



6847 N. Chestnut Street
P.O. Box 1204
Ravenna, Ohio 44266
Phone (330) 297-0811

Dear Prospective Volunteer,

Thank you for your interest in the Volunteer Services program at Robinson Memorial Hospital. Our volunteers provide valuable service to our patients, visitors and staff while enjoying a unique opportunity for personal growth and satisfaction.

Enclosed you will find information concerning the process for entering volunteer service, along with an application to assist us in making the best use of your talents and interests. Please complete the application form and return it to:

**Volunteer Services
Robinson Memorial Hospital
6847 North Chestnut Street
Ravenna, Ohio 44266**

After we have contacted your references, we will call you to arrange a convenient time for an interview. For your interview, we ask that you bring the following:

1. Driver's license or state issued ID (*age 18 and over*)
2. Health Awareness Statement (included with application packet)
3. Immunization records
(see Health Awareness Statement Policy for specific requirements and guidelines)

We look forward to meeting with you and pursuing your interest in volunteering at Robinson Memorial Hospital.

Sincerely,

Volunteer Services Department
(330) 297-2591

www.robinsonmemorial.org



Robinson Memorial Hospital is an affiliate member of Summa Health System



Robinson
Memorial
Hospital



PROCESS FOR ENTERING VOLUNTEER SERVICE

Robinson Memorial Hospital is an affiliate member of Summa Health System

1. THE APPLICATION

As a prospective volunteer, you must be **at least 14 years of age** and should consider your willingness to complete **a minimum of 50 hours of service** during their first year (*exception for summer volunteer program and intern/externship applicants*). You should then complete the Volunteer Application, providing pertinent personal information, employment, volunteer experience, and personal or professional references. References will be contacted by phone upon receipt of application. Teen applicants are required to submit a school counselor/teacher recommendation and parent/guardian signature for their reference requirement.

2. THE INTERVIEW

Once satisfactory references are verified, a staff member from the Volunteer Services Department will call you to schedule a time to come in for an interview. The interview provides the opportunity to discuss your interests, skills and availability in order to determine whether a mutually acceptable volunteer placement can be made.

If the interview results in volunteer placement, you will also complete the following requirements on the same day as your interview:

3. CRIMINAL BACKGROUND CHECK AND PHOTO

All volunteers age 18 and over are required to submit to a criminal background check through fingerprinting. Volunteer status is conditional, awaiting these results. Please bring your drivers license or state-issued ID card with you on the day of your interview. A photo is also taken that day for a volunteer identification badge.

4. HEALTH REQUIREMENT

All new volunteers must have a 2-step Tuberculosis Skin Test (TST). The first step will be given on the same day of the interview at the hospital's Employee Health Clinic. During the visit to the Health Clinic, you will be asked to verify immunizations or history of having a varicella (chickenpox) infection. New volunteers born after 1956 or capable of child bearing must also verify two MMR (Measles, Mumps, Rubella) vaccinations. (See Health Awareness Policy for determining immunity and needed documentation).

5. ORIENTATION

Volunteer orientation provides important information about the hospital and volunteer roles. All new volunteers are required to:

- **view a 25 minute orientation on the computer (same day as interview)**
- **attend a scheduled 3-1/2 hour Orientation Class (sign-up at interview)**

6. TRAINING

Training for the volunteer assignment is provided within the department where you will serve and is done by an employee or an experienced volunteer.



VOLUNTEER APPLICATION

Robinson Memorial Hospital is an affiliate member of Summa Health System

PLEASE PRINT

I am interested in:

- Traditional Volunteer
 Summer Only Volunteer
 Intern/Externship
 Love on a Leash
 Pastoral Care

Date: _____

Dates: _____

Requested Dept: _____

Name: Last _____ First _____ M.I. _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone: (____) _____ Other: (____) _____

Email: _____ Birth Date _____ (Year optional if over 18 yrs.)

Alternate Address (i.e. school address, winter home address, etc)

Emergency Contact _____ Relationship _____

Home Phone (____) _____ Alternate Phone (____) _____

Education/Interests:

Check all that apply

High School Graduate High School _____ Graduation Year _____

_____ University/College Years Attended _____ Degree Earned _____

Other Schooling: _____

List any additional training, skills or interests that would assist us in placing you:

Personal History:

Any limitations related to health: _____

Have you been a resident of the State of Ohio for the past five consecutive years? Yes _____ No _____

Have you ever been convicted of a felony or misdemeanor? Yes _____ No _____

If yes, state offense, location and disposition (NOTE: A conviction will not necessarily disqualify you from volunteering)

Have you ever been suspended or excluded from participating in the Medicaid or Medicare programs or are you currently under investigation by either program? Yes _____ No _____

References

Please provide 2 adult references we can contact, not related to you, who have known you for a minimum of 1 year:
High School Students: Provide School Recommendation/Parental Consent Form instead

1. Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

2. Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Volunteer/Employment History or Reference:

Present or Last Employer and/or Volunteer Service _____

From: Month _____ Year _____ To: Month _____ Year: _____ May we contact? Yes _____ No _____

Address _____ City _____ Phone (____) _____

Position Held _____ Name of Supervisor _____

Description of Duties _____

Reason for Leaving _____

Have you ever volunteered or been employed at this hospital? Yes _____ No _____

If yes, please indicate Dates: _____ and Department _____

Pease read carefully & sign:

Qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, disability or veteran status.

I understand that I will be expected to abide by all volunteer policies. I also understand that I am committed to **serve a minimum of 50 hours within 1 year for a traditional volunteer position or minimum two visits per month for Love on a Leash.**

I understand the application, interview, background check, and placement process are required of all volunteer applicants and are in no way a contract of volunteer service or promise of future volunteer service. I understand I will be required to attend the volunteer orientation and complete a two-step TB screening (free of charge at the hospital).

I certify that the above information I have given on this application is true and complete. I authorize investigation of all statements contained in this application and understand that my giving false information is sufficient for my discharge, if accepted. Due to the nature of some volunteer positions, I authorize the companies, schools or persons named in this application to provide information regarding me and hereby release them from liability for issuing this information.

I understand that I may be required to participate in a criminal records check prior to my volunteer service. I understand that RMH will submit my fingerprints to the Ohio Bureau of Criminal Identification and Investigation (BCII) and/or the Federal Bureau of Investigation. This background check is conducted to ascertain whether I have been convicted of certain crimes or violations which could disqualify me from eligibility for volunteer service. If I fail to provide the information necessary to complete the required forms, or fail to provide impressions of my fingerprints, I will no longer be considered for volunteer service. My volunteer service at RMH is contingent upon a records check that does not reveal any disqualifying offense(s). If I am accepted as a volunteer, my status will be conditional pending receipt of this information.

This organization is not obligated to provide a placement, nor am I obligated to accept the position offered.

Signature of Applicant _____ Date _____



VOLUNTEER HEALTH AWARENESS STATEMENT

Robinson Memorial Hospital is an affiliate member of Summa Health System

Please DO NOT mail back with application. Bring this form with you to the interview.

Name: _____ Birthdate: _____ SS# _____

History of past illness: (Please circle)

- | | | |
|-------------------|----------------|-----------------|
| Anemia | Emphysema | Meningitis |
| Asthma | Encephalitis | Mumps |
| Black Lung | Epilepsy | Pneumonia |
| Bronchitis | Heart Disease | Polio |
| Cancer | Hepatitis | Rheumatic Fever |
| Chickenpox | Hypertension | Scarlet Fever |
| Diabetes | Kidney Disease | Skin Disease |
| Diarrhea, chronic | Liver Disease | Tuberculosis |
| Diphtheria | Measles | Whooping Cough |

Do you have a chronic draining infection or open wound? _____

Do you have any medical conditions that could interfere with your volunteer duties? ____Yes ____No

If yes, please explain _____

Immunizations

MMR(measles, mumps, rubella)
(mo/day/year) #1 _____
#2 _____

Varicella (Chickenpox) ____ Yes ____ No
If no, Immunization Dates:
(mo/day/year) ` #1 _____
#2 _____

Allergies: Drugs: _____ Food _____

Health Awareness Statement:

1. I will notify the Working Partners Clinic of any serious illness due to an infectious disease.
2. I will report any change in my health status that may affect my ability to be a safe hospital volunteer.
3. I will report any change in my health status that occurs after this date pertaining to the above history of questions.
4. I understand if I am unable to volunteer due to an illness, communicable disease or injury for five (5) continuous days, I must obtain a statement from my physician or I must obtain clearance to return to volunteering through the Working Partners Clinic.

Volunteer Signature: _____

Date _____

Robinson Memorial Hospital is an affiliate member of Summa Health System

TB Testing:

All new volunteers will have a 2-step Tuberculosis skin test (TST) provided free of charge at Robinson's Working Partners Clinic. The first step will be given prior to beginning volunteering. *This process will require two separate visits to the clinic for the skin tests, and then 2 follow-up visits within a specific time frame to check the skin test.* If you are a positive reactor, you will have a baseline chest X-Ray, provided by RMH. Volunteers in selected service areas will follow the hospital's Tuberculosis Policy & Procedure guidelines and may be required to have annual TB testing based on CDC criteria. Only one step is required if documentation is provided that a TST was performed within the previous 12 months.

Determining and Providing Varicella (Chickenpox) Immunity:

1. If a new adult volunteer is unable to provide documentation of two varicella immunizations OR confirm they have had chickenpox, a titer (blood draw) will be performed to verify immunity.
2. If the varicella titer is negative, the varicella vaccine will be administered (adults only) in the Working Partners Clinic and repeated in 4-8 weeks. Volunteers will follow the RMH Herpes Zoster Virus (VZV): Varicella (Chickenpox) and Herpes Zoster (Shingles) Policy.
3. All teen (age 14-18) and college internship volunteers must provide documentation of two varicella immunizations or history of having a varicella infection.

Determining and Providing MMR (Mumps, Measles, Rubella) Immunity:

1. Volunteers born before 1957:
 - Documentation of physician diagnosed measles and mumps or
 - Lab evidence of measles, mumps, rubella immunity or
 - Documentation of one dose of MMR vaccine

If unable to provide any of the above documentation, a MMR titer (blood draw) will be performed to verify immunity.

2. Volunteers born in 1957 or later:
 - Documentation of physician diagnosed measles and mumps or
 - Lab evidence of measles, mumps, rubella immunity or
 - Documentation of 2 doses of live measles/mumps vaccines on or after the first birthday separated by 28 days or more and at least 1 dose of the live rubella vaccine.

If unable to provide any of the above documentation, a MMR titer (blood draw) will be performed to verify immunity.

If a MMR titer is negative, then an MMR vaccine will be administered (adults only) in the Working Partners Clinic according to the hospital's MMR Policy. All teen (age 14-18) and college internship volunteers must provide documentation of MMR immunizations or history of having the infection.

Exposures or Injuries:

Volunteers are not asked to perform duties where it is reasonably anticipated that there will be contact with blood or other potentially infectious materials. However, in the event a volunteer sustains an exposure (needlestick, splash, or bite) or other injury while on duty, the volunteer must fill out an Employee Injury/Illness Work-Related Report. The volunteer will notify the Volunteer Services Department Manager of the exposure or injury and report to the Working Partners Employee Health Clinic during usual clinic hours (Monday through Friday – 7:30 AM - 4:00 PM). At all other times, the volunteer will page the Nursing Coordinator on duty. If the injury is serious, the volunteer will report to the Emergency Department for evaluation. Expenses incurred during evaluation and treatment may or may not be the responsibility of the volunteer.

TEEN VOLUNTEER APPLICANT SCHOOL RECOMMENDATION/PARENTAL CONSENT FORM

Each student who applies for volunteer service *is required to have a recommendation from a school counselor or teacher, along with parental/guardian consent.* We would appreciate your evaluation and comments to help us choose teen volunteers who will best benefit from our program and serve our organization. Please return the completed form to the student or mail directly to: **Volunteer Services, Robinson Memorial Hospital, 6847 North Chestnut Street, Ravenna, Ohio 44266**

Thank you for your assistance,
 Volunteer Services Department
 (330) 297-2591



Robinson Memorial Hospital is an affiliate member of Summa Health System

Parent/Guardian Consent: I authorize the release of information from my son's/daughter's school to the Volunteer Services Department of Robinson Memorial Hospital and consent to their application for volunteer service.

Parent/Guardian Signature _____ Date _____

School Recommendation:

Student Name _____ Grade _____
 (Print name)

	Excellent	Good	Average	Below Average
Attendance				
Scholastic Record				
Dependability				
Courtesy				
Willingness				
Initiative				

Could volunteer activity in any way negatively affect this student's school performance?

Other Comments: _____

Counselor/Teacher

Signature _____ Title _____

School _____ Date _____