Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Dear Student:

Thank you for your interest in the Summer Student Volunteer Program at Jefferson Health - Northeast. Becoming a student volunteer involves making a commitment and being responsible and dependable. Our requirement for service is that you must be available to commit to an **eight-week** service schedule (volunteering for 4-hours a day, one day a week).

Enclosed please find an Application, two Letters of Recommendation and Immunization Requirement Policy Forms. The Letters of Recommendation are to be filled out by your teachers. **We require verification of your immunizations (measles, mumps and rubella vaccinations, (MMR), and a PPD test for Tuberculosis). We now also require proof of all COVID 19 Vaccinations. Please have your physician follow the instructions on the Immunization Policy Page.**

After your Application is complete and your Recommendation Letters and Immunization Forms have been received, you will be contacted by the Volunteer Services Department to inform you as to the status of your application.

It is important to note that there are only a certain number of designated student volunteer positions available for service, so there may not be an opportunity for you at the time you are requesting to become a volunteer.

Please return all correspondence to the Volunteer Services Department. You can return the forms via mail, scan, fax or email as a Word document. Our contact information is below. If you have any questions, please call our Department at 215-612-4170.

APPLICATIONS WILL ONLY BE ACCEPTED FROM FEBRUARY UNITL APRIL FOR THE SUMMER PROGRAM.

PLEASE NOTE: Jefferson Health – Northeast reserves the right to reject an application or terminate the service of a volunteer if, in the hospital's opinion, it is in the best interest of the hospital to do so.

Thank you for considering Jefferson Health – Northeast for providing your volunteer service.

Sincerely,

Caroline Williams

Caroline Williams, BA, CHES, CTTS
Director, Volunteer Services
Jefferson Torresdale Hospital
10800 Knights Road
Philadelphia, PA 19114
Office: 215-612-4171
Fax: 215-612-5027
Caroline.Williams2@jefferson.edu

Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Dear Parent and/or Guardian:

The Volunteer Services Department of Jefferson Health – Northeast is delighted that your child is interested in serving as a student volunteer.

Enclosed please find an Application, two Letters of Recommendation and an Immunization Policy Form. The Letters of Recommendation are to be filled out by your child's teachers. **It is mandatory that we also receive verification of your child's measles, mumps and rubella vaccinations, (MMR), and a PPD test for Tuberculosis. Also, verification of the COVID 19 vaccinations**. Please have your physician follow the instructions on the Immunization Policy Page. Also, our program requirement is that your child be available to commit to serve for an **eight-week period**. If you are planning an extended summer vacation, you must inform us about your plans. This may disqualify your child from our program.

After we receive your child's completed Application along with the completed Letters of Recommendation and Immunization Forms, your child will be contacted by the Volunteer Services Department to inform he/she as to the status of the application.

IMPORTANT: It is important to note that there are only a certain number of designated student volunteer positions available for service, so there may not be an opportunity for your child at the time he/she is requesting to become a volunteer.

If your child has been approved for our Summer Volunteer Program, your child may be contacted for an interview and/or an invitation to attend a mandatory Orientation. If your child cannot attend the Orientation, he/she cannot volunteer.

Please return all correspondence to the Volunteer Services Department. You can return the forms via mail, scan, fax or email as a Word document. Our contact information is below. If you have any questions, please call our Department at 215-612-4170.

PLEASE NOTE: Jefferson Health – Northeast reserves the right to reject an application or terminate the service of a volunteer if, in the hospital's opinion, it is in the best interest of the hospital to do so.

Sincerely,

Caroline Williams

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Director, Volunteer Services
Jefferson Torresdale Hospital
10800 Knights Road
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Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

STUDENT VOLUNTEER APPLICATION

(Students must be 16 years of age or older)

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Email Address: _____

Birth Date _____ School: _____

Month/Day/Year SSN: _____

At what location do you plan to volunteer? (Please circle one of the following)

Bucks Hospital Torresdale Hospital Frankford Hospital

What day(s) will you be available to work? _____

What time(s) will you be available to work? _____

Present Grade _____ Are you doing volunteer service for school credit? _____

If so, for what teacher/subject?

_____

Parent's or Guardian's Names

_____

Are you able to perform all functions of the positions for which you are applying with or without reasonable accommodations? _____

_____

Were you ever a volunteer in the past? _____ Where? _____

What do you want to do and see in the hospital as a volunteer? _____

_____

_____

Are you a member of any school or community activities? _____
_____
_____

What are your hobbies and interests? _____
_____

What do you plan to do after graduation? _____
_____
_____

Tell us about yourself, what are you proud of accomplishing? What is your best quality? Why do you wish to volunteer at Jefferson Health - Northeast?

_____
_____
_____
_____

Date: _____

_____
Student's Name (PLEASE PRINT)

_____
Student's Signature

PLEASE NOTE: Jefferson Health – Northeast reserves the right to reject an applicant or terminate the service of a volunteer if, in the hospital's opinion, it is in the best interest of the hospital to do so.

Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

PARENTS CONSENT

(MUST BE COMPLETED)

I hereby give my consent for my son/daughter (please print)_____
Child's Full Name
to take part in the Student Volunteer Program at Jefferson Health – Northeast.

I understand that he/she will provide verification of the measles, mumps and rubella (MMR) vaccinations, and a PPD test for Tuberculosis, as well as proof of all COVID 19 Vaccinations. Please have your physician follow the instructions on the enclosed Immunization Policy Page.

I understand that a criminal background check will be performed using my child's social security number before beginning service.

(IF A SUMMER VOLUNTEER) I understand that my son/daughter is making a commitment of at least **8 WEEKS** of service to Jefferson Health - Northeast in a dependable, responsible manner and I will support his/her efforts to do so.

_____
Parent or Guardian

(IF A YEAR-ROUND VOLUNTEER) I understand that my son/daughter is making a commitment of **12 months** of service to Jefferson Health - Northeast in a dependable, responsible manner and I will support his/her efforts to do so.

_____
Parent or Guardian

Please return to:
Volunteer Services Department
Jefferson Torresdale Hospital
10800 Knights Road
Philadelphia, PA 19114

Or fax/email your completed application to:
Fax: 215-612-5027 or
Email: Caroline.Williams2@jefferson.edu

PLEASE NOTE: Jefferson Health - Northeast reserves the right to reject an applicant or terminate the service of a volunteer if, in the hospital's opinion, it is in the best interest of the hospital to do so.

REV. 3/22

Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

PARTICIPATION IN THE STUDENT PROGRAM

Volunteers serve without pay and are responsible for their own transportation and to provide the required uniform. A volunteer is expected to be reliable and regular in attendance.

REQUIREMENTS

- Must be 16 years of age or older.
- Must be able to work a regular weekly assignment.
- Must have two references completed by teachers.

All students accepted for the Student Volunteer Program are required to attend an orientation session. After orientation there will be on-the-job training. Staff and experienced volunteers will participate in the training process.

Uniforms:

The current Student uniform is a red golf shirt and black or khaki colored pants.

No jeans, t-shirts, high heel shoes, shorts, stretch pants or legging pants are acceptable. SNEAKERS are preferable.

An ID badge will be issued at the orientation session and must be worn at all times while in the hospital.

PLEASE NOTE: Jefferson Health - Northeast reserves the right to reject an applicant or terminate the service of a volunteer if, in the hospital's opinion, it is in the best interest of the hospital to do so.

Applications are available in the Volunteer Services Department Office or by calling 215-612-4170.

Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

IMMUNIZATION POLICY FOR PROSPECTIVE VOLUNTEERS

Jefferson Health - Northeast requires that all employees and volunteers born in or after 1957 show proof of immunity for measles, mumps and rubella.

MEASLES Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of receipt of two doses of measles containing vaccine (measles, MR, or MMR) given on or after twelve months of age.
- prior health care provider diagnosed measles.
- laboratory evidence of measles immunity.
- born before 1957.

MUMPS Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of one dose of mumps containing vaccine (mumps or MMR) given on or after twelve months of age.
- documentation of health care provider diagnosed mumps disease.

RUBELLA Any one of the following are acceptable as proof of immunity:

- laboratory evidence of rubella immunity.
- documentation of one dose of rubella containing vaccine (rubella, MR, or MMR).

***We also require verification of a PPD test for Tuberculosis, and proof of all COVID 19 Vaccinations.**

Anyone unable to show proof of immunity for measles/mumps/rubella, will be required to receive the necessary immunization from their family physician as a condition of volunteering.

Volunteers excluded from measles/mumps/rubella immunization are pregnant volunteers and volunteers with immuno-suppression.

Proof of Immunization Must Be Submitted on Your Physician's Formal Letterhead with Accompanying Reports. Applications Without This Documentation Will Be Returned.

Any questions, please feel free to contact our office at 215-612-4170.

Caroline Williams BA, CHES, CTTS
Director, Volunteer Services

Rev. 3/22

STUDENT VOLUNTEER PROGRAM
LETTER OF RECOMMENDATION

(Please Print or Write Clearly)

STUDENT:

_____

Last First Middle Initial

ADDRESS:

_____

CITY/STATE/ZIP:

_____

SCHOOL:

_____

The applicant above is a candidate for the Student Volunteer Program at Jefferson Health - Northeast. Please use your judgment to comment on the following questions that assess potential, maturity, and personal competencies of the applicant. This uniform letter of recommendation allows the Volunteer Services Department to make a fair decision about each applicant. Your cooperation in completing and promptly returning this form will be appreciated.

1. How long have you known the applicant?

_____

In what capacity?

_____

_____

_____

_____

_____

2. How is this student's academic performance and self-motivation?

3. How is the applicant's personality, maturity, and ability to work with others? What are the applicant's strengths and weaknesses? If possible, give illustrations.

4. Does the applicant show dependability and commitment to a project?

5. Please use this space to give your overall assessment and additional comments.

To the best of your knowledge, would you recommend this student to Jefferson Health Northeast's Volunteer Program?

Date: _____ _____
Signature

_____ _____
Name Title

_____ _____
Address City/State/Zip

Please return this Letter of Recommendation either directly to the student or it may be mailed to:

Director of Volunteer Services
Jefferson Torresdale Hospital
10800 Knights Road
Philadelphia, PA 19114

Thank you for your time and effort in completing this information

REV. 3/22

STUDENT VOLUNTEER PROGRAM
LETTER OF RECOMMENDATION

(Please Print or Write Clearly)

STUDENT:

_____

Last First Middle Initial

ADDRESS:

_____

CITY/STATE/ZIP:

_____

SCHOOL:

_____

The applicant above is a candidate for the Student Volunteer Program at Jefferson Health - Northeast. Please use your judgment to comment on the following questions that assess potential, maturity, and personal competencies of the applicant. This uniform letter of recommendation allows the Volunteer Services Department to make a fair decision about each applicant. Your cooperation in completing and promptly returning this form will be appreciated.

1. How long have you known the applicant?

_____

In what capacity?

_____
_____
_____
_____
_____

2. How is this student's academic performance and self-motivation?

3. How is the applicant's personality, maturity, and ability to work with others? What are the applicant's strengths and weaknesses? If possible, give illustrations.

4. Does the applicant show dependability and commitment to a project?

5. Please use this space to give your overall assessment and additional comments.

To the best of your knowledge, would you recommend this student to Jefferson Health - Northeast's Volunteer Program?

Date: _____ _____
Signature

_____ _____
Name Title

_____
Address City/State/Zip

Please return this Letter of Recommendation either directly to the student or it may be mailed to:

Director of Volunteer Services
Jefferson Torresdale Hospital
10800 Knights Road
Philadelphia, PA 19114

Thank you for your time and effort in completing this information. Rev.3/22

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

DHHS Office of the Inspector General (OIC) Application Addendum Form

It is the policy of Jefferson Health - Northeast, consistent with the mandate of state and federal regulations not to employ or contract with any individual or corporation listed on any Federal Exclusion List.

Such lists include and are not limited to the following:

- DHHS/OIG Cumulative Sanction Report/List of Excluded Individuals/Entities (http://oig.hhs.gov/exclusions/index.asp)

Your signature below attests to the following:

- That you have been advised of and understand the importance of truthful responses concerning the aforementioned obligations.
- That you, are not currently listed on any List of Excluded Individuals or Entities maintained by the federal government and you do not anticipate being place or any exclusion list by the federal government.
- That should there be cause that your name may appear on any List of Excluded Individuals or Entities, you will promptly advise your immediate supervisor and Human Resources of the potential of such an event.
- That you have not been convicted of any healthcare related offense or other offense that is likely to cause your name to appear on any list of Excluded Individuals or Entities.
- That you understand that any false statements related to your employment or any subsequent appearance on any exclusion list maintained by the government will result in immediate termination of your employment.
- That you understand that your continued employment is contingent upon satisfactory reference validation.

I have carefully read the above statements and understand that signing this document attests that I am not excluded individual within the context of the above statements.

Print Name: _____

Signature: _____

Date: _____

Rev.3/22