Volunteen Program

Information Packet and Application

Piedmont Rockdale Hospital

Summer 2025

Dear Applicant,

Thank you so much for your interest in the Piedmont Rockdale Hospital Volunteen Program, which runs from **June 2 – July 25, 2025.**

A volunteen is a high school student who serves Piedmont Rockdale Hospital without salary. This program is for students who attend. Each student will be accountable to the manager of Patient Experience and the charge nurse of the department you work in.

The objective is to provide an educational experience in a hospital setting, giving you a chance to see healthcare professionals in action. While spending time in one of the departments at the hospital, you may find your passion, or you may discover that this kind of occupation is not what you thought it would be. Either way, it's good to have the experience which will allow you to start making plans for your future career path.

To participate in this program, you must:

- Be at least 14 years old by orientation day (**May 17, 2025**)
- Be able to volunteer **32** hours. This is achieved by working one, four-hour shift each week for 8 weeks. Ou will be allowed to make-up missing hours due to family vacations, driver's education, sports and school events, church activities, etc.
- Have at least a "B" average in all studies
- Provide a sealed copy of your high school transcript
- Return a completed application

Applications will be accepted **March 17 – April 18, 2025**

Please return the following items by email as separate attachments:

- The completed application
- Parent/Guardian Agreement
- Consent for Treatment
- Photo Authorization Contract for the Volunteen Program
- **Two** letters of recommendation from teachers or adult non-relative
- Official school transcript
- Proof of clear TB Test
- Proof of completed Varicella vaccination record
- Headshot, from the shoulders up, in front of a plain, neutral wall (for badge photo)

All applications must be **emailed** to: Brianne.baxter@piedmont.org

Student's Name: _____

FACTS FOR NEW VOLUNTEENS

Volunteens must work a 4-hour shift per week. The program begins on June 2, 2025 and ends on July 25, 2025.

Volunteens may only work Monday-Friday between the hours of 8:00am and 4:00pm.

A volunteen is expected to report promptly to their service area on the assigned day and time. If you are unable to work as scheduled, please notify the program director by phone call or text (404-977-8599).

An interview with volunteen committee members is **required**. A **parent/guardian must attend** the interview with the student. Interviews will take place on Saturdays, with dates listed below.

The volunteen **must** attend the orientation session on May 17 from 8:00am – 12:00pm in classroom 2 Building A of Piedmont Rockdale Hospital.

If selected, volunteens will be provided with a polo/golf style shirt to wear as part of your uniform. You will also need to wear kaki pants and comfortable, closed toe shoes.

POSSIBLE JOB DUTIES

Make sure the patient's room is clean before the patient enters.
Fold and put out linens in the patient's room.
Make beds if necessary and tidy room.
Escort patients to their room or to the bathroom.
Round on patients in the lobby area and those in treatment rooms.
Help with special requests: retrieving water, blankets, etc.
Filing paperwork, preparing welcome packets, or other clerical tasks.

IMPORTANT DATES

Saturday Interviews (Student and a Parent/Guardian must attend your chosen date/time) …… **April 19 or April 26**
A link to choose your date and time will be emailed to you once a completed application has been returned
Application Due Date …… **Friday, April 18**
Orientation …… **Saturday, May 17**
Summer program begins …….. **Monday, June 2**
Summer Program Ends …….. **Friday, July 25**

At the end of the program, you will receive a certificate with your volunteer hours at Piedmont Rockdale Hospital which you may use for college applications or for your resume. We will also provide recommendation letters.

Student's Name: _____

Zero Tolerance Policy

The following discipline issues will result in immediate termination from the Piedmont Rockdale Hospital Volunteen Program:

- Violation of the HIPPA policy
- Theft of hospital, patient, employee, volunteer, or guest property.
- Willful damage of hospital property.
- Fighting or attempting bodily injury to any person on hospital property.
- Public display of affection (PDA) of any type.
- Immoral or lewd conduct.
- **Use of cell phone** to text, check social media, or make non-emergency phone calls while on duty.
- Refusal to perform assigned task-insubordination.
- Walking off the assigned service without permission or leaving assigned area for extended period of time.
- No gum chewing.
- Harassment of any form.
- Coercing or harassing patients, employees, volunteers or guest.
- Malicious practical joking /horseplay.
- Reviewing, accessing or revealing confidential information.
- Deliberate verbal or physical abuse of a patient, guest, volunteer or employee.
- Willful violation of safety regulations.
- Possession of firearm or weapon on hospital property.
- Consumption or possession of alcohol or drugs on hospital property.
- Falsification of time and attendance records.
- Smoking on hospital campus. We are a smoke free campus.
- Inappropriate verbal, written or physical conduct of a sexual or threatening nature.

Student's Name: _____

(Official Use Only) Date received _____/_____/_____

Piedmont ROCKDALE

Volunteen Program

APPLICATION

EMAIL TO: brianne.baxter@piedmont.org

☐ New Volunteen ☐ Returning Volunteen Birthdate: _____ / _____ / _____

Which school do you attend?

_____

First Name: _____ Middle Initial: ____ Last Name: _____

Cell number: _____ Email: _____

Street Address:

_____

City: _____ State: _____ Zip: _____

Grade you will enter this fall: _____

Which day are you most available to volunteer: M Tu W Th F am/pm

Do you have an area of interest in the medical field? Please tell us about it, be descriptive as this will help place you in the best area.

_____

_____

_____

_____

_____

_____

Student's Name: _____

What extra-curricular activities are you involved in:

_____

_____

_____

_____

_____

Will you require any accommodations to perform the job duties? __Yes __No

If yes, please explain: _____

Student's Name: _____

Parental/Legal Guardian Agreement

I hereby permit my child, _____ to join the Volunteen Program at Piedmont Rockdale Hospital. I understand the importance of responsibility and will assist my child in complying with the program's rules and regulations. I will assume responsibility for his/her transportation.

1. I have read and understand the **"Zero Tolerance Policy"** (included in this packet).
2. I agree that my student's identification badge will be turned in at the end of the program.
3. In the event of a medical emergency, I permit the physicians in the emergency department of Piedmont Rockdale Hospital to treat my student at my expense.
4. I understand that for my student to participate in the program, all-necessary information must be completed and received by email no later than **April 18, 2025**
5. If my child is notified by email to come for an interview, I agree to attend the interview as well.
6. I understand that my child is required to attend orientation on **May 17, 2025** and volunteer at least one day a week for four hours.
7. I understand the volunteen may be required to wear a surgical/medical mask while in patient-facing areas.
8. In the event the volunteen is unable to volunteer or, notice should be given by phone call or text as early as possible.
9. I understand the volunteen are highly encouraged to receive the COVID-19 and flu vaccinations.
10. I understand the volunteen will need to have a clear Tuberculosis reading prior to orientation.

Your student will be notified by email if they have been selected to come for an interview. All interviews are held on Saturdays. A PARENT/GUARDIAN MUST ATTEND THE INTERVIEW WITH THE STUDENT. Students who are accepted into Volunteen Program will be notified by emails after all interviews are completed. Attending an interview does not guarantee acceptance into the program.

Orientation on Saturday May 17, 2025 from 8:00am – 12:00pm is mandatory for students accepted into the Volunteen program. There will be no exceptions. In addition, you cannot be absent the first week of volunteer service. Please do not apply if you cannot meet these requirements.

Parent or Guardian's Name: _____

Address: _____

Work Address: _____

Email:

_____

Cell Number: _____ Work Number: _____

_____ _____

Parent/Guardian Signature **Date**

Student's Name: _____

VOLUNTEEN MEDICAL HISTORY & PARENTAL CONSENT FORM

ALL YOUTH VOLUNTEERS MUST BE COVERED BY A FAMILY HOSPITALIZATION POLICY, WHICH MUST BE LISTED BELOW. SHOULD IT BECOME NECESSARY TO VISIT THE EMERGENCY DEPARTMENT WITH YOUR CHILD, YOUR INSURANCE WILL BE USED TO COVER THE VISIT. SHOULD THIS BE NECESSARY, WE WOULD MAKE EVERY EFFORT TO REACH YOU.

Permission is hereby granted to treat my child, _____, for any problems that might occur while on duty as a volunteen for Piedmont Rockdale Hospital.

Signature of Parent or Guardian: _____ Relationship: _____

Policy Number: _____ Policy Holder's Name: _____

Name of Company:

_____

The Administration at Piedmont Rockdale Hospital needs written consent for volunteens to receive emergency treatment in the event of a serious illness or accident if you cannot be contacted.

HISTORY

List all drugs and medications the volunteen is presently taking:

Drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

List any Allergies: _____

_____

_____

Signature Printed Name

Date: _____/_____/_____

Student's Name: _____

Photo Authorization Contract for Volunteen Program 2025
Authorization for Use/Disclosure of Protected Health Information
For Piedmont Healthcare Marketing and Public Relations' Purposes ONLY
For: **Piedmont Rockdale Hospital,** 1412 Milstead Ave., Conyers, GA 30012

I, _____, hereby request and authorize an affiliate of **Piedmont Healthcare, Inc.**:

(Initial Desired Options)
__**N/A**__ To permit: _____to be **present** during my medical care on: _____
(Print observer name) *(Date)*

__**N/A**__ To use any information provided by me, my family or the medical staff related to my story as a patient of a Piedmont Healthcare affiliate in connection with any publications (including but not limited to newspapers, television and/or radio broadcasts, audio/video recordings, drawings and sketches, books, brochures, magazines, videotapes, motion pictures, websites or other publicly distributed materials) in such manner and at such times and in such places as Piedmont Healthcare, Inc. shall determine without restriction at its sole discretion.

____ (Initial here) To take and use photographs, video recording, slides and any comment made verbally or recorded or made by me for publications or advertising purposes (included but not limited to newspapers, television and/or radio broadcasts, audio/video recordings, drawings and sketches, books, brochures, magazines, videotapes, motion pictures, websites or other publicly distributed materials) in such places as Piedmont Healthcare, Inc. shall determine without restriction at its sole discretion.

__**N/A**__ To release my name and condition as determined by my nurse/physician upon request from the media and/or release the signed and dated statement attached to this form. I understand the purpose for this use or disclosure of my information is for Piedmont Healthcare, Inc. educational, public relations and/or marketing purposes. I hereby release and forever discharge Piedmont Healthcare (including, without limitation, its affiliates and their respective officers, directors, employees, medical staff and agents) from any and all manner of claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the disclosure and the public exposure resulting from such use or disclosure of my information.

Volunteen Full Name: _____

Volunteen Date of Birth: _____

Phone # (Home): _____ (Work): _____(Cell):_____

E-mail Address: (please print clearly!) _____

Current Address: _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that Piedmont Healthcare, Inc. has acted in reliance on this Authorization. A revocation form may be obtained from the Piedmont Healthcare Marketing and Public Relations Department. The completed revocation must be presented to the Piedmont Healthcare Marketing and Public Relations Department. I further understand that this Authorization is specific to the information agreed to above and for the purpose written above. Piedmont Healthcare, Inc. shall not condition treatment on the receipt of this specific Authorization.

I further understand that this **Authorization** is valid until revoked by me or my legal personal representative in writing, noting that information used or released prior to the receipt of the written revocation cannot be revoked.

_____ _____
Volunteen Name (PRINT) **Date**

_____
Patient or Legal Representative Signature

Student's Name: _____

Required Letter of Recommendation – From a non-relative.

Please complete this form and return to the student.

Student Name: _____ Date: ____ / _____/_____

Your Name:

_____

Your Email Address:

_____

How Long Have You Known This Student? _____

Relationship:

_____

The individual named above has applied for the **Volunteen Program** at **Piedmont Rockdale Hospital.** Your assistance is requested in evaluating the applicant with regard to the following qualities. Candid completion of this information will give us an opportunity to properly review his/her qualifications.

On a scale of 1-5 (poor-excellent) I would like to make the following rating on this student:

EXTROVERSION---friendly/good communication skills……1 2 3 4 5
BEHAVIOR/ATTITUDE---cooperative……1 2 3 4 5
MATURITY---self-confidence……1 2 3 4 5
SENSE of RESPONSIBILITY……1 2 3 4 5
ATTITUDE TOWARD TAKING DIRECTIONS…… 1 2 3 4 5
DEPENDABILITY……1 2 3 4 5

INAPPROPRIATE USE OF CELL PHONE …(circle) never sometimes often

Additional comments you wish to share:

_____
_____
_____
_____
_____

_____
Signature of person completing recommendation

Student's Name: _____

Required Letter of Recommendation – From a non-relative.

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Student Name: _____ Date: ____ / _____/_____

Your Name:

_____

Your Email Address:

_____

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ATTITUDE TOWARD TAKING DIRECTIONS…… 1 2 3 4 5
DEPENDABILITY……1 2 3 4 5

INAPPROPRIATE USE OF CELL PHONE …(circle) never sometimes often

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_____
_____

_____
Signature of person completing recommendation

Student's Name: _____