3. **Medical Emergency Authorization Form** - Signed by a parent.
4. **Background Check Authorization Form** - Signed by applicant and parent, only if student is under 18 years of age.
5. **Student Volunteer Guidelines Form** – Signed by applicant and parent.
6. **Confidentiality Statement**
7. **Volunteer Reference Form** – Needs to be completed by an adult. (Non relative.)
8. **Provide a copy of government issued ID** (i.e. Driver's License). If you do not have a government issued ID, we will accept a copy of your school ID.

Upon receipt of all the required forms, the application will be reviewed based upon interests and availability with our current openings and needs. Interest interviews will be held to learn more about positions. If availability and interests do not match our openings, applications will be placed on file for up to one year. Applications are reviewed on a rotating basis as positions open.

Student volunteer positions are in high demand. Every effort is made to accommodate applicants, however, all are not able to be accepted. The onboarding process to become a volunteer involves many steps and takes on average 2-4 weeks to complete or 3-6 weeks for summer positions.

If you have any questions, please contact Guest Services at (847) 618-4450. Our hours are Monday through Friday from 7:30 am - 4:00 pm. The office can also be reached at volunteer@nch.org. Thank you for your interest in volunteering!

Sincerely,

Kelly Behrens
Guest Services Coordinator
KBehrens@nch.org

NORTHWEST COMMUNITY HEALTHCARE HIGH SCHOOL STUDENT - VOLUNTEER APPLICATION

| | | | |
|--|---|--|-------------------------|
| Name: | | | |
| | <i>LAST NAME</i> | <i>FIRST NAME</i> | <i>MIDDLE</i> |
| Address: | | | |
| | <i>ADDRESS</i> | <i>CITY</i> | <i>STATE</i> <i>ZIP</i> |
| Email: | | | |
| Primary Phone: | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | |
| Secondary Phone: | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | |
| Date of Birth: <i>(Must be 16 years old)</i> | | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male | |
| Parents Name: | | Parents Phone: | |

EDUCATION

| | |
|------------------------|----------------------------------|
| Name of School: | Year in School: |
| Career Desired: | Expected Graduation Year: |

VOLUNTEER PREFERENCES & INTERESTS:

Spring & Fall Semesters – Shifts available to students are weeknight evenings (4-8pm) or weekend shifts (between 8am-9pm), pending availability.
Summer Program – Day and evening shifts on weekday or weekends may be available pending availability.

| | | | | | | | |
|--|--|--|--|---|--------------------------------------|---|--|
| Day Preference(s): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun | | | | | | | |
| Time Preference(s): <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening | Date Available to Start: | | | | | | |
| When do you want to volunteer? (Check all that apply) <input type="checkbox"/> Summer <input type="checkbox"/> Fall Semester <input type="checkbox"/> Spring Semester | | | | | | | |
| Are you volunteering to fulfill a requirement or an assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify class/program name & # of hours: | | | | | | | |
| Why are you interested in volunteering? <i>(3 sentences minimum)</i> | | | | | | | |
| Please list any extra-curricular activities, skills or interests that may help us place you in a volunteer position: | | | | | | | |
| <p>NCH offers many different volunteer opportunities for students. The below list includes general areas. Indicating an interest does not guarantee an applicant a volunteer position. Please select your general interests: <i>(Check all that apply)</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Administrative/Clerical (i.e. data entry, filing)</td> <td><input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc)</td> </tr> <tr> <td><input type="checkbox"/> Discharge/Escort/Wheelchair Assistance</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Information Desk/Way-Finding</td> <td></td> </tr> </table> | | <input type="checkbox"/> Administrative/Clerical (i.e. data entry, filing) | <input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc) | <input type="checkbox"/> Discharge/Escort/Wheelchair Assistance | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Information Desk/Way-Finding | |
| <input type="checkbox"/> Administrative/Clerical (i.e. data entry, filing) | <input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc) | | | | | | |
| <input type="checkbox"/> Discharge/Escort/Wheelchair Assistance | <input type="checkbox"/> Other _____ | | | | | | |
| <input type="checkbox"/> Information Desk/Way-Finding | | | | | | | |

REFERRAL

| | |
|---|--------------------|
| How did you hear about volunteer opportunities at NCH? | |
| Are you acquainted with anyone who is a volunteer or employee at NCH? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name & relationship: | Department: |

WORK EXPERIENCE

| | |
|--|---|
| Have you had a job? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, is this your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Present or Most Recent Employer Name: | |
| How long have you / did you work there? | |
| Job Title/Description: | |

VOLUNTEER EXPERIENCE

| | |
|---------------|-------------------|
| Organization: | Year(s) Involved: |
| Job Title: | Duties: |
| Organization: | Year(s) Involved: |
| Job Title: | Duties: |

EMERGENCY CONTACT

| | | |
|-------|---------------|--------|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

REFERENCES: *(Not Relatives)*

Please give us the name of adults who are aware of your character and interests, who would be willing to serve as a reference.

| | | |
|-------|---------------|--------|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

PERSONAL HISTORY

| |
|---|
| Do you have any mental or physical restrictions which might prohibit you from volunteer job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please advise: |
| Have you ever been convicted of a crime, other than a traffic violation or misdemeanor, in the last seven years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: |

VOLUNTEER AGREEMENT:

- I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT MISREPRESENTATION OF INFORMATION PROVIDED BY ME IN THIS APPLICATION WILL RESULT IN DISQUALIFICATION FOR CONSIDERATION IN THE VOLUNTEER PROGRAM. I FURTHER UNDERSTAND THAT IF I PARTICIPATE IN THE VOLUNTEER PROGRAM, ANY MISREPRESENTATION OF FACTS, AS STATED OR IMPLIED, IS CAUSE FOR DISMISSAL.
- I UNDERSTAND THAT COMPLETING THIS APPLICATION DOES NOT GUARANTEE ME A VOLUNTEER ASSIGNMENT.
- IF ACCEPTED I WILL OFFER MY SERVICES WITHOUT MONETARY COMPENSATION.
- IF ACCEPTED I AGREE TO COMPLY WITH ALL THE HOSPITAL'S RULES AND REGULATIONS, AND THOSE SPECIFIC TO THE VOLUNTEER SERVICES DEPARTMENT.
- I UNDERSTAND AS A CONDITION OF INITIAL AND CONTINUED PARTICIPATION IN THE VOLUNTEER PROGRAM, I AGREE TO COMPLETE ALL HEALTH REQUIREMENTS AS DETERMINED BY EMPLOYEE HEALTH, AND MUST SHOW ABILITY TO PERFORM THE JOB, WITH OR WITHOUT ACCOMMODATION.

APPLICANT'S SIGNATURE: _____ DATE: _____

PARENT'S SIGNATURE: _____

Medical Release Form – MINOR VOLUNTEER



Please have your medical provider complete this form.

Completed Forms - can be faxed to 847-618-4499 or can be attached to the volunteer application.

TO BE COMPLETED BY VOLUNTEER APPLICANT:

| | | | |
|--|--|-----------------------|--|
| Full Name: | | Date of Birth: | |
| Phone: | | | |
| <p>Dear Medical Provider – I am interested in participating in the Volunteer Program at Northwest Community Hospital. Please complete this form with the requested medical health history and include your recommendations about my abilities and/or possible restrictions. I authorize this release of information.</p> <p>Volunteer Signature: _____</p> <p>Parent/Guardian Signature: _____</p> | | | |

TO BE COMPLETED BY MEDICAL PROVIDER:

| | | | |
|---|--|--------------------|----------------------------------|
| Provider Name: | | Phone: | |
| Practice Name: | | | |
| Address: | | | |
| Abilities & Restrictions: | | | |
| <p>1. Was the above person, at date of last examination, in good physical and mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Last Exam: _____</p> <p>2. Is the above person able to safely and satisfactorily volunteer in this setting without harm to others? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Do you have any recommendations regarding the amount of standing, walking, lifting, or pushing (wheelchairs) this individual can safely perform? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain: _____</p> | | | |
| Immunization History: | | | |
| <p>Volunteers are required to submit record of all of the following health and immunization requirements. If health records are not available, titer testing is required for verification of communicable disease immunity. The health requirements ensure the safety of our patients and team members.</p> | | | |
| <p>1. <input type="checkbox"/> Check the box if you are attaching the above person's immunization record, which includes: <input type="checkbox"/> MMR – Measles (Rubeola), Mumps, Rubella (German Measles) <input type="checkbox"/> Varicella <input type="checkbox"/> TDAP</p> | | | |
| 2. Influenza (Flu) - Required from September thru end of March | | Date: _____ | <input type="checkbox"/> Unknown |
| 3. COVID-19 – Primary Vaccination Series (Pfizer, Moderna, J&J) | | Date(s): _____ | <input type="checkbox"/> Unknown |
| 4. Tuberculosis – One-Step TB Test* | | Date: _____ | |
| <p>(*TB test is not required at time of application but needs to be completed before volunteer start date.) <i>We will accept proof of a TB test from outside providers. A negative TB test performed within the last 90 days is acceptable (at time of Employee Health clearance appointment). TB Testing may be available by NCH Employee Health for a fee (this option can be discussed with the Volunteer Department).</i></p> | | Result: _____ | <input type="checkbox"/> Unknown |
| <p><input type="checkbox"/> Individual will request a medical or religious exemption for the following immunization(s): _____</p> | | | |
| Medical Provider Signature: _____ | | Date: _____ | |



MEDICAL EMERGENCY TREATMENT AUTHORIZATION

To Whom It May Concern:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____

Name of Parent/Guardian: _____

Relationship to Minor: _____

Address: _____

Parent/Guardian Primary Phone: _____

Parent/Guardian Secondary Phone: _____

Parent/Guardian Email: _____

Family Physician Name: _____

Family Physician Phone: _____

Specific medical allergies, chronic illness or other conditions:

Other Contact in Case of Emergency:

Name: _____ Phone: _____

Relationship: _____

Release is only intended for times when minor is volunteering with NCH.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed: _____
Parent/Legal Guardian



BACKGROUND CHECK DISCLOSURE & AUTHORIZATION

All Northwest Community Healthcare volunteers are required to complete a background check.

NCH will cover the cost of these background checks. The background checks will be conducted via a secure online system where individuals can conveniently and confidentially enter their own information.

FOR INDIVIDUALS UNDER THE AGE OF 18 –

- **You must have your parent sign the waiver on the back of this page and submit it with your application.**
- If you are over the age of 18, you do not need to complete this form.

Thank you for your understanding and compliance to this policy that helps protect the safety of our patients, employees, visitors and volunteers.

*Please note: NCH is following the Illinois Healthcare Worker Background Check Act for disqualifying convictions. Volunteers will be able to seek a waiver from the state for misdemeanors. We will continue to **not** accept court ordered service hours.*

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Northwest Community Healthcare (“the Company”) may obtain information about you for employment/volunteer or contractor purposes from a third party consumer reporting agency and may disclose your background check and the information in it to third parties in conjunction with your assignment(s) or proposed assignment(s) to them. Thus, you may be the subject of a “consumer report” which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your criminal history, social security verification, motor vehicle records (“driving records”), verification of your education (including transcripts), or other background checks.

These searches will be conducted by **Accurate Background, 7515 Irvine Center Dr., Irvine, CA 92618, (800)-216-8024, www.accurate.com**.

Signature: _____ **Date:** _____

Parent Signature:** _____ **Date:** _____

**Required if under the age of 18

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the separate documents entitled DISCLOSURE REGARDING BACKGROUND CHECK, DISCLOSURE FOR INVESTIGATIVE CONSUMER REPORT, if applicable, A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and OTHER STATE LAW NOTICES and certify that I have read and understand each of those documents. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” by **Northwest Community Healthcare** (the “Company”) at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by **Accurate Background, 7515 Irvine Center Dr., Irvine, CA 92618, (800)-216-8024, www.accurate.com** and/or the Company. This information may include, but not be limited to, information regarding my criminal history, social security verification, motor vehicle records (“driving records”), verification of my education or employment history, or other background information. I agree that a facsimile (“fax”), electronic or photographic copy of this Authorization shall be as valid as the original.

Signature: _____ **Date:** _____

Parent Signature:** _____ **Date:** _____

**Required if under the age of 18



Northwest Community Healthcare High School Student Program Volunteer Guidelines Acknowledgement

Name: _____

Date: _____

Both the applicant and their parent should carefully read these guidelines and acknowledge your agreement by signing below.

If I am selected to be a volunteer at Northwest Community Healthcare, I understand that I am REQUIRED to:

- Review and complete the Volunteer Orientation.
- Complete the online background check form.
- Complete the health requirements:
(Health requirements are not required during the application process.)
 - One-Step TB (tuberculosis) test. Will accept proof of test if within the last 90 days (at time of Employee Health clearance appointment, not date of application submission). If you do not have a TB test completed, you can get one through your own provider or you can get one through our Employee Health Services department (for a fee) at the time of your health clearance appointment.
 - Proof of vaccinations that includes:
 - COVID-19 (one full dose)
 - Varicella (chicken pox)
 - Rubella (German measles)
 - Rubeola (measles)
 - Mumps
 - TDAP
 - Proof of influenza (flu) vaccine during the flu season (usually August through May).
- Volunteer regularly at a minimum of **4 hours per week**.
- Volunteer a **minimum of 50 hours** to fulfill obligation. *(Approximately 3-4 months.)*
- Purchase a NCH volunteer uniform (your choice of a polo or smock jacket) for \$25.
- Comply and follow all NCH and Volunteer Program policies, procedures and standards.
- Arrive on time for my shift and volunteer according to agreed schedule.
- Notify my department supervisor/contact if I need to be absent or late on my assigned day(s).
- Complete all competency and training requirements. Including annual volunteer safety training.
- Upon completion of my volunteer services, notify the Volunteer Department / Guest Services and return my ID badge.

I understand that if I do not fulfill these commitments, I will not qualify to remain in the program. I also understand that if I do not fulfill these commitments, the Volunteer Department will not provide verification of hours or recommendation letters.

Volunteer Signature

Parent Signature



Confidentiality Statement

I understand and agree that in the performance of my duties as an employee or volunteer of Northwest Community Hospital, or its affiliate, I will frequently have access to confidential information regarding patients, employees, volunteers and the Hospital, and I am expected to hold this information in confidence. Such information may only be read, taken, used, copied or discussed in conjunction with the direct performance of my duties. As an employee, I understand that any violation of this confidentiality of patient, employee, volunteer, or hospital information will result in corrective action, and may include termination of my employment. As a volunteer, I understand that any violation of this confidentiality of patient, employee, volunteer, or Hospital information will result in immediate dismissal from the Volunteer Program.

Signature

Date

Print Name

NORTHWEST COMMUNITY HEALTHCARE

VOLUNTEER REFERENCE FORM

(For High School Students Only)

DATE: _____

VOLUNTEER APPLICANT'S NAME: _____

The student listed above is applying for a volunteer position at Northwest Community Healthcare.

You are being asked to recommend this person as a potential volunteer. Our volunteers are asked to make a weekly time commitment (4 hours) for a minimum of 50 hours. Candidates must show an interest in volunteering, have the maturity to work in a hospital setting, provide great customer service and be able to interact with other staff, volunteers and the general public.

Please complete the questions listed below and return the form to us by:

- Email – scanned copy to volunteer@nch.org
- Fax – (847) 618-4499
- Mail – Northwest Community Healthcare, Attn: Guest Services Department
800 W. Central Rd, Arlington Heights, IL 60005

Your comments will be kept confidential. If you have any questions or concerns you may call the Guest Services / Volunteer Department office at (847) 618-4450. Thank you in advance for your assistance.

REFERENCE NAME: _____

RELATIONSHIP: _____

(Reference must be an adult that is not a relative.)

EMAIL: _____

PHONE: _____

1. How long have you known him/her and in what capacity? _____

2. Describe any of his/her notable qualities:

3. Do you feel the applicant is appropriate for interaction with patients and families, please explain:

4. Any additional comments:
