



168 South Howell Street • Hillsdale, Michigan 49242-2081 • Telephone (517) 437-4451

Volunteer Application Packet

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Caring. Commitment. Community.

A hundred and five bed, not-for-profit hospital, Hillsdale Hospital serves the 47,000 plus residents of Hillsdale County.

We are fortunate to have many specialists on our Active Medical Staff, including OB/GYNs, Orthopedic Surgeons, General Surgeons, Gastroenterologists, Internal Medicine physicians, Urologists, and Oncologists. Additionally, Specialists from out-of-town come to Hillsdale Hospital to see patients.

As a full service hospital, Hillsdale Hospital provides laboratory, radiology, cardiopulmonary, and physical therapy services on both an inpatient and outpatient basis. Our outpatient surgery program continues to expand with the addition of new specialists to our Medical Staff.

A professional and caring atmosphere is essential for patients' speedy recovery; therefore, we concentrate on providing our patients the individual attention so important in the art of healing. We do not just talk about "quality" and "caring" - - we provide it.

THE VOLUNTEER PROGRAM

People volunteer for many reasons. It may be that they wish to become actively involved in the community, meet new people, explore career possibilities, share skills and experience, or just because it feels good to give an extra special touch when people are sick. Whatever the reason, volunteers do make a difference. Hillsdale Hospital volunteers play an integral role in the daily operations of the hospital.

A High School/College Volunteer Program was established for younger volunteers. The primary goal of this program is to provide an overview of the health care field to young people as they plan their careers. The program runs year-round.

ATTRIBUTES OF A GOOD VOLUNTEER

1. Genuine interest in what you are doing and a commitment to do it well.
2. A positive and friendly attitude.
3. Dependability.
4. Discretion and adherence to maintaining confidentiality inside and outside the hospital.
5. Compassion and a sense of caring, particularly when working with patients.
6. Being non-judgmental and respectful of our patients' privacy.
7. Understanding the volunteer's role and staying within those boundaries.

PLACEMENT PROCESS

Prospective volunteers are required to fill out a volunteer application form and be personally interviewed by the Director of Volunteer Services. Assignments are made according to the volunteer's interests and skills, as well as the needs of patients and staff. Volunteers in a particular service area report to and are supervised by the staff person in charge.

Each volunteer is required to sign a confidentiality statement before they begin their assignment.

Any concerns or problems that a volunteer may have while on duty should be directed to the Department Manager or staff person in charge.

TRAINING

Training is provided for each volunteer in two parts:

A. **Basic Training**

A general orientation is given by the Volunteer Services Department for new volunteers.

B. **Department Specific Training**

On the job training for a specific assignment is provided by the appropriate supervisor and/or an experienced volunteer.

INFORMATION FOR VOLUNTEERS

Each time you report to Hillsdale Hospital for volunteer service, you are expected to "sign-in" at the Volunteer Attendance Book. When you have completed your service, you will "sign-out", indicating your time of departure. The Volunteer Attendance Book is located in the Main Lobby, at the Information desk.

The Director of Volunteer Services records volunteer hours worked on a monthly basis and includes the hours on the hospital's monthly statistical reports. Therefore, IT IS VERY IMPORTANT THAT YOU RECORD YOUR HOURS WORKED IN THE ATTENDANCE BOOK.

Unless otherwise indicated, you are to wear khaki pants and golf shirt and/or top. You are also required to wear a nametag and rubber-soled shoes at all times while on duty. (No sandals, shorts, jeans are accepted.)

PLEASE BE PUNCTUAL AND DEPENDABLE.

Notify the supervisor of the area to which you are assigned as soon as you know you are unable to come in. Do not report to the hospital if you feel ill.

Do not reassign yourself, please. If you are unhappy with your assignment following a fair trial period, discuss this with the Volunteer Services Director.

ALWAYS CHECK WITH YOUR SUPERVISOR before leaving your department or if you have a question about your responsibilities.

IF YOU HAVE AN ACCIDENT WHILE SERVING AS A VOLUNTEER and require first aid, notify your supervisor and go to the Emergency Department. Incident reporting forms are located in the individual departments.

Hillsdale Hospital ETHICS FOR VOLUNTEERS

1. Hillsdale Hospital volunteers and staff are bound by the same code of ethics. All information concerning patient diagnosis and treatment is confidential. This information must be held in confidence.
2. Volunteers represent Hillsdale Hospital – please keep this in mind as you perform your duties.
3. Volunteers do not read patient records. Authorized staff are the only ones who have access to this information.
4. All volunteer service to the hospital is important. Be willing to accept suggestions and supervision. If you are asked to do something and you have not been instructed in it or you feel unsure of it, ask questions. It is better to ask too many questions rather than too few.
5. Be courteous and pleasant to patients and visitors.
6. Knock on doors. DO NOT GO IN IF MARKED ISOLATION.
7. Do not make personal phone calls from the phones on the floors, unless you have an emergency. NO CELL PHONES/TEXTING. You will be released from the volunteer program if this occurs.
8. Do not have friends visit you while on duty.
9. Do not give a patient food, drink, or adjust the bed without first checking with a nurse.
10. Please do not bring your own problems with you to the hospital. The patients have their own troubles. It is better to smile and assure the patient you are happy to help them in any way you can.
11. Any accident or unusual occurrence to a patient or to yourself should be reported to the department head immediately and to the Volunteer Services Director as soon as possible.
12. Sound and noises may be magnified in hospital corridors, so discussion should be kept at a minimum and voices low when in the hospital environment.
13. Discussion of patient issues should take place out of the patients' environment. Do not ask questions in front of patients.
14. Abide by the policies and regulations of the hospital when on the premises.

SMOKING

Because of the hazard and our concern for all, SMOKING IS NOT PERMITTED in any part of the hospital or on its grounds.

INFECTION CONTROL AND PERSONAL HYGIENE POLICY

The goal of this policy is to insure that adequate infection control procedures exist to safeguard patients and volunteers from infectious disease, as well as to review basic personal hygiene guidelines.

Volunteers must have evidence of a negative TB test within the last year. Drug Screens/Flu Shots are required annually thereafter. TB testing and flu shots are provided free of charge by Hillsdale Hospital.

Volunteers are not to report to work if they have any symptoms of communicable disease such as colds, coughs, runny nose, abscesses, fever, or unexplained rash.

Volunteers will not enter rooms with isolation or precaution signs on the door.

Hands shall be washed before and after entering/leaving a patient's room.

Hands shall be washed after using the restroom, blowing your nose, disposing of soiled dishes or utensils, before handling food and being with patients.

As perfume, cologne or perfumed lotions/soaps may be nauseating to some patients, such as those returning from surgery, it is suggested that use of these be kept to a minimum.

If serving patients, do not provide personal care or assistance to them. The nurse in charge should be notified if assistance is requested by a patient.

FIRE INSTRUCTION

Hillsdale Hospital is equipped with an alarm system that is directly connected with the Hillsdale Fire Department.

Learn the location of the Fire Alarm in your service area.

Fire extinguishers are placed in strategic locations throughout the hospital. Read and learn the instructions for their operation.

Fire doors are installed to contain fires within given areas. Know the means of exit from your area. Become familiar with locations of the fire doors and their purpose.

The hospital code for FIRE is CODE RED.

If there is a fire in the immediate area where you are volunteering, report to the supervisor – you may be needed to assist.

DISASTER PROCEDURES

Each volunteer should review the hospital's disaster procedures that are located in each department of the hospital and in the Volunteer Services Office.

Emergency Codes:

Code Blue	Initiate CPR
Code Pink	Child Abduction
Code Orange	Bio-Terrorism Event
Code Red	Fire
Dr. Strong	Aggressive Situation
Code Gray	Missing Geriatric Patient
Code Green	Missing Person
Code Yellow	Bomb Threat
Code Silver	Person with Weapon or Hostage

I have read and understand the following to become a Hillsdale Hospital volunteer. If I do not follow the guidelines above I do understand that I will be released immediately from the volunteer program.

Signature

Date

Parental signature required if under 18 years of age

Parent Signature

Date



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VOLUNTEER APPLICATION

Name _____ Date _____

Address _____ Birthday _____ (month/day)

City _____ State _____ Zip _____

Email Address _____

Telephone (H) _____ (C) _____

In case of emergency, notify _____

Address _____ Telephone _____

Have you ever been convicted of a crime? Y N

If so, for what, when, and where? _____

Are there any felony charges pending against you? Y N

If so, for what, when, and where? _____

Have you ever been convicted of a felony? Y N If yes, please describe _____

Do you smoke? Y N

Current high school/college information (if applicable):

Name of school _____ Grade/Year _____

Is volunteer work a requirement for school credit? Y N If yes, how many hours in what time frame? ____

Education (please list schools attended and degrees attained) _____

Previous employment/volunteer experience/participation in other community organizations _____

References (please list two with mailing addresses, phone numbers and email address):

Do you have any work restrictions? Y N If yes, please explain _____

Areas of Interest (please circle):

Obstetrics	Med/Surg	Emergency Room	Surgery
Skilled Nursing	CardioPulmonary	Physical Therapy	Medical Records
Clerical	Dietary	Laboratory	CCU

Other _____

Days and times available for volunteer assignment _____

Date available to start _____

Anticipated length of your volunteer services (for example, one year, one semester) _____

How did you become interested in our volunteer services program? _____

Please return this application to:
Judy Gabriele, Director of Development
Hillsdale Hospital
168 South Howell Street
Hillsdale, Michigan 49242
(517) 437-5236
jgabriele@hillsdalehospital.com



VOLUNTEER ORIENTATION CHECK LIST

Volunteer Name _____

Date _____

- ___ Hospital/Department Tour
- ___ Confidentiality Statement
- ___ Service Excellence
- ___ Cafeteria/Meals/Eating prior to volunteering
- ___ Injury/Incident Reports
- ___ No Smoking Policy
- ___ ID Badge
- ___ Attendance/Schedules/Dependability
- ___ Assignments/Job Descriptions
- ___ Recording Hours
- ___ Cell Phones
- ___ Infection Control/Hand Washing Procedure/Scrub-in/Scrub-out
- ___ TB Testing/Drug Screen/Flu Shot
- ___ Wheelchair Procedure
- ___ Personal Hygiene/Dress Code/Uniform
- ___ Parking
- ___ SDS/Disaster and Fire Manual location

I have completed the orientation for Hillsdale Hospital and I am ready to fulfill my commitments as a volunteer.

Volunteer Signature _____ Date _____

Orientation Instructor Signature _____



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CONFIDENTIALITY POLICY

Guidelines for hospital-related information and patient health information:

All individuals having knowledge of any information concerning the hospital, physicians, patients, or employees shall hold that information in the strictest confidence. This includes all employees, physicians, volunteers, students, visitors, board members, or other personnel directly or indirectly involved in patient care or hospital business.

Patient health information is protected by law and legal recourse is available to the patient if this information is disseminated in any form, verbal or written.

All patient and other hospital-related information is confidential and is not to be discussed with anyone not immediately concerned with that information.

This policy shall be made known to all volunteers and students when they first start at the hospital. Breach of confidentiality shall be grounds for immediate termination of the individual's role as volunteer.

I acknowledge that I have read, understand, and will observe the above confidentiality policy.

Print Name

Signature

Date



VOLUNTEER SERVICES DEPARTMENT WHEELCHAIR TRANSPORTATION POLICY

When transporting patients by wheelchair, care for their safety and comfort by following the guidelines listed below:

1. Always introduce yourself and be friendly, cooperative and cheerful.
2. Check the handbrakes to be sure they are locked when wheelchair is not in motion.
3. When assisting a patient in or out of a wheelchair, BE SURE to set the brakes.
4. See that patient's arms are inside the arm rests, not hanging over the side.
5. See that the patient's feet are securely placed on the foot rests.
6. Ask the patient if he/she is ready before moving wheelchair and explain where you are taking him/her.
7. Push vehicle slowly. SEE your way ahead.
8. Approach corners, doorways cautiously . . . COLLISION DANGER!
9. Pull vehicle through swinging doors.
10. At the elevator, be sure the floor is at level before proceeding. Always back a wheelchair onto the elevator, so as to be facing forward when exiting.
11. Avoid short, quick stops which tend to throw the patient forward.
12. Never lift a patient out of a wheelchair. CALL A NURSE TO MOVE THE PATIENT.
13. Transport patient feet first on a stretcher. Have assistance at front. Use side rails.
14. Push vehicles from the end, not the sides, to avoid injury.
15. On ramps, control vehicle from low side, get help if load or traffic is heavy.
16. Never block aisles or exits . . . even temporarily.
17. Never leave the patient unattended.

Signature: _____ Date: _____



VOLUNTEER SERVICES DEPARTMENT HANDWASHING POLICY

HANDWASHING

Many infections and diseases are carried by the hands. To avoid this, it is extremely important that you wash your hands often and in the proper manner.

Wash Your Hands

1. When coming on rotation.
2. When your hands are obviously dirty.
3. Between handling of patients.
4. When leaving an isolation area.
5. After handling used dressings, sputum containers, soiled urinals, catheters and bedpans.
6. Before and after contact with a patient's face or mouth.
7. After using the toilet.
8. After blowing or wiping nose.
9. Before eating.
10. On completion of duty.

Hand Washing Procedure

1. Remove all jewelry.
2. Moisten hands well with warm running water.
3. Apply soap to well wet hands. Work up a lather using friction; be sure to get between fingers and around the nails.
4. Rub all surfaces for at least 30 seconds or more. Sing one verse of Happy Birthday!
5. Rinse with running water flowing off the hands.
6. Avoid touching the inner surface of the sink.
7. Dry hands thoroughly with paper toweling; turn facet off with paper towel, open door and then discard towel in wastebasket.

Signature_____Date_____



VOLUNTEER SERVICES DEPARTMENT PERSONAL HYGIENE POLICY

Volunteers are representative of the hospital and shall observe good personal hygiene at all times. This shall include:

1. **Body and Hair**
Keep body clean by bathing daily and using a deodorant. Keep teeth and mouth clean. Keep hair washed and neatly styled. Long hair should be pulled back from the face and off the shoulders. Perfume should be used conservatively. No facial or tongue piercing. No visible tattoos.
2. **Fingernails and Hands**
Keep fingernails short and clean. Light colored and colorless nail polishes are acceptable. Bright and dark polishes hide dirt under the nails.
3. **Hands should be washed:** After visiting the restroom; between each patient; touching your hair or using a toothpick; after coughing, scratching your face, sneezing or blowing the nose; after handling a patient's tray or other soiled dishes; after handling money.
4. **Clothes**
Wear clean, neatly pressed clothes. Freshly laundered underclothing is as important as outer garments. Be sure all seams and buttons are secure. Wear tennis shoes, dress or khaki pants. No hooded sweatshirts, blue jeans, sandals, shorts, sweatpants, Capri's or short tops.
5. **Shoes**
Shoes shall be comfortable and low-heeled for safety. No sandals or clogs please.
6. **Jewelry**
A maximum of two pair of modestly sized pierced earrings may be worn at a time, provided the earrings are in the traditional lobe placement of the ear. With respect to body adornment, no cartilage, eyebrow, tongue, nose, lip or other forms of visible body piercing may be evident. No visible tattoos may be evident.
7. **Alcohol – Substance Abuse**
If a volunteer arrives on the job with liquor on his/her breath, they will be asked to leave and shall not be allowed to return for future rotations.

Signature _____ Date _____



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DRUG SCREEN CONSENT FORM

I hereby consent for Hillsdale Hospital to collect a urine sample from me, to determine the presence of drugs or controlled substances. Further, I give my consent for the releases of the test results to the authorized department that sent me here.

Print Name: _____

Signature: _____

Date: _____

Cell Phone #: _____

Signature: _____

(Parental signature required if under 18 years of age)

LIST ANY MEDICATIONS THAT YOU HAVE TAKEN IN THE PAST TEN DAYS:

You will need to provide a picture ID.



Minor Consent for TB Testing

_____ has my permission to be given a TB skin test/x-ray so that he/she may participate in the Hillsdale Hospital Volunteer Services volunteer program.

I understand and agree that TB testing is offered by the hospital only under the following circumstances and I hereby state that each of the following statements is true:

1. My daughter is not currently pregnant or nursing.
2. My son/daughter has never had a positive reaction to a TB skin test.

I also understand that my son/daughter may have the following adverse reaction to the TB test: redness, tenderness, and/or swelling at the injection site.

I agree that if my son/daughter experiences any adverse reaction from the TB test, I will immediately bring it to the attention of the Emergency Department at Hillsdale Hospital.

Signature of Parent or Guardian

Date



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**2016-2017 Influenza Vaccine Consent Form
VOLUNTEER**

Information about Individual to Receive Vaccine (Please Print)

NAME (Last)		(First)		(M.I.)
AGE	DATE OF BIRTH: Month: Day: Year:			
ADDRESS				
CITY	STATE	ZIP	DAYTIME PHONE NUMBER (517)	

Screening for Vaccine Eligibility

The answers to the following questions will help is to determine if you can get the influenza vaccine. Please mark YES or NO for each question.	YES	NO
1. Are you ill today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any other serious allergies? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction to a previous dose of influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barre Syndrome? (Guillain-Barre Syndrome is a type of temporary severe muscle weakness)	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR VACCINATION:

I give consent to be vaccinated with the influenza vaccine. I have received the 2016-2017 Vaccine Information Sheet for the Influenza vaccine and understand the risks and benefits. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Michigan Department of Public Health and Hillsdale Hospital.

Signature of person receiving vaccine or Signature of Parent/Guardian:

Sign: _____

Date: _____

FOR ADMINISTRATIVE USE ONLY

Date Administered	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number Exp. Date
Signature of Vaccine Administrator					