

Volunteer Services
9400 Turkey Lake Road
Orlando, FL 32819

Dear Prospective Volunteer:

Thank you for your interest in the Teenage Volunteer Program at Dr. P. Phillips Hospital. Teenage volunteers are an important part of our organization. Your presence and help provide comfort and support to the many patients and staff with whom you will come in contact. As a volunteer, you will be certain of a satisfying and rewarding experience learning and working side-by-side with our dedicated staff.

There are three teen volunteer sessions per year. The spring session begins in January and ends the last week of May. The summer session begins in June and ends the weekend before public school starts in August. The fall session starts in September and ends the last week of December.

Please find enclosed the **Teenage Volunteer Application** package which includes a list of volunteer opportunities. Teenage volunteers must be at least sixteen (16) years of age. Three recommendations, two from teachers and one from your guidance counselor, are required for each applicant. The teen must maintain a "B" average or above (minimum 3.0 GPA required) in school. Teen volunteers will also be required to submit to a drug and tuberculosis screening at our occupational health office and attend an orientation prior to volunteering.

You will be required to volunteer for one full session: fall spring or summer, but you may volunteer for as many sessions as you wish. You will be scheduled for a certain time each week. Of course, the amount of time and the day and time that you volunteer will be entirely up to you.

Applications must be submitted at least **8 weeks prior** to the upcoming session. Placement is on a first-come, first served basis and is not guaranteed.

Unfortunately, Orlando Health does not accept court-ordered community service volunteers; nor will Volunteer Services verify volunteer hours for court-ordered community service.

Again, we appreciate your interest in volunteering at Dr. P. Phillips Hospital. Our volunteers are a vital part of the caring spirit that thrives in our community. If you have any questions, please feel free to call me at 321-842-7288.

Sincerely,

Chante' Wallace

Chante' Wallace
Manager, Volunteer Services

APPLICATION FOR DR. P. PHILLIPS HOSPITAL TEENAGE VOLUNTEER PROGRAM

Date: _____	Graduation Year: _____		
Name: _____ (last) _____	(first) _____	(MI) _____	Phone Number: _____
Address: _____ (street) _____		(city) _____	(zip code) _____
E-Mail Address: _____			
Date of Birth: _____		Age: _____	Social Security Number: _____
Parent's Name: _____ (last) _____		(first) _____	Phone Number: _____
Address (if different from above): _____			

School Attending: _____ Grade: _____

School Guidance Counselor: _____ Phone Number: _____

Family Physician: _____ Phone Number: _____

Have you ever applied before to the Dr. P. Phillips Hospital Teenage Volunteer Program? Yes No

List your special skills: _____

List your reasons for joining the Teenage Volunteer Program: _____

List the areas of the hospital that interest you: _____

What days of the week are you available to volunteer? What hours?

S M T W T F S

8-12 12-4 4-8 Other

For Office Use Only:

Please return application to:

Chante' Wallace
Volunteer Services
Dr. P. Phillips Hospital
9400 Turkey Lake Road
Orlando, FL 32819-8014

Interview _____
Orientation _____
PPD/Drug Screen _____
Uniform _____ Badge _____
Placement _____

RECOMMENDATIONS

Applicant: _____

Ask your teachers (two teacher recommendations required) and your counselor for his/her recommendation and signature.

TEACHER RECOMMENDATION

His/her grade average is at least a "B." (minimum GPA 3.0 required) Yes No

Comments, if any: _____

Teacher: _____ Phone Number: _____
(Signature) (Printed Name)

School: _____ Date: _____

TEACHER RECOMMENDATION

His/her grade average is at least a "B." (minimum GPA 3.0 required) Yes No

Comments, if any: _____

Teacher: _____ Phone Number: _____
(Signature) (Printed Name)

School: _____ Date: _____

GUIDANCE COUNSELOR RECOMMENDATION

His/her grade average is at least a "B." (minimum GPA 3.0 required) Yes No

Comments, if any: _____

Teacher: _____ Phone Number: _____
(Signature) (Printed Name)

School: _____ Date: _____

PARENTAL/GUARDIAN CONSENT FORM

My son/daughter _____
has my consent to participate in the Teenage Volunteer Program at Dr. P. Phillips
Hospital. I have read and agree to the conditions below.

Parent/Legal Guardian Signature: _____

Date: _____

Volunteer must:

- Be a student between the ages of 16 and 18 and in the 9th grade or over.
- Maintain a "B" grade average or better.
- Have the recommendation of two teachers and a high school guidance counselor.
- Work at least one shift per week.
- Provide his/her own transportation to and from the hospital.
- Purchase khaki slacks. One uniform polo shirt will be provided.
- Be required to undergo tuberculosis (PPD) and drug and alcohol testing prior to their service in the hospital.
- Neither the hospital nor Volunteer Services are responsible for the Teenage Volunteer when assigned hours are completed.
- Adhere to the personal conduct, membership requirement, dress code and appropriate behavior. Failure to comply may result in immediate dismissal from the volunteer program.

DR. P. PHILLIPS HOSPITAL

CODE OF ETHICS FOR TEENAGE VOLUNTEERS

I will hold all information regarding patients, guest, staff and all matters pertaining to the hospital absolutely confidential.

I interpret the word volunteer to mean that I agree to work without compensation in money or expectation of future employment.

I expect to exemplify the corporate Standards of Behavior at all times by being punctual, conscientious, dignified, courteous, and considerate to others.

I expect to wear an approved uniform and maintain a professional appearance while on my volunteer service.

I expect to do my work according to the departmental standards.

I recognize that I am part of the Dr. P. Phillips Hospital team and am willing to help develop good teamwork both within the volunteer group and other departments throughout the hospital.

I assume certain responsibilities and expect to be accountable for what I do.

I am willing to attend orientation and to be trained for my particular services.

I anticipate being assigned to a service that meets my needs, one that I enjoy, and that meets the needs of the hospital.

I am willing to adhere to the Teenage Volunteer's sign-in/out procedure and follow the set procedure when I cannot or am unable to report for duty.

I am willing to commit to a minimum of one full session of volunteer service.

I pledge to demonstrate tolerance and respect for all persons, and to avoid being judgmental of those different from me.

I will be sensitive to the restrictions of my position as a volunteer and will refer questions beyond my scope of responsibility to the appropriate authority.

I understand that the Volunteer Department reserves the right to terminate volunteer status as a result of (a) failure to comply with Dr. P. Phillips Hospital's policies, rules and regulations; (b) unsatisfactory attitude, work or appearance; or (c) any other circumstances which, in the judgment of the Department director, would make my continued service as a volunteer contrary to the best interests of the organization.

I accept this code willingly and agree to follow it during my service as a Dr. P. Phillips Hospital Teenage Volunteer.

Signed: _____

Date: _____

Parent/Legal Guardian Signature: _____

Date: _____

TEENAGE VOLUNTEER PROGRAM PARENTAL RELEASE

My son/daughter has my permission to participate in the Teenage Volunteer Program at Dr. P. Phillips Hospital. I understand that participation in this program will involve a 3-4 hour weekly commitment of service for the duration of the session.

I understand that my son/daughter must adhere to the hospital policies and procedures as stated in the Teenage Volunteer Manual. These policies and procedures are made clear to the teen volunteer during orientation.

I understand that my son/daughter can be released from the teen program and forfeit all hours earned for the current session if they are caught demonstrating any of the following:

- Falsifying time records.
- Failure to report to assigned service area or leaving service area without consent.
- Failure to notify the volunteer office and assigned area if absent.
- Failure to report for two consecutive weeks or more.
- Excessive absences (more than 2 during summer session and more than 4 during fall and spring session).
- Leaving hospital property during work shift.
- The use of cell phones, I-Pods, I-Pads, gaming devices or Bluetooth headsets during work shift. Cell phones are not allowed in work areas and must be kept in lockers provided during volunteer shifts.
- Performing personal tasks (such as homework/reading) while on duty and not focusing on your duties as assigned.
- Stealing.
- Sleeping while on duty.
- Smoking on hospital property.
- Not adhering to hospital volunteer dress code.
- Failure to adhere to any policy or procedure as stated during orientation.

If my son/daughter is injured in the course of their duties at Dr. P. Phillips Hospital, they are to report the injury to a staff member in their assigned area or the Volunteer Services Department.

I understand that my son/daughter is volunteering their time without expectations of employment or monetary compensation.

Name of Teen Volunteer (Please Print)

Signature of Parent/Guardian

Date

PARENTAL CONSENT FORM

- Teen Volunteer must be a high school student and be at least 16 years old.
- Teen Volunteers must maintain a GPA of 3.0 or higher and submit a copy of their report card with their application.
- Teen Volunteers are required to undergo tuberculosis and drug testing prior to their service in the hospital.
- Teen Volunteers are required to work one shift per week but may work a maximum of two shifts per week.
- Teen Volunteers are allowed 2 excused absences per session. Unexcused absences are not permitted and may result in dismissal from the program.
- Teen Volunteers *must* complete the entire session in order to receive their community service hours. At the end of the session, Teen Volunteers are responsible for requesting hour documentation from the Teen Volunteer Coordinator. Each high school will typically have a specific form to be used for this purpose.
- Teen Volunteers are required to return their Orlando Health issued ID Badge and uniform on their last day of service. Teen Volunteers who have fulfilled all session requirements are welcome to continue volunteering in the next session but must communicate to the Teen Volunteer Coordinator that this is their intention.
- Teens that have been arrested or convicted of a crime are **not eligible** for enrollment into the Teen Volunteer Program. Orlando Health does not offer court ordered community service hours.
- Teen Volunteers must provide their own transportation to and from the hospital.
- Teen Volunteers are **not** permitted to leave their assigned hospital campus while on duty.
- Loitering in hallways, on unassigned nursing units, or any other area of the hospital or campus before, during, or after their shift is **not** permitted.
- Teen Volunteers are not permitted to use any hospital computer or printer for their personal use. Cell phone usage is not permitted while on duty. Teen Volunteers are required to lock their cell phones up during their shift in a cell phone locker which is provided. Teen Volunteers should excuse themselves from their assignment location if they need to make a call or send a text.
- Any violation of conduct, dress code or inappropriate behavior may result in immediate dismissal from the Teen Volunteer Program. The Teen Volunteer Coordinator reserves the right to dismiss the volunteer if any such violation is committed.

My son/daughter _____ has my consent to participate in the Teen Volunteer Program at Orlando Regional Medical Center. I have read and agree to the conditions listed above.

Printed name

Relationship to volunteer

Signature

E-mail address or phone number

Title: **Volunteer Dress Code**
Dr. P. Phillips Hospital

Page 1 of 3

Policy #: 2991-0001

Replaces #:

Issue Date:

Issued By: Manager Volunteer Svcs.

Revision Dates: 7/28/00, 8/24/06, 2/21/07

I. PURPOSE

All volunteers of the Dr. P. Phillips Hospital are expected to portray a professional appearance to patients, visitors and the general public.

II. POLICY

The success and acceptance of Dr. P. Phillips Hospital depends in large measure upon the image its volunteers present. Therefore, a dress code has been established to present a professional impression to our patients and the general public, as well as to develop pride in Dr. P. Phillips Hospital and its volunteers.

III. PROCEDURE

A. Adult Uniform

The Adult uniform will consist of two options:

Option 1: A navy blue jacket, provided by Volunteer Services, will be worn with a white shirt or blouse. For the ladies, a white shell is also acceptable. White or khaki slacks or a white skirt (ladies) are to be worn with the jacket. Shoes are to be white sneakers or white rubber sole shoes. See section C for specific information.

Option 2: A navy blue camp shirt provided by Volunteer Services will be worn with khaki or natural color slacks (chinos) or skirts (ladies). White or khaki color sneakers or rubber sole shoes are to be worn with this uniform. See section C for specific information on shoes.

B. Teenage Uniform

The Teenage uniform will consist of a royal blue or red, embroidered, polo shirt furnished by the Volunteer Manager. The shirt will be worn with khaki slacks (chinos) and plain white rubber soled shoes.

C. General Guidelines

1. Fabrics should be those traditionally acceptable for business wear such as polyesters, tweeds, wool or wool-like fabrics, cotton or cotton blends. Fabrics that are not acceptable are sheers, clinging jerseys, open crochets, crepe satins, or elaborate printed or sweatshirt-type fabrics that suggest casual sportswear.
2. Denim of any type or color is not acceptable.
3. Jeans or jean-style pants of any type are not acceptable.
4. Appropriate undergarments must be worn.
5. Polo shirts may be worn tucked in or outside of slacks. If worn outside, the shirts must be an appropriate length, not above the belt or below the buttocks.
6. Shoes are to be worn at all times. Shoes must be either predominantly white (or beige/tan with khaki slacks) sneakers/athletic shoes or any white rubber soled shoe. Shoes must be in good repair. **No casual boots, flip-flops, slippers, thongs, flat sandals, jellies, beach shoes, deck shoes or clogs are allowed.**
7. The ORHS photo identification badge must be worn at all times. The badge must be worn above the waist with the photo visible and facing out.
 - a. Volunteer service pins may not be worn on the name badge. Pins may be worn on jacket or polo shirt.

- b. Damaged, faded, worn or lost ID badges must be replaced.
- 8. Holiday costumes may not be worn without prior approval of the Volunteer Manager.
- 9. Gum chewing, smoking or tobacco chewing while on duty is strictly prohibited.
- 10. No hats or caps may be worn. Barrettes and pony tail holders are acceptable.
- 11. Clothing and accessories, which could pose a safety hazard, must be avoided.
- 12. Tattoos must be covered.
- 13. Body cleanliness is mandatory.
- 14. Fingernails will be kept short, clean and well groomed.
- 15. Hair must be neatly cut, styled and clean at all times.
- 16. Clothes must be clean and pressed at all times.
- 17. Perfumes and colognes, which could be distracting or offensive to patients and staff, should be avoided.
- 18. Blue tooth devices may not be worn while on duty.

D. Female Dress Code

- 1. Full-length slacks are permitted. Regular (knee or slightly below) length skirts are appropriate.
- 2. Appropriate hosiery is required. Socks or stockings must be worn.
- 3. Split skirts, culottes, gauchos, knickers, crop-pants, stretch or stirrup pants, harem-pants or "after 5" clothing is not permitted.
- 4. Jewelry and accessories, which could be distracting or offensive, should be avoided. No nose decorations, including rings and studs are allowed with the exception of religious reasons with prior notice to the Volunteer Manager. No more than two earrings per lobe are permitted.
- 5. Make-up that is not distracting or offensive may be worn. Nail polish is permissible if it is a daywear color and fresh and not chipped. Fingernails should be of a length that does not hinder the ability to perform the functions of the job. Nail jewelry and nail decorations are not permitted.

E. Male Dress Code

- 1. Slacks should be an appropriate length, not too short or too long.
- 2. Large ornamental belt buckles are not appropriate.
- 3. Socks must be worn.
- 4. Men with hair extending beyond collar length must have it neatly secured in a ponytail.
- 5. Jewelry shall be kept to a minimum. No earrings, nose decorations, including rings and studs are allowed with the exception of religious reasons with prior notice to the Volunteer Manager.
- 6. Make-up and nail polish are not permitted.
- 7. Beards, sideburns and mustaches shall be neatly trimmed.

I have read and received a copy of the Dress Code Policy and Procedure and will abide by the guidelines.

Signature

Date

VOLUNTEER OPPORTUNITIES

Dr. P. Phillips Hospital

Admitting Dept.

Description: Greet patients/guests coming in for diagnostic treatments. Escort patients to their designated treatment areas. Assist staff with clerical duties as requested.

Hours: Monday-Friday 3p-6p, Saturday 9a-1p

Art/Activity Cart

Description: The art/activity cart is designed to provide creative activity for patients and families that provide stress relief, decrease loneliness and anxiety. Volunteers bring art supplies, puzzles, books and magazines to patients and families.

Hours: Volunteer hours are available 10am to 6pm daily.

Environmental Services

Description: Volunteers assist with light cleaning duties throughout the hospital such as dusting, damp wiping, dust mopping, refilling hand sanitizer dispensers and vacuuming.

Hours: Volunteer hours are available 8am-9pm, daily

Food and Nutrition

Description: The Food and Nutrition Department provides all dietary needs for in-patients as well as cafeteria service for staff and guests. Volunteers assist with kitchen/cafeteria duties such as stocking beverage coolers, replenishing salad bar, keeping cafeteria table clean, refilling salt & pepper shakers, making sure there are food trays available. Assist kitchen staff with some prep work.

Hours: Volunteer hours are available 8 am to 9pm, daily

Healing Arts

Description: Musicians, artists, storytellers, clowns, etc. to entertain patients and guests on patient floors and lobby areas. (Baby grand piano provided in lobby).

Hours: Volunteer hours are available 7 days a week from noon to 8 pm.

Information Desk

Description: Greet patients, visitors and guests as they enter the hospital. Answer phone, assist patients/guests with directions, look up room numbers, escort people when necessary. Give out pertinent information as necessary.

Hours: Weeknight and weekend hours available.

Main Laboratory

Description: Retrieve lab specimens from the pneumatic tubes and deliver samples to technical area. Deliver out-patient requisitions to phone center. File in-patient requisitions. Empty and place used biohazard bags in red trash bag and place labels in shred box. Retrieve tubes from centrifuge and spin coagulation tubes in the hematology area.

Hours: Volunteer hours are available 8am- 4pm, Monday through Saturday.

Nursing Unit

Description: Answer telephone at nurse's station. Answer the call lights. Check and fill patient water pitchers. Restock floor inventory. Assist nurses with clerical duties.

Hours: Volunteer hours are available 8a-8p, 7 days a week.

Perry Pavilion

Description: Assist with general housekeeping duties in the Perry Pavilion.

Hours: Volunteer hours are available 11am-4p, Saturday and Sunday

Radiology Department

Description: Greet and assist patients with paperwork. Maintain supply of necessary forms. Monitor the waiting area. Replenish the supply of patient education materials and maintain displays.

Hours: Volunteer hours are available 10am-7pm, 7 days a week.

DPH Scripts – Retail Pharmacy

Description: The retail pharmacy fills prescriptions for patients and team members. Volunteers are needed to assist customers at the drop off and pick up window and assist with the payment transactions.

Hours: Volunteers are available 9am-7pm, 7 days a week.

Spiritual Care Department (Available Summer Session Only)

Description: Assist staff with clerical duties to include filing, copying, computer inputting, special projects, and rounding with the aromatherapy cart in public areas.

Hours: Volunteers are available 8a-4p, Monday thru Friday.

Transportation Department

Description: Transport patients in wheelchairs to and from different locations within the facility. Call transport dispatcher when a patient is not appropriate for their abilities to transport. Sanitize wheelchairs after every use by wiping down with disinfectant wipes.

Hours: Volunteer hours are available 11am-7pm, 7 days a week.

Volunteer Office

Description: Run errands throughout the hospital and make deliveries such as flowers to patients. Assist in patient chart copying by picking up/delivering the chart to medical records and back to the nursing unit. Answer the phone in the volunteer office. Assist with special projects such as stuffing envelopes, using paper cutter, copying etc.

Hours: Volunteers are available 8a-4p, Monday thru Friday.

Volunteer Training

All Teenage Volunteers are required to attend a general hospital orientation at Dr. P. Phillips Hospital prior to beginning volunteer service. Unit specific training is provided by the service area staff to which the volunteer is assigned.

ORLANDO HEALTH

1414 Kuhl Ave. • Orlando, FL 32806

NON-EMPLOYEE STATEMENT OF CONFIDENTIALITY

Last Name:	First:	MI:
Phone Number:	Title:	
Company:	Phone Number:	
Date of Birth:	(Used in resetting passwords)	

As a non-employee performing services for Orlando Health, you may have access to confidential information including patient, financial or business information obtained through your association with Orlando Health. The purpose of this agreement is to help you understand your personal obligation regarding confidential information. **Signed acknowledgement of this form is required prior to issuance of computer network or application credentials (user ID and password) and prior to commencement of any services for Orlando Health.**

Confidential information is valuable and sensitive and is protected by law and by strict Orlando Health policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires protection of confidential patient information contained within a healthcare information system. Inappropriate disclosure of patient data may result in the imposition of fines up to \$250,000 and 10 years imprisonment per incident. Information made available through the Orlando Health computer network, the internet or by any other means is not to be discussed, replicated, or disseminated in any manner to anyone who is not officially and directly given access to this data. In addition to patient data this includes but is not limited to: financial information, business information (such as contracts, business strategies and plans, etc.), personnel information and other information of a sensitive or confidential nature.

Accordingly, as a condition of my access to confidential information, I acknowledge and agree that:

1. I will not access confidential information for which I am not an authorized user and for which I do not have a legitimate "need to know", whether on the computer system, in files, or in any other location. This includes accessing my own, my family members', my friends' and my co-workers' medical or other confidential information without proper access permission.
2. I will not in any way divulge, copy, disclose, sell, loan, review, alter or destroy any confidential information unless expressly permitted by existing policy or except as properly approved in writing by an authorized individual within the scope of my duties at Orlando Health.
3. I will not utilize another user's password in order to access any system nor will I reveal my computer user access code to anyone for any reason. I understand that I am personally responsible for all transactions and information entered into the computer under my assigned user access code.
4. If I observe or become aware of any unauthorized disclosure of confidential information, I will report it immediately to my Orlando Health supervisor or contact person.
5. If I observe or become aware of a security breach (any incident in which there occurs an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system), I will contact my Orlando Health supervisor or contact person, or the Orlando Health Information Services Help Desk at 321.841.7378.
6. I will not seek personal benefit or permit others to benefit personally from any confidential information to which I may have access.
7. I understand that all information medium is the property of Orlando Health and it shall not be used inappropriately or for personal gain regardless of:
 - a. The medium on which it is stored (i.e., paper, computer, videos, recorders).
 - b. The system which processes it (i.e., computers, voicemail, telephone systems, facsimiles).
 - c. The methods by which it is moved (i.e., electronic mail, over the internet, face to face conversation, facsimiles).
- I also understand that Orlando Health reserves the right to inspect or monitor any company owned, leased or controlled computer, computer device, network, computer facility, storage device, voicemail or telephone system at any time for any reason and that Orlando Health may divulge any information found during such inspections or monitoring to any party it deems appropriate. I understand that I should not consider electronic communications (including the internet, email, telephone, voice mail, facsimile, interactive pager, etc.) to be either private or secure, nor have an expectation of privacy in anything I create, store, send or receive on the computer and the network or any other electronic communications medium.
8. I will not use patient names within the body of an email; I will use names only in an attachment to the email.
9. I understand that if I am transferred to another department, my user access code may not necessarily be appropriate for the new area and may be changed or deleted.
10. I understand that if my association with Orlando Health terminates for any reason, my user access code will be deleted immediately.
11. I agree to abide by all Orlando Health rules and regulations as specified unless altered by a separate contractual agreement.
12. I understand that my failure to comply with this agreement may result in action against me personally and/or against the business or individual with which Orlando Health contracts for my services, which action may include but is not limited to my being removed from performing services for Orlando Health, as well as potential civil or criminal penalties.

Signature _____ Date _____

Signature and Department at Orlando Health Sponsoring Representative _____