HOW TO BECOME A JUNIOR VOLUNTEER

Welcome, and thank you for your interest in volunteering with Casa Colina. We appreciate the support and contributions volunteers make to our organization.

The "Casa Colina Family" is comprised of many members and the volunteers at Casa Colina are very special. You will become part of a team that takes pride in the way we serve our community. Offering excellent healthcare and concern to our patients and their family members in a professional, friendly and courteous manner is of the utmost importance to us. If you join us, you will represent Casa Colina and we know you will set a good example. **Please note: Junior Volunteers must be at least 16 years of age and the application does require a parent or guardian's signature.**

Following, is the process to becoming a volunteer. This process must be completed within one month of your attendance at orientation. We hope you will enjoy volunteering at Casa Colina.

- The completed application is to be returned to the Human Resources Department via US Mail or hand delivered. Human Resources will review and determine if the volunteer meets the requirements.
- Once, the application has been turned into Human Resources, the potential volunteer must attend an orientation. Orientation dates will be emailed to the volunteer approximately two weeks before the orientation.
- At the orientation the volunteer will receive the first TB test.
- The volunteer will return to Casa Colina within 24-72 hours of orientation to have the TB test read.
- Once the TB test is cleared the volunteer can return to Human Resources to receive his/her badge, volunteer assignment and purchase the volunteer jacket.
- Additionally the volunteer will be responsible for receiving a second TB test once the volunteer assignment begins (this is required by the Department of Health and Casa Colina policy due to the high incidence of TB in our geographical area).

Casa Colina volunteers are required to volunteer a minimum of 6 months and 100 hours. Volunteers must work a minimum 1 hours per week.

VOLUNTEER APPLICATION

JUNIOR VOLUNTEER

(For volunteers between the ages of sixteen & eighteen years of age)

Parental consent is required throughout this application

Today's Date _____

Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ E-mail _____

Work # _____ Work Extension _____

Driver's License # _____ Cell/Pager # _____

How were you referred to Casa Colina Centers for Rehabilitation? _____

Employment History

Current:

Position/Title _____

Company Name _____

Supervisor's Name _____ Phone Number (_____) _____ - _____

Dates of Employment _____

Previous:

Position/Title _____

Company Name _____

Supervisor's Name _____ Phone Number (_____) _____ - _____

Dates of Employment _____

Position/Title _____

Company Name _____

Supervisor's Name _____ Phone Number (_____) _____ - _____

Dates of Employment _____

Vocational and/or Special Trainings: _____

_____

_____

Educational History

Current:

Study Emphasis _____ School _____

Highest Grade Achieved _____ Degree/Certificate? _____

Dates of Attendance _____

Previous:

Study Emphasis _____ School _____

Highest Grade Achieved _____ Degree/Certificate? _____

Dates of Attendance _____

References

Name _____ Relationship _____

Phone Number (_____) _____ - _____ Years Known _____

Name _____ Relationship _____

Phone Number (_____) _____ - _____ Years Known _____

Name _____ Relationship _____

Phone Number (_____) _____ - _____ Years Known _____

Special Skills/Experience

Special Skills and/or Knowledge: _____

_____

Hobbies and Interests: _____

_____

Community and/or Club Affiliations: _____

_____

Previous Volunteer Experience: _____

_____

Reason(s) For Volunteering: _____

_____

Events For Which You Would Like To Volunteer (please list names and dates): _____

_____

_____

_____

1. Do you speak any language(s) other than English? ❒Yes ❒No
   Language(s): _____
2. If yes, would you be willing to act as a translator while on duty as a volunteer? ❒Yes ❒No
3. Is volunteer work a requirement for school credits? ❒Yes ❒No
4. Do you have any physical disability/condition which may interfere with your work? If yes, explain: ❒Yes ❒No

   _____

   _____

6. Do you require any special accommodations? ❒Yes ❒No
   If yes, please describe: _____

   _____

Emergency Contact

Emergency Contact Name _____ Relationship _____

Home # _____ Alternate # _____

Photo Release

I hereby give my authority to Casa Colina to photograph me and use the photos for educational and/or commercial purposes, such as human-interest stories, advertisements, promotions, etc., at the discretion of the corporation.

Date:_____ Signed: _____

Signature of parent, or legal guardian:_____ Date_____

Volunteer Expectations

If accepted as a volunteer, I understand that my services are donated to Casa Colina without contemplation of remuneration or future employment.

Date:_____ Signed: _____

Signature of parent, or legal guardian:_____ Date_____

Background

Have you ever been convicted of, plead guilty or nolo contendere to a crime? Do not identify traffic infractions, or misdemeanor marijuana convictions occurring more than two years ago, or convictions for which the criminal record has been expunged, sealed, or eradicated, or misdemeanor convictions for which any probation has been completed and the case dismissed by the court. ❒Yes ❒No

If yes, state the nature of the crime(s), when and where convicted and disposition of the case(s).

_____

_____

No applicant will be denied the opportunity to volunteer solely on the grounds of the conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position applies may, however, be considered.

I hereby certify that the above is true and complete to the best of my knowledge. I realize that this information is confidential and may be used to determine my eligibility to volunteer in Centers for Rehabilitation, Inc. to make inquiry to my physician regarding the state of my health. The name and address of my physician are provided above.

Date:_____ **Signed:**_____

Signature of parent, or legal guardian:_____ **Date**_____

CASA COLINA
Hospital and Centers for Healthcare

CONFIDENTIALITY AGREEMENT

It is likely that your volunteer work assignments may involve or expose you to work of a confidential nature. In some or all of its aspects, your volunteer work may involve contact with trade secrets and confidential information of Casa Colina, or confidential information which has been entrusted to us regarding our patients, clients, residents, employees, volunteers or vendors.

You are expected to protect the interests of Casa Colina and our patients, clients, residents, employees, volunteers or vendors by not disclosing to anyone who does not have a legitimate need to know, any information that is considered as trade secrets or other proprietary information of Casa Colina or our vendors, or confidential information of our patients, clients, residents, volunteers, or employees. Information which we may consider trade secrets, confidential or proprietary includes:

- Information about patients, clients, residents, employees, volunteers or vendors;
  What is 'individually identifiable health information' or protected health information'?
  Any health information relating to a person's health, care received or payment for services. This includes diagnosis, treatment received or prognosis. It also includes demographic information, such as, name, address, social security number, medical record number, zip code, phone number, etc. It includes protected health information in any form, including written, oral, or electronic.
- Information about current or future program or product design (other than that which is typically shared during market or sales efforts);
- Financial data (of Casa Colina, patients, clients, residents, employees, volunteers or vendors);
- Marketing strategies;
- Prototypes, plans, designs or blueprints (i.e., plan or proposal for expansion or curtailment of operations, mergers, acquisitions or joint ventures, as well as information relating to increasing or decreases in business, unusual management developments, litigation or purchases or sales of substantial assets).
- Technological data or prototypes, computer software and/or programming codes (i.e., all communication systems, including electronic mail, internet, voice mail, phone system); and,
- Any information that may be used by competitors against us or our patients, clients, residents, employees, volunteers or vendors.

As a condition of your volunteer service, you agree that you will not, except as required in the conduct of Casa Colina's business or as authorized in writing by the President/CEO of Casa Colina, disclose, either during the time you provide volunteer services, or any time thereafter, any trade secret or confidential information relating to Casa Colina, our patients, clients, residents, employees, volunteers or vendors that you may in any way acquire by reason of your volunteer service by Casa Colina, including the identity of current and prospective patients, clients, residents, employees, volunteers or vendors.

The confidentiality of all patients, clients, residents, volunteers and employees shall be maintained at all times by all personnel and volunteers. Discussions concerning a patient's, client's or resident's condition or other related information shall take place in treatment areas or private areas, and only with those people involved in care of the individual(s).

You are expected to respect the confidence and trust placed in us by our patients, clients, residents, employees, volunteers or vendors by keeping their information confidential. The professional relationship between each patient, client, resident, employee, volunteer or vendor and Casa Colina requires that there be no disclosure of information about the affairs of either party to others. This includes responses to inquiries from salespeople, the press, contractors, other companies or the public. Should anyone make inquiries about our relationship with, or the affairs of a patient, client, resident, employee, volunteer or vendor, immediately report the inquiry to the Foundation office or the person supervising your work. Violations to medial privacy laws will result the organization with administrative penalties.

To further protect the interests of Casa Colina, you must secure permission from the Foundation Director, before making a public presentation as a representative of Casa Colina.

By signing below, I hereby agree to abide with all legal policies and practices of Casa Colina, Inc. and Subsidiaries, including the confidentiality agreement.

_____ _____ _____

Date Signature

Signature of parent, or legal guardian:_____ Date_____

Volunteer Application – *Medical Questionnaire*

Today's Date _____

Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ E-mail _____

Work # _____ Work Extension _____

Driver's License # _____ Cell/Pager # _____

Date Of Birth _____ Height _____ Weight _____ ❒ Male ❒ Female

Date of last tetanus shot: _____ Date of last tuberculosis test: _____ Result: _____

How were you referred to Casa Colina Centers for Rehabilitation? _____

5. Do you have any food allergies or dietary restrictions? ❒Yes ❒No
6. Are you currently under the care of any medical specialist or doctor? ❒Yes ❒No
7. Are you currently taking *any* medications? ❒Yes ❒No

Have you experienced any of the following? Please check all that apply.

- ❒ Allergies-Any
- ❒ Arthritis
- ❒ Asthma/Respiratory Problems
- ❒ Back Conditions
- ❒ Bowel/Urinary Issues
- ❒ Chronic Colds or Cough
- ❒ Communicable Disease
- ❒ Diabetes
- ❒ Ear Perforation
- ❒ Ear/Throat Infections
- ❒ Fainting/Blackouts
- ❒ Headaches
- ❒ Heart Defect/Disease
- ❒ Hemophilia
- ❒ Hernia/Ruptures
- ❒ High Blood Pressure
- ❒ Kidney Stones/Infection
- ❒ Knee/Joint Conditions
- ❒ Lung Disease
- ❒ Seizures/Convulsions
- ❒ Shortness Of Breath
- ❒ Skin Infections
- ❒ Surgeries
- ❒ Tuberculosis

If you answered, "Yes" to any of the questions above or if there are conditions not listed, please elaborate on the next page or on the back page including date[s] of occurrence.

Please complete all information below as it is necessary for us to have should you require medical care.

Health Insurance Company _____ Policy Number _____

Personal Physician _____ Physician's # _____

Physician's Address _____

Emergency Contact Name _____ Relationship _____

Home # _____ Alternate # _____

- If the volunteer is under 18 years of age, the signature of a parent, spouse or legal guardian is required.
- Volunteers, while on duty, are covered by liability insurance.

Consent For Treatment

1. IN CASE OF EMERGENCY, the UNDERSIGNED authorizes Casa Colina staff and personnel to provide such medical assistance as they determine to be necessary. The UNDERSIGNED authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the participant, including anesthetics, which they determine necessary or advisable, pending receipt of a specific consent from the UNDERSIGNED. The UNDERSIGNED authorizes necessary care by paramedics.

   Date:_____ Signed: _____
   Signature of parent, or legal guardian:_____ Date_____

2. I hereby give permission for my son/daughter to have the required test(s) for TB screening (PPD or Chest X-Ray) at Casa Colina. This permission extends to their annual test if and when required.

   Signature of parent, or legal guardian:_____ Date_____

3. I hereby certify that the above is true and complete to the best of my knowledge. I realize that this information is confidential and may be used to determine my eligibility to volunteer in patient areas. I authorize Casa Colina Centers for Rehabilitation to make inquiry to my physician regarding the state of my health. The name and address of my physician are provided above.

   Date:_____ Signed: _____
   Signature of parent, or legal guardian:_____ Date_____

Use this space or the back for additional information or explanations:

_____

_____

_____

_____

CASA COLINA
Hospital and Centers for Healthcare

ACKNOWLEDGEMENT AGREEMENT

I _____, have read and acknowledge the requirements and expectation of my duties as a volunteer. I understand and agree that I must volunteer a **minimum of 100 hours and 6 months** with Casa Colina. I further understand that I must volunteer a minimum 1 hour per week.

Name: _____

Signature: _____ Date: _____

IF THE VOLUNTEER IS UNDER 18 YEARS OF AGE A PARENT OR GUARDIAN MUST ALSO SIGN:

Parent/Guardian Name: _____

Signature: _____ Date: _____

Casa Colina will not sign-off on any hours or complete any school required paperwork if this agreement is not fulfilled

CASA COLINA
Hospital and Centers for Healthcare

TB Test Schedule
Casa Colina ADHC Bldg. 5
Monday, Tuesday, Wednesday and Friday
7:00am to 11:00am
And
1:00pm to 4:30pm

Health Questionnaire

Volunteer Information	
Name	
Address	
City/State	
Social Security number	
Phone number	
Date of birth	
Age	
Marital Status	
Department	

Since completing your last questionnaire have you had or do you have any of the following:

Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Abdominal Pain			Jaundice		
Alcohol Abuse			Kidney Disease or Nephritis		
Allergy			Kidney Stone or Blood in Urine		
Asthma			Loss of Memory		
Back Injury			Marked Fatigue		
Bone joint or other ailments			Menstrual Difficulty		
Chest or Lung Disease			Nervous or Mental Trouble		
Chronic Back Trouble			Pain or Pressure in chest		
Chronic Cough			Painful Joints		
Constipation			Palpitation, Heart Disease or Murmur		
Depression			Paralysis (including infantile)		
Diabetes			Pleurisy		
Dizziness or Unconsciousness			Pneumonia		
Drug or Narcotic Addiction			Pregnancy		
Ear Infection/Discharge			Serum Reaction		
Eye, Ear, Nose, Throat Trouble			Shortness of Breath		
Epilepsy: Convulsions or seizure			Sinusitis		
Fracture			Skin Disorders		
Frequent Headaches			Sleeplessness		
Frequent or Painful Urination			Spitting of Blood		
Gallbladder Trouble			Thyroid Disorder		
Hearing Impairment			Tobacco Use		
Hemorrhoids			Tuberculosis		
Hernia/Rupture			Tumor, Growth, Cyst or Cancer		
High or Low Blood Pressure			Undue Worry or Fear		
Increase or Decrease in Weight			Sexually Transmitted Disease		
Have You:					
Worn Glasses?			Had foot trouble?		
Worn a Hearing Aide?			Lived with anyone who had Tuberculosis (TB)?		
Worn a back brace or support?			Missed time for health reasons? If yes, number of days?		

Do you take medicine? ☐ Yes ☐ No

Type: _____ Dosage: _____ Frequency: _____

Type: _____ Dosage: _____ Frequency: _____

Have you had any illness or injuries during the past year? ☐ Yes ☐ No

Describe: _____

Have you been under a doctor's care within the last year? ☐ Yes ☐ No

Describe: _____

Have you been advised to have any operations? ☐ Yes ☐ No

Describe: _____

Have you been hospitalized? ☐ Yes ☐ No

Why: _____

Are you receiving or have you received in the past, compensation or pension as a result or injury or illness? ☐ Yes ☐ No

Describe: _____

Have you been rejected for life insurance, military service or employment? ☐ Yes ☐ No

Explain: _____

Have you ever:	**Yes**	**No**		**Yes**	**No**
Had prior positive TB skin test			Night sweats/chills		
Received INH			Persistent cough for more than 2 weeks (TB)?		
Received the BCG vaccine			Blood streaked sputum		
Unusual fatigue for more than 2 weeks			Fever associated with cough for more than 1 week		
Weight loss unrelated to dieting			Other unusual symptoms		
Loss of appetite for more than 2 weeks			List:		

I declare the above information is true and I am aware that misrepresentations of omission may be cause for dismal from the organization. I am aware of the physical requirements of the position for which I am applying. I will permit physicians or health facilities that have treated me to furnish information to Casa Colina upon request. I understand that results of this assessment may be shared with administration, supervisors and or case managers.

_____ _____ _____ _____

Signature of Volunteer **Date** **Signature of Conservator/Parent** **Date**

(If volunteer is under 18) for 1st & 2nd TB Tests

1 step PPD Vitals: **This requires that a second skin test be done 30 days after initial PPD**

_____ Employee can provide proof of negative PPD reading prior to hire Total Charges:

2nd Step PPD Vitals: **ONLY REQUIRED IF THE EMPLOYEE HAS NEVER HAD A PPD READING BEFORE**

Date test given _____ **Time:** _____ **Given By:** _____

Right Arm_____ **Left Arm**_____ **TST,5TU:** _____ **Lot#:** _____ **Expires:** _____

Date test read: _____ **Time:**_____ **Read By:** _____

Reaction: _____ **Induration Size:** _____**mm** **Erythema Size:** _____**mm**

Follow up: _____