NIAGARA FALLS
MEMORIAL MEDICAL CENTER

Junior Volunteer Summer Program
July 7 – August 25, 2023

(ALL forms must be completed and returned by June 16, 2023)

1. You must be 14 years of age and completed 8th grade by July 1, 2023, TO APPLY.

2. Complete the Junior Volunteer Application including the agreement on the back of the application signed by you and your parent or guardian and return by **June 16, 2023** to:

   Judy Villani, Director of Volunteer Services
   Niagara Falls Memorial Medical Center
   621 Tenth Street
   Niagara Falls, NY 14302

   (Application may be faxed: 278-4614 or emailed: judy.villani@nfmmc.org)

3. Give the Junior Volunteer Reference Form to your school counselor to complete. Your school counselor must send or fax the form to the Volunteer Office by **June 16, 2023**.

4. I will schedule an appointment, ***if necessary***, for an interview for **new volunteers** in the Volunteer Office in June. Interviews will last 15 minutes. Please do not hesitate to call me if you have any questions.

5. Please have your family doctor complete the enclosed health form and return it with the completed application. You are required to have two measles, mumps, and rubella (MMR) inoculations, and a Diptheria-Tetanus (within the last 10 years) and a COVID vaccine **prior to volunteering**. You may get these inoculations from your doctor or from the health department. This is a New York State Health Department regulation and a Niagara Falls Memorial Medical Center policy.

Junior Volunteer Orientation will be held on Wednesday, June 28th @ 10am

This orientation is REQUIRED for all new volunteers.

PLEASE NOTE: *Acceptances are based on the recommendation of the school counselor and good citizenship.*

NIAGARA FALLS MEMORIAL MEDICAL CENTER

JUNIOR VOLUNTEER APPLICATION

Print Name: _____

Telephone: _____ Date of Birth: _____

E-Mail Address: _____

Address: _____ City: _____ Zip: _____

Parent's Name: _____ Parent's Work Phone: _____

School: _____ Graduation Year: _____ Grade Completed 6/22: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Director of Volunteer Services determines assignments based upon the needs of NFMMC.

Day(s) (Please circle day & time you wish to volunteer)
Sunday Monday Tuesday Wednesday Thursday Friday Saturday
Time(s) 9am-12noon 12noon – 3pm 1pm-4pm 3pm-8pm

Areas of Interest (Please check):
_____ Finance: 9:00 – 12noon and/or 12noon - 3:00pm (Monday – Friday only)
_____ Patient Transport (Escort): 8:00 – 4:00 (Monday – Friday only)
_____ Occupational/Physical Therapy: 9:00 – noon & 1-4 (Monday – Friday only)
_____ Nursing Unit – Hours & days flexible 9:00am – 8pm all week
_____ Office Clerical: 9:00 - noon and/or 12:30 – 3:30 (Monday – Friday only)
_____ Pharmacy: 9:00 – noon and/or 12:30 – 4:30 (Monday – Friday only)
_____ Gastro: 7:30 – noon and/or noon –2:00 (Tuesday & Thursday only)
_____ Surgery & Recovery: 9:00 – noon and /or 12:30 – 3:30 (Monday – Friday only)
_____ Nursing Home Activities: 9:15 – noon and/or 1:15 – 3:30 (all week)
_____ Other: (please add a choice not listed) _____

Please state briefly why you wish to become a Junior Volunteer:

If accepted as a Medical Center volunteer, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and not seek to obtain confidential information from a patient.

2. My services are donated to the Medical Center without expectation of compensation or future employment and given with humanitarian, religious, or charitable reasons.

3. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign political petitions on Medical Center premises unless I receive the express authorization of the **Director of Volunteer Services** to engage in these activities.

4. **I shall submit to a TB skin test (PPD). I understand that there is no cost to volunteers for this service. I hereby authorize person(s) making tests to report the results to the Medical Center**.

5. I shall be punctual and conscientious; conduct myself with dignity, courtesy, and consideration of others and endeavor to make my work professional in quality.

6. I shall attempt to resolve any problems related to my volunteer activities with my department supervisor or with the **Director of Volunteer Services.**

7. I shall make my best effort to fulfill my commitment to the Medical Center by completing all assignments I accept.

8. I shall at all times uphold the philosophy and standards of the Medical Center.

9. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
   - A) Failure to comply with Medical Center policies, rules, and regulations.
   - B) Absences without prior notification.
   - C) Unsatisfactory attitude, work, or appearance.
   - D) Any other circumstances which in the judgment of the Director of Volunteer Services would make my continued service as a volunteer contrary to the best interests of the Medical Center.

10. **<u>No</u> cell phones or other computer devices are to be used in a NFMMC department *when volunteering***. Niagara Falls Memorial Medical Center (NFMMC) is not responsible for any lost or stolen personal items.

I have read each of the above conditions and agree to be bound by them.

Junior Volunteer Signature: _____ Date _____

Volunteer Parent Signature: _____ Date _____
(If volunteer is under age 18)
This signature also provides approval to administer the PPD (TB) skin test.

NIAGARA FALLS MEMORIAL MEDICAL CENTER

To: School Counselors
From: Judy Villani, Director of Volunteer Services
Re: Junior Volunteer Reference Forms

Each applicant for our **Junior Volunteer Program** has been asked to notify your office of his or her interest in being a junior volunteer. Please complete and return this form for each potential volunteer. You may mail or fax the form. Thank you for your cooperation.

Student's Name: _____

School: _____

Please rate the student on a scale from 1-10 in the following areas:

		Poor	Average	Outstanding
1.	Good attendance/reliability	1 2 3	4 5 6 7	8 9 10
2.	Sense of responsibility	1 2 3	4 5 6 7	8 9 10
3.	Ability to follow directions	1 2 3	4 5 6 7	8 9 10
4.	Consideration of others	1 2 3	4 5 6 7	8 9 10
5.	Neatness	1 2 3	4 5 6 7	8 9 10
6.	Good manners/discretion	1 2 3	4 5 6 7	8 9 10

Highly recommended: _____

Recommended with the following reservations: _____

Not recommended (explain): _____

Signed: _____ Date: _____
(School Counselor)

Return to: Judy Villani - Director of Volunteer Services
Niagara Falls Memorial Medical Center
621 Tenth Street
Niagara Falls, NY 14302
FAX: 278-4614

NIAGARA FALLS
Memorial Medical Center
Niagara's Premier Health Network

Volunteer Services Department
621 Tenth Street
Niagara Falls, NY 14302
Phone: (716) 278-4440 Fax: (716) 278-4614

Junior Volunteer Health Form

DOCTOR OR HEALTH SERVICES NURSE SECTION

Dear Doctor or Health Services Nurse:

The New York State Health Department and Niagara Falls Memorial Medical Center (NFMMC) policy require that we have the following medical history recorded for each volunteer before he/she becomes an active volunteer. As an active volunteer, he/she may be assigned to work directly with patients and could be performing a variety of tasks. These tasks may include pushing patients in wheelchairs & carts, lifting moderate loads, running errands, standing or sitting.

This section must be completely filled out by the applicant's doctor or nurse to ensure that the volunteer (applicant) is free of communicable diseases, and that the applicant is physically able to perform the tasks outlined. **All information is required to volunteer at NFMMC.**

Applicant's Full Name: _____ Date of Birth: _____

The applicant is in general good health and is free from communicable disease? ___ Yes ___ No

If no, please explain: _____

List any restrictions: _____

Two MMR inoculations are required for anyone born since January 1, 1957. If two MMR inoculations were not given, please provide other proof of immunity:

Date of first MMR: _____ (after 12 months of age)
Date of second MMR: _____

Other proof of immunity: _____

Date of last Diphtheria-Tetanus (must be within last 10 years): _____

Applicant has had CHICKENPOX? ___ Yes ___ No ___ Unknown

Doctor or Health Services Nurse Signature: _____

Print name of person completing the form: _____
Address: _____
City/State/Zip: _____
Phone: _____

Please return to: Director of Volunteer Services
Niagara Falls Memorial Medical Center
621 Tenth Street, Niagara Falls, NY 14302 **FAX: 278-4614**