



## VOLUNTEER INTERVIEW CHECK SHEET

ALL Volunteers **Print & COMPLETE** the following forms to bring to your interview:

- Health Form
- Documentation of Measles, Mumps, Rubella, Rubeolla, or MMR Vaccine, Varicella/Chicken Pox Disease or vaccine and recent TB Test. (If you do not have documentation you will be sent to our hospital lab after your interview and placement is arranged.)
- Two Reference Forms  
(filled out by employer, teacher, counselor, etc.)  
*You may bring the Reference before you begin your volunteer service if you cannot get the forms completed before the interview.*
- Volunteer Agreement
- Orientation Check List
- Orientation Quiz

Teen volunteers (under 18 years of age) must also bring:

- Permission for Lab and TB Test

If you cannot keep your interview appointment, please call the Community and Volunteer Resources Office to re-schedule at 786-624-4431 or e mail any staff member:

[Aida.panceira@mch.com](mailto:Aida.panceira@mch.com)



# VOLUNTEER REFERENCE FORM

DATE: \_\_\_\_\_

NAME OF APPLICANT: \_\_\_\_\_

NAME OF REFERENCE: \_\_\_\_\_

PHONE: \_\_\_\_\_

ADDRESS - STREET: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

The applicant has applied to become a Volunteer at Miami Children's Hospital. Please complete the reference information and return to us as soon as possible.

How long have you known the applicant? \_\_\_\_\_

What is your relationship to the applicant? \_\_\_\_\_

Does s/he get along well with peers, adults and children? \_\_\_\_\_

Please evaluate the applicant's personality traits such as attitude, initiative, common sense, and ability to take instruction.

SIGNATURE OF REFERENCE: \_\_\_\_\_

RETURN APPLICATION TO:

MIAMI CHILDREN'S HOSPITAL  
COMMUNITY AND VOLUNTEER RESOURCES  
3100 S.W. 62 AVENUE  
MIAMI, FL 33155



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NAME OF REFERENCE: \_\_\_\_\_

PHONE: \_\_\_\_\_

ADDRESS - STREET: \_\_\_\_\_

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Or FAX: 305-662-8356

(FOR TEENS ONLY)  
PARENTAL CONSENT FORM FOR  
LABORATORY BLOOD TEST

This is consent for Laboratory Blood Test to test for Tuberculosis exposure, immunities to Rubella, Measles IGG (Rubeola) and Varicella Zoster (Chicken Pox).

I hereby give my permission for my daughter/son: \_\_\_\_\_

to have **Laboratory Blood Test** done. I understand that there is no charge for this service.

Print Name of Parent or Guardian: \_\_\_\_\_

Signature of Parent

or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



## VOLUNTEER HEALTH FORM

Please fill out this form as completely as possible. **Bring this form with you to your interview.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

| HAVE YOU HAD ANY OF THE FOLLOWING? | YES | NO | UNKNOWN |
|------------------------------------|-----|----|---------|
| CHICKEN POX                        |     |    |         |
| RUBELLA (GERMAN MEASLES)           |     |    |         |
| MEASLES (SEVEN DAY)                |     |    |         |
| IMMUNIZED FOR:                     |     |    |         |
| RUBELLA                            |     |    |         |
| MEASLES                            |     |    |         |

HAVE YOU EVER HAD A TUBERCULOSIS TEST? YES [ ] NO [ ]

WAS THE RESULT? POSITIVE: [ ] NEGATIVE: [ ]

**Do you have or are you being treated for?:**

|  |                     |  |                            |
|--|---------------------|--|----------------------------|
|  | Allergies           |  | Hearing Problems           |
|  | Asthma              |  | Immune Deficiency          |
|  | Chronic Cough       |  | Skin Disorders/Rashes      |
|  | Diabetic on Insulin |  | Partial Blindness          |
|  | Epilepsy            |  | Wrist, Back or Neck Injury |

List all medications you are taking: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Volunteer Orientation Checklist

**Instructions:** Initial each item as you learn the information or procedures required.

Name: \_\_\_\_\_

- I will sign-in at the Touch Screen when I ARRIVE on campus, and sign-out right before I LEAVE campus.
- Meal ticket procedures. - Volunteers are eligible for a Meal Ticket after 3 or more hours of service has been provided on the scheduled day.
- I must always wear my Volunteer Uniform and Volunteer I.D. Badge and look neat and professional.
- NO Shorts, Blue Jeans (unless RL Volunteer) or Torn Clothing.
- I understand I must make a minimum commitment of 3 months of service when assigned to a non-patient area or 6 months of services when assigned to a patient area.
- I agree to be reliable and dependable. I agree to be consistent with no more than 2 absences during any 3 month period of time.
- If I cannot come in on my Scheduled Day, I will call the Community and Volunteer Resources Office before that day (786)624-4431 and my supervisor.
- I will consult with the community & Volunteer Resources Staff if I need a schedule change.
- Job Description will be reviewed with me on my first day of voluntary service.
- I know the Infection Control Guidelines. I understand the importance of Hand Washing. I will not volunteer when I am sick.
- I have read and recognize all Emergency procedures.
- I agree to all the Safety Guidelines in the Volunteer Handbook.
- Park in the Visitor Parking Garage.
- I agree to report any unusual events immediately to my supervisor. I understand this is for an Incident Report.
- HIPAA (Health Insurance Portability and Accountability Act) I acknowledge that unauthorized use, dissemination or distribution of protected health information created or received by Miami Children's Hospital (MCH) or MCH off-site entities is a violation of the HIPAA privacy regulations.
- I agree to NOT handle personal or professional business while volunteering, including NO cell phone use and texting information while on duty as a volunteer.
- I agree to NOT EXCHANGE phone numbers, email or other social networking information with patients and families.
- I agree to NEVER take pictures using my camera or cell phone while on duty as a volunteer.
- I agree to abide by all the Confidentiality and Privacy Guidelines.
- I have attended a New Volunteer Orientation Presentation. I have read all the information in the Volunteer Handbook and the Hand-outs. I agree to abide by all these guidelines rules, regulations, as well as the policies and procedures established by the Community & Volunteer Resources Department and the hospital. Any volunteer who knowingly disregards the rules will be subject to disciplinary measures, such as suspension or dismissal.

Volunteer Signature: \_\_\_\_\_

Date: \_\_\_\_\_



PLEASE PRINT CLEARLY:

Volunteer Name: \_\_\_\_\_

### VOLUNTEER AGREEMENT

I agree to volunteer the assigned schedule under the following commitment: (Check One)

1.  Summer Commitment (Beginning one week after school ends, thru the last week before school begins)
2.  3 month consistently (Non-Patient Area)
3.  6 month consistently (Patient Area)

I agree to be consistent with no more than 2 absences during any 3 month period of time. I will call the Community & Volunteer Department when I am unable to volunteer on my assigned day and time. I understand that my hours will not be verified if I do not meet this minimum commitment.

Failure to keep this commitment will result in being placed on a **resigned** status and taken off the volunteer schedule. If I wish to be considered to return to the volunteer program, I understand I will need to discuss the possibility of a NEW schedule with the volunteer staff.

SIGNED:

DATED:

\_\_\_\_\_  
VOLUNTEER SIGNATURE

\_\_\_\_\_

\_\_\_\_\_  
PARENT SIGNATURE  
(If volunteer under age 18)

\_\_\_\_\_



## Volunteer Program Orientation Review

**NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Who do you call if you will be late or absent?

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2. What is the volunteer uniform and dress code?

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3. Explain HIPAA as it relates to you as a volunteer?

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4. What is considered identifiable Protected Health Information (PHI)?

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5. What is Confidentiality and Privacy?

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6. What is the single most effective way to protect against infection?

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7. What is an INCIDENT and what do you do if it occurs while you are volunteering?

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8. What do you do if an accident or anything unusual occurs while volunteering?

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9. How many absences can you have over a three-month period?

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10. Where can you find the **emergency codes** and **manual** in the event of an emergency?

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11. What does **CODE RED** represent and **R-A-C-E** stand for?

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12. **P-A-S-S** refers to pulling a fire extinguisher in the event of a fire. It represents: **Pull - Aim - Squeeze - Sweep.**

True  False

13. How do you maintain sensitivity to Cultural Diversity?

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14. Under what circumstances and how do you contact security?

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15. What is the **MSDS manual** and when is it used?

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16. Under rules for volunteers, what are some of the things you should do or not do to avoid crossing boundaries with patients & their families?

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17. What do the following codes mean:

- a. Code Blue: \_\_\_\_\_
- b. Code 36: \_\_\_\_\_
- c. Code Lindbergh: \_\_\_\_\_
- d. Code 13: \_\_\_\_\_

The Joint Commission (TJC) on accreditation of healthcare organizations has been accrediting healthcare organizations for more than 50 years. The Joint Commission evaluates the quality and safety of care for more than 15,000 healthcare organizations. TJC requires all hospital staff and volunteers to know the above information. You can be questioned at any time by a TJC representative while volunteering. Thank you.

**MY SIGNATURE MEANS I HAVE READ AND KNOW ALL THE INFORMATION IN THE VOLUNTEER ORIENTATION HANDBOOK.**

**VOLUNTEER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_