PARTNERS OF
Black River
MEMORIAL HOSPITAL

Dear Prospective Volunteen:

Thank you for your interest in the Volunteen Program. Being a Volunteen is a very rewarding experience. In addition to the satisfaction you receive from helping others, you will also gain insights into the medical field as a possible profession.

To be a Volunteen you must:

1. Be 14-18 years old
2. Complete the application containing your signature and that of a parent or guardian.
3. List two personal references (individuals who are over 18 years old and not a member of your immediate family).
4. Attend the general orientation session on **Thursday, June 9, 11:30 am until approx. 3:00 pm** at the hospital and the training session for the facility at which you are assigned. (Note: our orientation day may have to change if the last day of school changes!)
5. Complete the health history form.
6. Maintain at least average grades in school (C average).
7. Accept your assignment in good faith and be present when scheduled or arrange for a replacement. Volunteering is a commitment.
8. Teens will be required to be fully vaccinated against COVID-19, or submit religious or medical exemption, for BRMH review. To request exemption, contact Volunteer Services for forms.

You will receive a letter with details prior to the general orientation. If you have any questions, please call Cindy Clark at 715-284-1391, or email clarkc@brmh.net or contact Sarah Osegard at 715-284-3606, or email osegards@brmh.net.

We look forward to meeting you.

Sincerely,

Cindy Clark and Sarah Osegard
Volunteer Services Department

Please return the completed application, permission form, personal release and health record by May 2, 2022 to:

Black River Memorial Hospital
Attn: Sarah Osegard
711 West Adams Street
Black River Falls, WI 54615

VOLUNTEEN APPLICATION FORM

PARTNERS OF Black River MEMORIAL HOSPITAL

Date: _____ Please write T-shirt size: _____
(shirts are adult size)

Name: _____

Address: _____
Street *City* *State* *Zip*

Phone #: _____ Birth Date: _____ Age: _____

School Attending: _____

Present Grade in School: _____ Graduation Year: _____

School Activities: _____

Other Activities: _____

Career Plans: _____

Currently Employed? _____ Company: _____ Hrs per Week: ____

Father: _____ Work/Cell Phone: _____

Mother: _____ Work/Cell Phone: _____

Emergency Contact: _____ Phone #: _____

Family Physician: _____ Phone #: _____

Do you have any physical restrictions, limitations, or health problems which may affect your performance as a volunteen? Please describe: _____

_____

How did you become interested in becoming a volunteen? _____

_____

Number the following facilities in order of preference (First, second, third choice):
Pine View _____ Meadowbrook _____ Black River Memorial Hospital _____

List two character references, not relatives (teacher, clergyman, employer):
Name Mailing Address Phone

_____

_____

I understand that if accepted as a Volunteen, it is my responsibility to read the rules and regulations for Volunteens, to be prompt and regular in my service and to perform my assigned duties to the best of my ability.

_____ _____
Signature of Applicant Date

Volunteen Program

PARENTAL PERMISSION FORM

Date: _____

I hereby give permission for my son/daughter _____ to participate in the Volunteen Program at Black River Memorial Hospital (BRMH) or Pine View Care Center or Meadowbrook. I certify that my son/daughter is _____ years of age and that his/her birth date is _____.

I authorize any health screening that is required for participation in the Volunteen Program. My child is voluntarily choosing to volunteer at BRMH and I will not hold BRMH liable for any illness from COVID-19. Vaccination against COVID-19 is REQUIRED to volunteer at Black River Memorial Hospital. Proof of vaccination or exemption form will be required before orientation.

I understand that as a volunteen my son/daughter is making a commitment to the hospital and/or nursing homes. He/she has an obligation to carry out the responsibilities he/she undertakes. I will take part in this commitment by assuring that he/she will report on time for assignments. I will also make sure notice is given when he/she cannot be there at the scheduled time.

To volunteer at BRMH, my child will attend the general orientation session on **Thursday, June 9, 11:30 am until approx. 3:00 pm** at the hospital.

Due to COVID-19, my child may be required to wear source control, such as a mask and/or eye protection while volunteering. My child may be asked to wear their own face covering into the hospital, and then be provided with an appropriate mask for use while volunteering. Proper mask use and hand hygiene will be taught at orientation.

My child will return the permission forms, personal release and health record by **June 9.**

_____

Signature of Parent/Guardian

_____

Home Phone Work Phone Cell Phone

Consent to Photograph/Interview/Video

I hereby consent to and authorize Black River Memorial Hospital and its agents, staff and representatives to make, use, edit, reproduce and publish any of the following (strike if not applicable): photographs, video, verbal comments, written comments, taped interview and other audiovisual records of me. I consent to and authorize the use of these items in the following manner (strike if not applicable): internal publications, community or public announcements, internet/website, email, social media, release to the media, and patient and medical professional education. This consent shall act to expressly release from liability Black River Memorial Hospital, any and all of its staff, its agents, representatives, consultants and physicians.

Name (printed)_____

I am over 18 years of age: ☐ Yes ☐ No*

_____ _____

Signature of above-named person Witnessed by

Address_____ Address_____

_____ _____

Date_____ Date_____

*If the above-named person is under 18 years of age or is otherwise unable to consent, consent should be given by parent or guardian as follows:

I hereby certify that I am the parent or guardian of _____.

The person named above is unable to consent because_____.

For the above-named person, I do hereby give my consent and authorization to the foregoing on behalf of him/her/them.

_____ _____

Signature of guardian or parent Signature of witness

Thank you!

VOLUNTEER SERVICES
HEALTH RECORD

Black River MEMORIAL HOSPITAL

Name: _____ Phone: _____
Please Print

Address: _____
Street *City* *State* *Zip*

Emergency Contact Name: _____ Phone: _____

ALLERGIES

☐ Food: _____
☐ Medications: _____
☐ Latex
Describe your reaction(s) to the items listed above: _____
_____

CHILDHOOD ILLNESSES

Have you ever had any of the following illnesses?

☐ Measles	☐ German Measles (Rubella)	☐ Whooping Cough
☐ Scarlet Fever	☐ Polio	☐ Mumps
☐ Shingles	☐ Other: _____	

IMMUNIZATIONS

Provide copies of immunizations, TB testing or immune titer records, if possible. If records are not available, a blood draw will be performed, at no cost to you, to determine immunity status.

Measles MMR: 1) _____ 2) _____ **OR** Titer Results: _____
Mumps MMR: 1) _____ 2) _____ **OR** Titer Results: _____
Rubella MMR: 1) _____ 2) _____ **OR** Titer Results: _____
Varicella/Chicken Pox Status: _____ **OR** Titer Results: _____
Hepatitis B status: _____ Tetanus Date: _____
Tdap ☐ or Td ☐
COVID-19: 1) _____ 2) _____ 3) _____
Optional

To the best of my knowledge, I am free from contagious disease and know of no condition which would prevent me from performing volunteer activities.

I further consent to pre-service laboratory testing and vaccination, if indicated.

Signature: _____ Date: _____