Premier Health
Atrium Medical Center

One Medical Center Dr.
Middletown, Ohio 45005

atriummedcenter.org

Dear Junior Volunteer Applicant:

Thank you for your interest in becoming a volunteer at Atrium Medical Center. Our Adult and Junior volunteers perform a valuable service to our hospital as well as our patients and families. We are so grateful you have decided to join us.

The process of becoming a Junior Volunteer begins with our application packet:

- A **personal application**
- The **Physician Form** is for your doctor to complete. Your doctor's office can return it to you, they can mail it to us or even fax it to us.
- The **Authorization to Release Medical Information Form** needs to be completed by you and returned with your application. (Your doctor may ask for a copy as well.)
- A **school recommendation** is to be completed by a counselor or teacher. We also provide a pre-addressed envelope to make it easy for your school to return the recommendation to us.

If any of the forms are missing from this packet, you may download them at **www.atriummedcenter.org**. *See Volunteer Services at bottom of page.*

A parent or guardian **must** sign all forms enclosed.

Once **all forms** have been returned to our office, we will contact you via telephone or email to schedule an interview/orientation with you to discuss volunteer openings, safety guidelines within the hospital, days/times you would like to volunteer, etc.

If you need more information or if we can answer any questions, please contact our office.

Volunteer Services
513.974.5201

One Medical Center Drive
Middletown, OH 45005
Website: atriummedcenter.org
Volunteer Services: 513.974.5201

VOLUNTEER APPLICATION: Junior

Name ____ ____________________
First *Last* *Middle Initial*

Address ______________________________ ______________________________________
Street *City* *State* *Zip*

Date of Birth ________________________________ Home Phone ___________________________

Email address _______________________________ Cell Phone ____________________________

Parent's Name(s) _________________________________ Work Phone ________________________

Emergency Contact ____
Name Relationship Home Phone Work Phone

Name of School ______________________ Current Grade (circle) 8 9 10 11 12

Graduation Year _______________ Career Interest ____

Volunteer Experience ____

Interests, Skills, School Activities ____

Family Physician ___________________________________ Phone ___________________________

Applicant's Signature______________________________________ **Date** _________________

To the Parent: Your signature below indicates your approval for your child's participation in the Junior Volunteer program at Atrium Medical Center **and** for him/her to take the required TB (tuberculosis) test, provided by the hospital at no charge. If you decline the TB test, we require a physician's statement showing your child is free from tuberculosis. Please initial here **only if you decline** the TB test: ___________

Parent's Signature ______________________________________ Date ______________________

PHYSICIAN FORM:

Please have your physician complete this form and mail or fax to Volunteer Services:

Phone: 513.974.5201 or FAX: 513.974.4504
One Medical Center Drive, Middletown, OH 45005

Dear Physician:

The individual listed below has applied to become a volunteer at Atrium Medical Center. The volunteer (or his/her parent/guardian) has signed below, granting permission for you to release medical information to the volunteer office.

Many of our volunteers work in direct contact with our patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard the patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering, but may not be able to physically or mentally perform the required tasks.

You may indicate blanket approval for any type of service, or you may impose some restrictions such as: no lifting; no pushing wheelchairs or heavy carts; or no patient contact because of a physical or emotional problem. ***Please use the section below to list restrictions and for any comments.***

We appreciate your prompt response in order to help us place this volunteer in the appropriate position within the hospital.

Volunteer Services

I give permission to my physician to release relevant medical information to The Atrium Medical Center Volunteer Services

Volunteer's Name: ____

If volunteer under age 18, Parent's Name: ______________________________

Parent's Signature: ____

Dates of first & second rubella shot or test showing immunity: _______________

(Or attach shot record documentation)

Physician comments, please list any restrictions or recommendations:

____

Physician's Name/Office: ___________________________ Date: __________

Physician's Signature: ____

AMC USE ONLY: This Section completed by AMC personnel.	
☐ Request Approved	
☐ Request Denied (Complete Patient Access Denial Form)	
☐ NA (Information released to persons other than the patient)	
Date:	**Initials:**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/PATIENT ACCESS FORM

Patient's Name: ______________________________ Unit #: not applicable Acct #: not applicable

Birth Date: ______________________ Social Security Number: __________________________

Service Date/Type(s): not applicable
(Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize (*insert name of physician/practice*) ______________________ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

INFORMATION REQUESTED

☐ Face Sheet	☐ Progress Notes	☐ X-ray Reports	☐ Pathology Reports / materials
☐ History / Physical	☐ Physician Orders	☐ Consultation(s)	☐ Operative Reports
☐ Discharge Summary	☐ EKG Interpretations	☐ Laboratory Reports	☐ Copy of Entire Record

☒ Other - Please Specify: ***Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely***

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: ***60 days from date of signature below***. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

Information to be released to: Volunteer Services Supervisor

Address: Atrium Medical Center , P.O Box 8810
Middletown, OH 45042

This information is to be released for the purpose of: ☐ At the request of the patient **OR** ☒ Other (Please specify below):
To meet hospital Infection Control Guidelines (immunity to rubella) and any limitations for the safety of the volunteer, patients and visitors

I understand that I may revoke this authorization in writing at any time, except if Atrium Medical Center has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Atrium Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except that Atrium Medical Center may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Atrium Medical Center may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

Signature of patient or representative: ______________________ **Date:** ____________

If you are the representative of the patient*, describe the scope of your authority to act on the patient's behalf. Please check one below:*

☐ Guardian ☐ Parent of Minor ☐ Power of Attorney Over Healthcare

*This authorization will be accepted up to **60 days** from date of signature.*

Signature of witness: ______________________________

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations

A photocopy of this authorization is to be accepted the same as the original.

Confidential Recommendation:
Junior Volunteer Application

Parental Consent:
I authorize the release of information from my son/daughter's records to the Volunteer Services Department of Atrium Medical Center.

Parent's Name: (please print) ____

Parent's Signature: __________________________________ Date _______________

Student's name: _________________________________ Grade Level _______________

Each student who applies to volunteer at the hospital must have a recommendation, preferably from a teacher or counselor at his/her school. We would appreciate your evaluation and comments to help us choose candidates who will benefit from our program, and who will best serve our organization, our patients and guests.

Many of our volunteers work in direct contact with patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering, but not physically, emotionally or mentally able to perform the required tasks.

Please return this recommendation to Volunteer Services in the attached self-addressed envelope. We appreciate your prompt response in order to help us place this applicant in the appropriate position within the hospital. If you have questions, please call Volunteer Services @ 513.974.5201.

	Excellent	**Good**	**Average**	**Below Average**
Attendance				
Scholastic				
Dependability				
Courtesy				
Cooperation				
Initiative				

Comments:
____
____

Name: ______________________________________ Title ____________________

School or Organization __________________________________ Date _______________