Department of Volunteer Services
716-898-3266

Dear Prospective Volunteer:

Thank you for expressing an interest in becoming a Junior Volunteer at the Erie County Medical Center Corporation. **You must be 16 years old** to volunteer at ECMC. Enclosed is an application for you to fill out, a consent form for your parent(s) or guardian to sign and a recommendation form for your guidance counselor or favorite teacher to complete. It is also required that you submit working papers and an up-to-date immunization record.

When you are ready to submit these materials, please call to schedule an interview by calling (716) 898-3266. At the interview, we will discuss what you hope to gain from your volunteer experience and what volunteer opportunities are available.

I look forward to working with you to better serve the patients and families at ECMCC.

Sincerely,

Kathi Mitri

Volunteer Coordinator

The Junior Volunteer Program provides guidance and encouragement to high school students considering a career in health care. The Junior Volunteer gains educational rewards, as well as the personal satisfaction one receives from unselfish service to others.

Appropriate volunteer duties include: clerical work such as typing, filing, or receptionist duties; transporting patients; running errands for staff; assisting patients with crafts; or visiting patients. Other duties may include packing supplies, delivering flowers and mail, and reading to or offering companionship to patients.

WHAT YOU NEED TO KNOW

1. **You must be at least 16 years of age.**
2. Because you are under 18 years old working papers are required before you can start your assignment. Your school guidance counselor can provide you with an application for working papers.
3. An orientation will be held at the beginning of the program. You will be required to attend the orientation in order to participate in the program.
4. A minimum total of 25 hours is expected; you may give more time if you choose.
5. You will receive a uniform to wear while on duty. It is your responsibility to keep it clean and neat. You will be issued an ID badge that must be worn at all times.
6. Please dress professionally as you represent ECMCC to our patients, visitors and staff. Jeans, bare midriffs, baseball caps, etc. are not permitted. The use of personal cell phones while on duty is not permitted.
7. Rubber soled shoes or sneakers are suggested. No open toe sandals or flip-flops are allowed.
8. Please be prompt and report for duty on the days you are scheduled. You may call the Volunteer Office at 898-3266 if you need to adjust your schedule.
9. At the end of the program, please let the Volunteer Coordinator know if your school will need verification of your volunteer hours.
10. When your volunteer service has been completed, please return your ID badge and your uniform to the Volunteer Coordinator.

Thank you in advance for your service to the patients, families and staff
of the Erie County Medical Center Corporation

Health Assessment_____
Orientation_____
Start Date_____
Location_____

Department of Volunteer Services
716-898-3266

Junior Volunteer Application

Last Name: _____ First Name: _____

Address: _____ City/Town/State: _____

Zip Code: _____ Phone: _____

Date of Birth: _____ Sex: M ☐ F ☐

Parent or guardian: _____ Phone: _____

Emergency Contact: (if parent or guardian cannot be reached) _____ Phone: _____ Relationship: _____

Are you 18 years old or older?
Yes ☐ No ☐

If no, what is your birth date?
Month_____ Day_____ Year_____

Do you have working papers?
Yes ☐ Please attach copy
No ☐ but will submit prior to beginning work

School: _____ Grade: _____

Are you volunteering to fulfill a school requirement?

Yes No If yes, number of hours needed_____ Name of school contact person: _____

Phone:_____

Please answer the following questions:

Why are you interested in volunteering at ECMCC? _____

_____

If you are interested in a particular area or assignment, please indicate your preferences: _____

_____

Are there any physical limitations that might affect your volunteer work? _____

_____

Please list previous volunteer experience or any organizations to which you belong: _____

_____

Do you have any special interests, hobbies, or talents? _____

E-Mail Address:_____

Your Signature:		Date:	

CORPORATION

Volunteer Services
PH: 716-898-3266
FAX: 716-898-4358

Dear Health Care Provider:

As a requirement for volunteering in a health care facility in New York State, each prospective volunteer must meet pre-employment health standards. Kindly complete and sign this form for your patient.
Thank you, Kathi Mitri, Volunteer Coordinator

Name: _____ Date of Birth: _____

1. Is this person in general good health and free from communicable disease?

   Yes No (If no, Please comment on revise side)

2. Date of last physical exam: _____/_____/_____ (must be in the last 12 months)

3. Tuberculin Skin Test in previous 12 months

Date of test ____/____/____ Type: _____ Result (circle one) Positive or Negative

Check if known prior positive TST test, treatment dates and latest x-ray date/ result
_____

4. Measles/Mumps/Rubella (MMR)

Two doses after 12 months of age…….Dates____/____/____ &
Dates____/____/____

OR Measles (Rubeola) – one option must be met:

□ Two immunizations after 12 months of age ……..……Dates___/___/___ &
___/___/___ **OR**

□ Blood titer documenting immunity…….……Date of test___/___/___

AND Mumps – one option must be met:
□ Two Immunization after 12 months of age……Dates ___/___/___ &
___/___/____ **OR**

□ Blood titer documenting immunity……Date of test ___/___/___

AND Rubella (German Measles) – one option must be met:
□ Immunization after 12 months of age……Date___/___/___ **OR**

□Blood titer documenting immunity……Date of test ___/___/___.

5. Varicella (Chickenpox or Shingles) – one option must be met:

□ Immunizations……Dates___/___/___ & ___/___/___ **OR**

□ Blood titer documenting immunity……Date of test ___/___/___

6. <u>OPTIONAL (not required)</u>: Hepatitis B – one option must be met:

□ Vaccine – Series of three……Dates___/___/___ & ___/___/___ & ___/___/___ **OR**

□ Positive Hepatitis B Antibody Test……...…Date of test___/___/___

7. Tetanus Pertussis-Diphtheria series as a child AND

Tetanus-Diphtheria booster less than 10 years ago……..…Date___/___/___

8. Influenza Vaccination (seasonal)

□ Immunization ……..…Date___/___/___

Signature of Examining Provider: _____ Date: ____/____/____

Print or Stamp Name: _____

JUNIOR VOLUNTEER PROGRAM
PARENT PERMISSION FORM

Department of Volunteer Services

716-898-3266

My son/daughter _____has my permission to serve as a Junior Volunteer at the Erie County Medical Center Corporation and is physically able to do so.

I understand that my child's eligibility for the Jr. Volunteer Program is contingent on his/her good health. I further understand that it is my responsibility to arrange for my child's transportation to and from the Medical Center.

Signature of Parent or Legal Guardian_____

Relationship_____ Date_____

JUNIOR VOLUNTEER PROGRAM
SCHOOL RECOMMENDATION
716-898-3266/fax: 898-4358

Department of Volunteer Services

STUDENT'S NAME _____

SCHOOL _____

	GOOD	AVE	BELOW AVERAGE	NOT ABLE TO EVALUATE
Willingness to learn	____	____	____	____
Ability to complete assigned duties	____	____	____	____
Responsibility	____	____	____	____
Dependability	____	____	____	____
Interpersonal Skills	____	____	____	____
Empathy for Ill/Handicapped Individuals	____	____	____	____
Honesty	____	____	____	____
Maturity	____	____	____	____
Personal Appearance/Grooming	____	____	____	____
Willingness to follow rules	____	____	____	____
Ability to follow instructions	____	____	____	____

What are this student's greatest strengths, abilities and talents?

What problem areas might impact on this student's performance as a Jr. Volunteer?

In 2-3 sentences, how would you discuss this student's motivation for volunteering and ability to contribute to our program?

SIGNATURE _____TITLE_____

SCHOOL _____

ADDRESS _____

PHONE _____

DATE _____