March 1, 2023

Dear Parents:

Thank you for allowing your child to be involved in the Caring Teen program here at Baptist Health-Fort Smith.

We believe the program is very beneficial for the students. Not only do they learn responsibility for devoting their time and energy to the program, but they can take a deep look into the medical field and see how many different departments it takes to make a hospital run.

Every step of this program is a learning process, from filling out the application, following instructions and interviewing.

With the amount of teens that apply for our program, not everyone will receive the volunteer assignment they are most interested in; again there are many different departments that make this hospital function as a team.

Not only is this a commitment for your child, it is also an eight week commitment for you as parents. You are committing to have your child at Baptist Health-Fort Smith every Tuesday and Thursday from 9:00 a.m. to 4:00 p.m. We do provide lunch for your child.

We expect our Caring Teens to take their volunteer assignments seriously, just as they would their class attendance or employment. If either one of you are unable to meet the required time commitment, we ask that they not apply. If your child is going to be gone for any prolong period of time during this program, they may want to reconsider being in the program until they can devote more time to it.

There will be a **mandatory** meeting for one parent and teen on Monday, April 10th starting at 5:00 p.m. and will run until 6:00 p.m. This is a drop in meeting. The meeting is in the Baptist Health Classroom on the first floor of the hospital. **If you and your child do not attend this meeting it will disqualify your child from the program.**

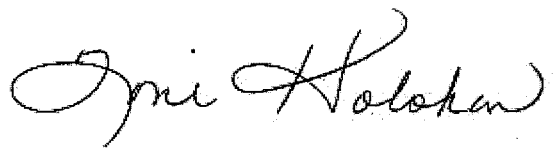
Hospital Orientation is mandatory; if your child can not make the Orientation which is June 6th they cannot participate in the Caring Teen Program.

Please remind your child that our primary mode of communication is through their phone and email. So please remind them to have their voicemail set up and to check their phone and email messages frequently.

The application must be completed by your child, if it is completed by anyone other than the person applying for the program, they will be disqualified from the program.

If you have any questions, please give me a call at 479-441-5555.

Thank you for standing with your child in this program.



Toni Holohan, CVM
Volunteer Manager

Students Signature
No electronic signatures

Parents Signature
No electronic signatures

Baptist Health-Fort Smith
Caring Teen Program
Checklist

(Make sure you have all the documents below before handing in your application packet.)

Do not print any document on both sides of a sheet of paper.

____Letter To Parents signed

____COVID-19 vaccination card

____COVID-19 Waiver

____Criteria Form signed

____Application

____Essay – 400 to 500 typed words, check your spelling, and count your words because I will.

____If Accepted I Agree Form

____Recommendation Form – Must be Baptist Health-Fort Smith recommendation forms, not letters of recommendations. **2 required**

____Recommendation Form – Must be Baptist Health-Fort Smith recommendation forms, not letters of recommendations. **2 required**

____Grades

____School or state ID (If available)

____Shot Records - Required

____Health Information Form

____Tobacco & Drug Testing Policy

____Gym Permission Slip Form

____Authority to interview/photo Form

Baptist Health

COVID-19 Risk Acceptance and Waiver

In choosing to engage in any of these or other volunteer opportunities that may become available, you are also agreeing again to abide by all Baptist Health policies and to conduct yourself in a professional manner. You understand that these activities may increase your risk of exposure to COVID-19 and other illnesses or injuries. COVID-19 is a pandemic virus which could cause you to become ill to the point of permanent harm or death. You accept that risk and understand that the risk of transmission of COVID-19 is high and that it appears to spread through the community easily, potentially putting you and those you come in contact with at risk. You additionally understand that contact with a known or suspected COVID-19 patient could require that you enter quarantine for at least fourteen (14) days. You further agree to maintain patient confidentiality and comply with all HIPAA and patient privacy rules. Certain risks are inherent to and associated with the various activities, research, and patient care conducted at Baptist Health.

By choosing to volunteer in these activities:

- You are agreeing to assume all of those risks and to hold harmless Baptist Health and the Board of Trustees of Baptist Health and Foundation, their agents, officers, and employees and to not hold them responsible or liable for any harm or injury, from any cause, relating to or arising from these activities.
- You are agreeing to indemnify and hold harmless the same entities and persons from the claims of other persons arising out of your acts or omissions.
- Also, you understand that any criminal act or intentional tort committed by another person against you is against Baptist Health policy and outside the scope of that person's employment or relationship with Baptist Health, and that Baptist Health is not vicariously liable for such acts.
- Finally, you understand that these conditions and agreements are binding on all of your heirs, executors, administrators, representatives, assignees, successors, and estates. By completing this form to serve as a Baptist Health Volunteer, you acknowledge that you have read and understand everything above.

Print Teen Name	Teen Signature	Date
Print Parent/Guardian Name	Parent/Guardian Signature	Date

Baptist Health
FORT SMITH

Thank you for your interest in the **2023 Caring Teen Summer Volunteer** program at Baptist Health-Fort Smith Hospital.

Due to the responsibilities encountered by Baptist Health volunteers, we have an extensive screening process.

Criteria:

- 14 to 17 years old
- Must be available Tuesdays & Thursdays
- Must be fully vaccinated for COVID-19
- We expect our Caring Teens to take their volunteer assignments seriously, just as they would their class attendance or employment. If you are unable to meet the required time commitment, we ask that you not apply.
- Not all teens who receive application packets will be accepted into the program.

Application Requirements:

- Have your COVID-19 vaccination card and waiver signed when application packet is submitted.
- Essay on topic provided 400 -500 typed words. Make sure you have counted your words. **I will not email/call you and tell you that you do not have 400-500 words. You will be disqualified.**
- All forms must have parent and teens signatures, **no electronic signatures, they are not legal.**
- No school email addresses, some emails did not get through our computer firewall and and applications were not received.
- A meeting on April 10th from 5:00 p.m. to 6:00 p.m. for one parents and teen is a mandatory meeting in the Baptist Health Classroom on the first floor of the hospital
- Once accepted into the program, we will have pictures made for our badges on May 22nd at 3:30 pm or May 24th at 2:30 pm. We will meet in my office and walk over to Human Resources.
- It is mandatory to attend the Caring Teen Hospital Orientation, June 6, 2023.

The application must be completed by your child, if it is completed by anyone other than the person applying for the program, they will be disqualified from the program.

Do not submit your application until you have all of the documents requirements. Use the checklist that is provided to make sure all documents are attached.

Applicants will receive a phone call/email confirmation - once ALL requirements are met. Most communication is done by phone/email. Please provide the teens phone number and email address so that we can have the opportunity to assess the teen's readiness for a volunteer position at our hospital, it is important that communication be handled by the teen directly.

Application MUST be turned into Baptist-Health-Fort Smith by **March 31st no later than 4:30 pm**. No applications will be accepted after that date.

I recommend you call and make sure your application and your recommendation forms have arrived. Give yourself enough time in case a recommendation form has not arrived.

If you are mailing the application packet, please allow at least 5 days for delivery. If it is delivered past the deadline it will not be counted. Do not email your application packet from a school email address, our firewalls will not always let your email in and I will not receive your application. If you email from your home email address, call and verify that I have received it.

You can hand deliver, fax, email or mail the completed Caring Teen application packet to:

Baptist Health-Fort Smith
Toni Holohan, Volunteer Services
1001 Towson Avenue
Fort Smith, AR 72902-2406
Phone 479-441-5555 antoinette.holohan@baptist-health.org
Fax: 479-441-4005

I would call and verify that I have received your application.

_____ _____

Parents signature - I have read the above information Date
No electronic signatures

_____ _____

Teen's signature - I have read the above information Date
No electronic signatures

Baptist Health
FORT SMITH

Deadline date to return to office is
3/31/2023
by 4:30 p.m.

NO APPLICATIONS WILL BE ACCEPTED AFTER THAT DATE.

Caring Teen Program
June 6, 2023 - July 27, 2023
1001 Towson Avenue
P.O. Box 2406
Fort Smith, AR 72902-2406

_____New Volunteer

_____Returning Volunteer

_____**Polo Size**

A $20 charge for all Polo's

Office Use Only

Date Received:

_____

Received By:

_____

PLEASE PRINT

Name:_____ Telephone :_____

Address: _____ Email : _____

(No school email addresses)

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security: _____

Parents Contact Information:
Name:_____ Telephone: _____

Name:_____ Telephone: _____

Emergency Contact:
Name:_____ Telephone: _____

Prior Volunteer Experience: _____

_____

Why do you want to volunteer at Baptist Health? _____

_____

Are you related to or do you know an employee of Baptist Health – Fort Smith Hospital? ___yes ___no

If so, what is their name? _____ Relationship _____

Department:_____ Contact Number: _____

I understand that my child can not volunteer in the same area as any family members or close friends.

Special talents, hobbies or interests:_____

_____

What other activities will you be involved with this summer? Will these interfere with volunteering here?

_____

_____

Cell Phones are **ONLY** allowed on lunch and break times. **If caught using cell phone during any other time, you will be terminated.**

Have you ever been convicted, or pleaded "no contest" to a felony and/or misdemeanor?
_____No _____Yes

The **Caring Teen Summer Program** is a eight week program. **All applicants must commit** to a regular weekly schedule of Tuesdays and Thursdays and must complete a **minimum of 98 hours.** With school practices and vacations, we require the student to have complete 98 hours before they end of the summer program.

I understand that if I am planning any prolonged period of time away during the 8 week program, this is not a program I should consider at this time.

If I am accepted as a Baptist Health-Fort Smith Caring Teen Volunteer, I understand that I am making a eight week commitment to volunteer during the summer.

My child has permission to ride to and from Baptist Health-Fort Smith Hospital with _____

I understand that it is Baptist Health policy that all volunteers must have the COVID-19 vaccine to volunteer.

_____ _____

Date Volunteer Signature- **Application must be completed by teenager**
No electronic signatures

_____ _____

Date Parent/Guardian Signature
No electronic signatures

Comments: _____

Caring Teen Essay

Topic

Why you are interested in participating in the Caring Teen Program and what you hope to learn from it.

400 – 500 TYPED words
I will count your words

Baptist Health
FORT SMITH

If Accepted As A Baptist Health Caring Teen Volunteer, I Agree That:

1. I will use confidential information, only as needed to perform my volunteer duties. I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to Baptist Health-Fort Smith Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.

2. My services are donated to the hospital and given for humanitarian, religious, or charitable reasons.

3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off of hospital property, or act as a runner or a capper for an attorney in the solicitation business. I shall report all known occurrences of solicitation for attorneys to the Volunteer Manager.

4. I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petition on hospital premises unless I receive the express authorization of the Volunteer Manager to engage in these activities.

5. I understand that I am required to have both COVID-19 vaccination and sign a COVID-19 wavier. I must provide my COVID-19 card with my application. I must also have a flu shot (when in season) as a condition of my acceptance into the volunteer program.

6. Shot records are required and must be up to date.

7. I must be clean and neat at all times, daily baths are required.

8. I shall attempt to resolve any problems related to my volunteer activities with my unit/department supervisor, and if unsuccessful, attempt to resolve any such problems with the Volunteer Manager.

9 I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

10. I shall at all times uphold the mission of the hospital.

11. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of :

Failure to comply with hospital policies, rules, and regulations which includes horse play in the hospital.

Breach of HIPAA or confidentiality standards.

Taking pictures and posting on ANY internet site.

Three absences without prior notification.

Unsatisfactory attitude, work or appearance.

Caught using cell phone during volunteer hours, other then lunch or break.

Being under the influence of alcohol or drugs.

Bring a weapon on the campus.

If a reasonable suspicion, drug test is administered and failure of the test.

Any other circumstances which, in the judgment of the Volunteer Manager, or Directors, which would make my continued services as a volunteer to the contrary best interest of the hospital.

This is not a full list of all reason for dismissal.

I have read all of the above conditions and I agree to adhere to them.

_____

Volunteer Signature
No electronic signatures

_____

Parent/Guardian Signature (if volunteer is under age 18)
No electronic signatures

Date _____

Baptist Health
FORT SMITH

Application deadline is 3/31/2023, nothing will be accepted after the deadline date.

Counselor/Teacher Recommendation Form **Do not give back to the students!**

Dear Counselor/Teacher:

_____has applied to the Caring Teen Program. Thank you for taking your valuable time to complete this evaluation. Your observations are an important part of this student's application. Would you please comment on this student's record in the following areas? **I have highlighted ones of great importance.**

Personal Qualities

Attitude towards school	___Excellent	___Good	___ Fair	___ Poor
Cooperation	___Always Cooperates	___Cooperates	___Sometimes cooperates	___Poor
Emotional Maturity	___Very mature	___Age appropriate	___Sometimes mature	___very immature
Integrity	___Highly trustworthy	___Trustworthy	___Usually trustworthy	___ Questionable
Follow Rules by supervisor or Administration	___Always follows rules	___Mostly follows rules	___ Sometimes follows rules	___Never follows rules
Leadership potential	___Leader	___Can follow or lead	___Leads on occasion	___Rarely leads
Reaction to criticism	___Excellent	___Good	___Fair	___Poor
Responsible	___Very responsible	___Usually responsible	___Sometimes responsible	___Rarely
Self-confidence	___Healthy self-image	___Needs some support	___Seems overconfident	___Poor self-image
Self-control	___Excellent	___Good	___Fair	___Poor
Warmth of personality	___Always friendly	___Usually friendly	___Occasional friendly	___Rarely friendly
Ability to work independently	___Consistently works well	___Needs help occasionally	___Needs help frequently	___Needs help

Work Skills

Class participation	___Joins in readily	___Contributes some	___Wants to dominate	___Rarely contributes
Ability to work in group	___Always works well	___Sometimes	___Has difficulty	___Has great difficulty
Ability to work independently	___Always works well	___Needs some help	___Needs help frequently	___Needs constant help
Completes assignments	___Consistently	___Usually completes	___Needs additional time	___Has difficulty completing
Follows directions	___Easily and	___Needs some help	___Needs	___Rarely
Takes initiative	___Always	___Usually	___Sometimes	___Rarely
Attention span	___Actively engaged	___Attentive	___Variable attention	___Requires frequent redirection

Social Skills

Peer relations	___Role model	___Healthy relationship	___Occasional problems	___Relates poorly
Relationship with adults	___Courteous	___Usually Positive	___Occasional problems	___Shows little respect
Concern for others	___Very considerate	___Considerate	___Usually considerate	___rarely considerate
Attitude towards school	___Excellent	___Good	___Fair	___Poor

Classroom conduct: **Please comment on the student's behavior/attitude:**

_____

Areas of greatest strength and greatest weakness/need:

_____

Would you recommend this student for the Caring Teen School Program? ___Yes or ___No **Application deadline is 3/31/2023**

Evaluator's name **(please print)**:_____ Phone no. _____

Evaluator's Signature: _____Date:_____Title/School:

_____

Please either fax to my office at 479-441-4005 or mail to Baptist Health-Fort Smith Volunteer Office 1001 Towson Ave. Fort Smith, AR 72902 If you are mailing please allow 5 days for delivery. DO NOT GIVE BACK TO THE STUDENT

Baptist Health
FORT SMITH

Application deadline is 3/31/2023, nothing will be accepted after the deadline date.

Counselor/Teacher Recommendation Form **Do not give back to the students!**

Dear Counselor/Teacher:

_____has applied to the Caring Teen Program. Thank you for taking your valuable time to complete this evaluation. Your observations are an important part of this student's application. Would you please comment on this student's record in the following areas? **I have highlighted ones of great importance.**

Personal Qualities

Attitude towards school	___Excellent	___Good	___ Fair	___ Poor
Cooperation	___Always Cooperates	___Cooperates	___Sometimes cooperates	___Poor
Emotional Maturity	___Very mature	___Age appropriate	___Sometimes mature	___very immature
Integrity	___Highly trustworthy	___Trustworthy	___Usually trustworthy	___ Questionable
Follow Rules by supervisor or Administration	___Always follows rules	___Mostly follows rules	___ Sometimes follows rules	___Never follows rules
Leadership potential	___Leader	___Can follow or lead	___Leads on occasion	___Rarely leads
Reaction to criticism	___Excellent	___Good	___Fair	___Poor
Responsible	___Very responsible	___Usually responsible	___Sometimes responsible	___Rarely
Self-confidence	___Healthy self-image	___Needs some support	___Seems overconfident	___Poor self-image
Self-control	___Excellent	___Good	___Fair	___Poor
Warmth of personality	___Always friendly	___Usually friendly	___Occasional friendly	___Rarely friendly
Ability to work independently	___Consistently works well	___Needs help occasionally	___Needs help frequently	___Needs help

Work Skills

Class participation	___Joins in readily	___Contributes some	___Wants to dominate	___Rarely contributes
Ability to work in group	___Always works well	___Sometimes	___Has difficulty	___Has great difficulty
Ability to work independently	___Always works well	___Needs some help	___Needs help frequently	___Needs constant help
Completes assignments	___Consistently	___Usually completes	___Needs additional time	___Has difficulty completing
Follows directions	___Easily and	___Needs some help	___Needs	___Rarely
Takes initiative	___Always	___Usually	___Sometimes	___Rarely
Attention span	___Actively engaged	___Attentive	___Variable attention	___Requires frequent redirection

Social Skills

Peer relations	___Role model	___Healthy relationship	___Occasional problems	___Relates poorly
Relationship with adults	___Courteous	___Usually Positive	___Occasional problems	___Shows little respect
Concern for others	___Very considerate	___Considerate	___Usually considerate	___rarely considerate
Attitude towards school	___Excellent	___Good	___Fair	___Poor

Classroom conduct: **Please comment on the student's behavior/attitude:**

Areas of greatest strength and greatest weakness/need:

Would you recommend this student for the Caring Teen School Program? ___Yes or ___No **Application deadline is 3/31/2023**

Evaluator's name **(please print):**_____ Phone no. _____

Evaluator's Signature: _____Date:_____Title/School:

_____

Please either fax to my office at 479-441-4005 or mail to Baptist Health-Fort Smith Volunteer Office 1001 Towson Ave. Fort Smith, AR 72902 If you are mailing please allow 5 days for delivery. DO NOT GIVE BACK TO THE STUDENT

Baptist Health
FORT SMITH

Health Information

PLEASE PRINT

Physician's Name_____ Phone Number _____

Address_____

Health Limitations_____

Allergic to _____

Are you in good health? ____Yes ____No Are you taking medications? ____Yes ____No

If yes, list _____

Do you have medical problems? ___Yes ___No

If yes, list _____

Have you ever had a tuberculosis skin test? ___Yes ___No In the last 12 months? ___Yes ___No

If yes, please provide documentation.

I certify that the above information is true and complete to the best of my knowledge. I realize this information is confidential and may be used to determine my eligibility to volunteer. I authorize Baptist Health-Fort Smith to make inquiry to my physician regarding the state of my health.

_____
Volunteer Signature
No electronic signatures

_____
Parent/Guardian Signature (If Volunteer is under 18)
No electronic signatures

_____
Date

Tobacco & Drug Testing Policy

I understand that Baptist Health-Fort Smith has a Tobacco Policy that does not allow their employees to smoke and that there is no smoking allowed on all Baptist Health-Fort Smith properties. I understand as a Auxilian/volunteer/volunteen, I am not allowed to smoke while I am volunteering. I understand that my clothes can not smell like smoke; if I smell like smoke I will be requested to go home and change.

Volunteen Signature_____ Date_____

No electronic signatures

Parents Signature_____ Date_____

No electronic signatures

If there is any reasonable suspicion, testing known as for cause drug testing will be performed. If supervisors have evidence or reasonable cause to suspect an Auxilians/volunteers/volunteens of drug use the Auxilians/volunteers/volunteens who are suspected of drug use or a policy violation are generally advised not return to work while awaiting their tests results. Generally, if an Auxilian/volunteer/volunteen is suspected of being drunk on the premises, a urine alcohol test will be administered and the Auxilian/ volunteer/volunteen will be send home.

Reasonable suspicion

Auxilians/volunteers/volunteens are subject to testing based on (but not limited to) observations by at least two members of management of apparent workplace use, possession or impairment. HR, the Volunteer Manager or the Clinical Quality Executive should be consulted before sending the Auxilian/volunteer/volunteen for testing. The Reasonable Suspicion Observation Checklist may be used to document specific observations and behaviors that create a reasonable suspicion that an Auxilian volunteer/volunteen is under the influence of illegal drugs or alcohol. Examples includes but not limited to:

- Odors (smell of alcohol, body odor).
- Movements (unsteady, fidgety, dizzy).
- Eyes (dilated, constricted or watery eyes, or involuntary eye movements).
- Face (flushed, sweating, confused or blank look).
- Speech (slurred, slow, distracted mid-thought, inability to verbalize thoughts).
- Emotions (argumentative, agitated, irritable, drowsy).
- Actions (yawning, twitching).
- Inactions (sleeping, unconscious, no reaction to questions).

I understand that if we have to test your child for any of the above, parents will be notified.

Volunteen Signature_____ Date _____

No electronic signatures

Parents Signature_____ Date _____

No electronic signatures

Day Pass _____ Week Pass_____ Inpatient Family Pass_____ Teen Volunteer Summer Pass_____

Marvin Altman Fitness Center
Visitor Consent Form
PLEASE PRINT!!!!!

Please Print

Visitor Name_____

Address _____

City/State/Zip_____

Telephone ( ) _____ Date of Birth_____

Today's date_____ E-Mail _____

Emergency Contact _____
Name Phone no

Medical Questionnaire

Please read the following questions and answer each by placing a check mark in either the "Yes" or "No" box.

1. Has your physician stated you have heart trouble? Yes _____ No_____
2. Do you frequently have pains in your heart or chest? Yes _____ No_____
3. Do you often feel faint or have serve dizziness? Yes _____ No_____
4. Has a physician stated you have high blood pressure? Yes _____ No _____
   a. If yes, is it currently being treated? Yes _____ No _____
   b. If yes, is it being controlled by a physician? Yes _____ No _____
5. Are you currently pregnant? Yes _____ No _____

Health Promotion Program

I, _____, acknowledge that I am a participant at the Marvin Altman Fitness Center.

I have answered the Medical Questionnaire listed above to the best of my ability and knowledge. I realize my admission to the program and beneficial results depends on the accuracy of my answers.

I understand that I will be undergoing physical activities for the purpose of enhancing my emotional, mental and physical well being. Although the activities are designed to minimized injury, I understand that I could be injured by physical contact, strain, or sprain, resulting in damage to bones, joint, ligaments or muscles. I also understand that I could sustain damage to my heart or respiratory system, which could result in injury or death.

Should any such injury, damage or death occur, I will not hold Marvin Altman Fitness Center or Baptist Health-Fort Smith responsible or liable.

I also understand that Marvin Altman Fitness Center and Baptist Health-Fort Smith are not responsible for lost or stolen property. With such understanding, I consent to participate at Marvin Altman Fitness Center.

Visitor's Signature_____
No electronic signatures
Parent or Guardian Signature_____
No electronic signatures
Staff Signature _____

Baptist Health
FORT SMITH

Authority to Interview / Photograph

Name _____

Please Print

Address _____ Phone _____

City/State/Zip_____

I hereby give consent to an interview/photograph by representatives of Baptist Health-Fort Smith (or other entity specified below) and release the hospital from any situation that may result from its use. I release any ownership to the audio, video, or photographs, and allow the hospital (or other entity specified below) to use these as needed.

This interview/photograph will be used for _____

Date _____

Signature of Teen _____

No electronic signatures

Signature of Parent _____

No electronic signatures