St. Catherine Hospital
Centura Health.

St. Catherine Hospital Teen-Med Application

Applications will not be accepted after Thursday, April 26, 2018 @ 4:00PM

Date______________

Name: (print) ____

Address: ____ Telephone: _________________

City_________________ State_____ Zip__________ What is your shirt size? _________

Email Address____ Cell Phone_________________

School Name: _____________________________ Grade (2019) ________________________

Father's Name: ____ Telephone: ___________________

Cell Phone____________________

Mother's Name: ____ Telephone: ___________________

Cell Phone____________________

Please list your past volunteer activities ____

What are your career goals and how do you plan to achieve them?

____

____

What do you hope to receive from your hospital experience? ___________________________

Are you interested in volunteering at the hospital during the school year? _______

(*Please Note: Incomplete applications will not be accepted*)

To be considered for the St. Catherine Hospital TeenMed Program, you must provide the following:

1) Four (4) letters of recommendation (use form attached) from a teacher, advisor, or other significant adult (not a family member)

2) A copy of your immunization records including two dates of MMR (Measles, Mumps and Rubella)

3) Understand a TB Skin Test will be given to you at orientation (no cost to you)

4) Show ID with your birthdate at Orientation. (Must be between the ages of 15-18 years of age)

Please chose the Session you want to attend wisely. Check your summer schedule for any camps, family activities, etc. you may want to attend while making your decision. Attendance in the TeenMed program is mandatory. You may not be absent during the TeenMed Session you choose.

Pick the Session you want to attend. Then pick the Rotation (AM or PM) you want to attend. You may only choose one Session and one Clinical Rotation time within that Session.

Session #1: June 4 – June 29, 2018 (Mon – Fri)

Orientation for Session #1 - June 4 – June 8
Time for Orientation - 1 PM – 5 PM
Place: Classroom 1 (ER entrance, walk up incline, take elevator to LL, turn left, #1 is on right).

Clinical Rotations for Session #1: June 11 – June 29, 2018

Choose Morning Rotation: 10:00AM – 1:00PM________
OR
Choose Afternoon Rotation: 12:00PM – 3:00PM________

Session #2: July 9 – August 3, 2018 (Mon – Fri)

Orientation for Session #2 - July 9 – July 13
Time for Orientation – 1 PM – 5 PM
Place: Classroom 1 (ER entrance, walk up incline, take elevator to LL, turn left, #1 is on right).

Clinical Rotations for Session #2: July 16 – August 2, 2018

Choose Morning Rotation: 10:00AM – 1:00PM_____
OR
Choose Afternoon Rotation: 12:00PM – 3:00PM ______

Teen and Parent/Legal Guardian - Please Read the Following Carefully and Sign All of the Release Forms.

I _____________________________(Teen) affirm the information provided on this application is true and complete. I understand before I begin the TeenMed program, I will complete the application requirements, sign the release of information form, attend orientation and any subsequent training sessions.

If I am selected to become a participant in the St Catherine Hospital (SCH) TeenMed program, I understand the necessity of maintaining, as privileged and confidential, all information which I may learn about St Catherine Hospital patients. This includes, but is not limited to, patient diagnoses, courses or care and treatment, prognoses, personal lives, relationships and concerns, family matters and all information contained between patients and SCH staff, between patients and volunteers, or between physicians and SCH staff in regard to any patient.

I agree that I will not leave the St Catherine Hospital campus without permission from the Volunteer Coordinator. I also agree my cell phone will be turned off at all times during the TeenMed program I attend.

I understand I will be dismissed from the program if I do not abide by St Catherine Hospital's rules and policies.

Teen Signature_____________________ Date_______

Parent/Legal Guardian Signature____________________ Date_______

Consent of Parent/Legal Guardian:

I hereby authorize St. Catherine Hospital to medically treat or manage any injury sustained, if after reasonable effort, I cannot be reached. This release is in effect for the period of time the applicant serves as a SCH TeenMed student.

I consent for my child to serve in the TeenMed program at SCH and consider him/her capable of undertaking the responsibilities of the program. I also grant permission for participation in events, such as a trip to EMS, without requiring additional permission forms. I certify that he/she is at least 15 years of age.

I understand a Tuberculosis skin test is required to allow my child to volunteer. Thereby, I give my permission for the staff of SCH to administer a TB Skin Test on my child at no cost to me.

I understand a hospital deals with the healing of humans and therefore my child may witness graphic (human anatomy, blood, etc.) situations.

Parent/Legal Guardian Signature __________________________Date___________

Hospital Staff/Visitor/Third Party Consent to be Recorded

Name: __________________________ **Facility/Entity and Department:** __________________

Purpose of Use/Disclosure: (indicate all that apply)

☐Publication in newspaper(s), magazine(s) or other publications

☐Broadcast by radio or television ☐Social Media (e.g., Facebook/Twitter/YouTube)

☐Centura marketing and public relations materials/publications/websites/advertisements/videos

☐Other: ____

By signing below, I grant to Centura Health and its affiliated facilities, agents, contractors, providers or associates (collectively, "Centura") the right to interview and/or take photographs of me. I understand that this consent includes, but is not be limited to, capturing video, audio, and digital images and any other mechanical means or medium of recording, preserving, and producing visual images and audio tape (hereinafter referred to as "Photographs" and "Interview Materials").
I acknowledge that the Photographs and Interview Materials created under this Consent will be the property of Centura or the designated third party. I understand that consenting to be photographed or interviewed is of no direct benefit to me. I waive any and all rights that I may have to any claims for payment or royalties in connection with the authorized use or disclosure of such Photographs or the Interview Materials, including the production, duplication, or publication thereof.

I, on behalf of myself and my heirs, representatives, and beneficiaries, agree to hold Centura and designated third parties who are involved in the production, duplication, publication or any other authorized use and/or disclosure of the Photographs and/or Interview Materials harmless from and against any claim for injury or compensation resulting from the taking of the Photograph or the Interview Materials or the authorized use or disclosure of such Photograph or Interview Materials.

I understand that, in the instance of external sources (such as media outlets or law enforcement agents) requesting permission to use the Photograph or Interview Materials, the Centura facility/entity is acting only as the intermediary, making it possible for the external source(s) to contact me.

I understand that:

1. This request is strictly voluntary and as such I may refuse to sign this consent. If I do refuse to sign this consent, I understand that I will not be photographed, filmed and/or interviewed. I further understand I can request to stop the taking of Photographs of me or interview at any time.
2. If I do not sign this consent, my employment/volunteer status/medical or AHP staff membership or privileges, as applicable, with Centura facilities will not be affected.
3. I may revoke this consent at any time in writing, except to the extent Centura has already taken action in reliance on this Consent.
4. I may receive a copy of this consent after I sign it, and if I request a copy.

By: ___________________________________ Date: ___________________________

Make a copy of this application for your reference

Questions? Call Shari Brandenburg, Volunteer Coordinator – 620-272-2522
Applications will not be accepted after Thursday, April 26, 2018 @ 4:00PM
Mail registrations to:
St. Catherine Hospital
Att Shari Brandenburg
401 E. Spruce
Garden City, KS 67846
Scan the completed application in and email to ShariBrandenburg@Centura.Org
Fax them to 620-272-2738

The Volunteer Department reserves the right to decline any application

St. Catherine Hospital
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Letter of Recommendation Form (Copy this form 3 times & use for all recommendations)

Recommender: **Please fax this form to Shari Brandenburg, 620-272-2738** or email it to ShariBrandenburg@Centura.Org *Do not give to student for authenticity.*

Student's Name____
Please rate the student on the following topics.

How do you rate the student's ability to think through issues? Excellent Good Fair Poor

How do you rate the student's level of oral communication? Excellent Good Fair Poor

How do you rate the student's level of written communication? Excellent Good Fair Poor

How would you rate the student's level of emotional maturity? Excellent Good Fair Poor

How would you rate the student's attendance/dependability? Excellent Good Fair Poor

How do you rate the student's level of responsibility/motivation? Excellent Good Fair Poor

How do you rate the student's ability to problem solve? Excellent Good Fair Poor

Does the student get along well with others? Excellent Good Fair Poor

Is the student respectful of authority? Excellent Good Fair Poor

Has the student had any involvement with drugs, alcohol or any substance abuse offense? YES NO

Has this student been involved in any disciplinary, corrective or "redirection" type of action? YES NO
If yes, please explain:

Is this student mature enough to handle graphic procedures and act appropriately in a hospital setting?
____

What makes this student a good candidate for the TeenMed program?

____

How long have you known the student and in what capacity?

How will this student impact St Catherine Hospital? Can you envision her/him helping others?

____

Recommender's Name (print)__________________________________ Phone _____________________

Position/Title: _____________________________________

Signature: ____ Date: ___________________