

**Teen Volunteer Application**  
**Centennial Medical Center- 2300 Paterson Street- Nashville, TN 37203**  
**Phone: 615-342-1753 Fax: 615-342-1759**

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Name \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Email \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Special needs/ concerns/ serious illness \_\_\_\_\_

**Business Experience:**

Employer \_\_\_\_\_ Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Working this summer? Y N If yes, anticipated schedule \_\_\_\_\_

**Volunteer Experience:**

Organization \_\_\_\_\_ Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Schedule Preferences:**

Preferred days/times \_\_\_\_\_ Length of commitment: 3 mo. 6 mo. Summer

Volunteer area of interest \_\_\_\_\_

Motivation for volunteering? \_\_\_\_\_

\_\_\_\_\_

**For office use only:**

Department Assigned \_\_\_\_\_ Start Date \_\_\_\_\_

**Teen Volunteer Letter of Recommendation**

Teen volunteer Application-Centennial Medical Center

All students applying for the teen volunteer program must submit recommendations from two of their current teachers, counselors, pastors, community leadership, etc.

Thank you to these mentors for taking the time to provide this information. If you have any questions, please contact the Volunteer Coordinator at 615-342-1753.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Organization \_\_\_\_\_ Phone \_\_\_\_\_

I understand the above noted student is applying to participate in the teen volunteer program at Centennial Medical Center. I believe this student is an ideal candidate to serve as a volunteer in a hospital setting, is responsible, and can provide compassion and mature judgment. I am confident this student will carry out their responsibilities with a high regard for the rules, policies and guidelines that must be strictly adhered to given the nature of healthcare.

Reference 1: Name \_\_\_\_\_ Class \_\_\_\_\_ Date \_\_\_\_\_

Additional Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reference 2: Name \_\_\_\_\_ Class \_\_\_\_\_ Date \_\_\_\_\_

Additional Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Teen Volunteer Agreement**

Teen volunteer Application-Centennial Medical Center

As a teen volunteer at Centennial Medical Center, I hereby pledge to the following:

1. To perform my volunteer duties to the best of my ability following orientation procedures.
2. To adhere to Centennial Medical Center's rules, procedures, policies and record-keeping requirements and to maintain absolute confidentiality of patient information and other hospital vital information which I may hear directly or indirectly.
3. To meet time and duty commitments and to provide adequate notice, preferably 24 hour notice, in cases of absence to my area supervisor and then volunteer coordinator.
4. To be punctual and conscientious in fulfilling my duties and accept suggestions gracefully.
5. To conduct myself with integrity, compassion, a positive attitude, respect and exceptional quality with all staff, visitors and patients with whom I come into contact.
6. To take any problems, criticisms or suggestions to my supervisor/ volunteer coordinator.
7. To maintain a clean and professional appearance and to return my badge upon completion of the teen volunteer program.
8. I understand my volunteer role can be terminated as a result of:
  - Failure to comply with rules, policies, procedures and record-keeping.
  - Unsatisfactory attitude, work, commitment or appearance.
  - Any other circumstances deemed contrary to the best interest of Centennial Medical Center.

**Teen Volunteer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Permission**

Requires parent/guardian signature

My son/daughter \_\_\_\_\_ has my consent to serve as a teen volunteer at Centennial Medical Center. I will encourage compliance with the rules and regulations. I understand he/she must be at least 15 years of age and will be punctual and committed to set schedule. I am aware that 3 unexcused absences from duty will result in dismissal from the program.

**Parent/ Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**CENTENNIAL MEDICAL CENTER  
TEEN VOLUNTEER- ANNUAL HEALTH INFORMATION**

**\*\*PLEASE COMPLETE ALL THREE SECTIONS AND SIGN ON THE BOTTOM OF PAGE\*\***

Employee Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Department: Volunteer Services Soc. Sec. Number: (last 4 digits) \_\_\_\_\_

**SECTION 1: TB SCREENING**

Past Positive PPD (TB Skin Test): NO \_\_\_\_ YES \_\_\_\_ (see back) Pregnant? (see back)

PPD Skin Test 0.1cc ID in arm: (Must be read by RN or MD between **48-72 hours** of administration)

Date given: \_\_\_\_\_ RN or MD signature: \_\_\_\_\_  
Date read: \_\_\_\_\_ RN or MD signature: \_\_\_\_\_

Results: NEGATIVE \_\_\_\_\_ SIZE 0 mm POSITIVE\* \_\_\_\_\_ SIZE \_\_\_\_mm

**\*POSITIVE TB SKIN TEST THIS TIME? EMPLOYEE MUST FOLLOW UP  
WITH THE EMPLOYEE HEALTH NURSE AT 342- 4818**  
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**SECTION 2:**

**PARENTAL / GUARDIAN PERMISSION FOR TB TESTING**

Teen Volunteer's Name \_\_\_\_\_  
Last First Middle Initial

Birth date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

Centennial Medical Center requires that all employees and volunteers have an annual TB skin test. To fulfill this requirement:

\_\_\_\_\_ I have attached a copy of my son/ daughter's TB skin test results performed within the past year.

\_\_\_\_\_ I give my permission for my son/ daughter, \_\_\_\_\_, to receive a TB skin test at Centennial Medical Center. I understand that he/ she will need to return two days later to have the results read by the Employee Health or Emergency nursing staff.

PARENT/ GUARDIAN SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

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**CENTENNIAL MEDICAL CENTER-Teen Application cont.**  
**QUESTIONNAIRE FOR SIGNS/SYMPTOMS OF TUBERCULOSIS**

I am unable to take the annual TB skin test because:

- I am pregnant
- I have a history of a past positive Tuberculin skin test
- I have a history of BCG vaccination
- I am allergic to the preservative found in the Tuberculin skin test



Check YES or NO for the following signs and symptoms of active tuberculosis:

- |   |          |         |
|---|----------|---------|
| Easy fatigue (Tire easily)                    | YES ____ | NO ____ |
| Anorexia (Decreased appetite)                 | YES ____ | NO ____ |
| Weight loss                                   | YES ____ | NO ____ |
| Fever   | YES ____ | NO ____ |
| Night sweats                                  | YES ____ | NO ____ |
| Chronic cough (lasting more than three weeks) | YES ____ | NO ____ |
| Sputum production (Cough up phlegm)           | YES ____ | NO ____ |

If yes, what does it look like? \_\_\_\_\_

- |   |          |         |
|---|----------|---------|
| Hemoptysis (Blood in sputum)  | YES ____ | NO ____ |
| Chest pain  | YES ____ | NO ____ |
| Dyspnea (Shortness of breath)   | YES ____ | NO ____ |
| Significant exposure to someone with active tuberculosis in the past year | YES ____ | NO ____ |

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department

\_\_\_\_\_  
Social Security Number (last 4 digits)

If you have questions, contact Employee Health/ Pamela Garrett at 342-4822

# Confidentiality and Security Agreement

I understand that the facility or business entity (the “Company”) in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the “Company”), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

- |   |  |
|---|--|
| <p>13. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.</p> <p>14. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.</p> <p>15. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient’s name is not used.</p> <p>16. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.</p> <p>17. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.</p> <p>18. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.</p> <p>19. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.</p> <p>20. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.</p> <p>21. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.</p> <p>22. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.</p> <p>23. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.</p> <p>24. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.</p> | <p>15. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.</p> <p>16. I will:</p> <p style="margin-left: 20px;">d. Use only my officially assigned User-ID and password (and/or token (<i>e.g.</i>, SecurID card)).</p> <p style="margin-left: 20px;">e. Use only approved licensed software.</p> <p style="margin-left: 20px;">f. Use a device with virus protection software.</p> <p>16. I will never:</p> <p style="margin-left: 20px;">a. Share/disclose user-IDs, passwords or tokens.</p> <p style="margin-left: 20px;">b. Use tools or techniques to break/exploit security measures.</p> <p style="margin-left: 20px;">c. Connect to unauthorized networks through the systems or devices.</p> <p>16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.</p> |
|---|--|
- The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):**
- |  |  |
|--|--|
| <p>17. I will only access software systems to review patient records when I have that patient’s consent to do so. By accessing a patient’s record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.</p> <p>18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.</p> <p>19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.</p> |  |
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Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name and COID	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	