REGINA HOSPITAL

Thank you for your interest in **Regina Hospital's Youth Volunteer Program.**
Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

Here is the process of getting ready to share your time and energy with us.

- Enrollment – Please call the volunteer office to schedule an interview after you have completed the attached enrollment paperwork. I hope that we can offer you an area of service that is compatible with your interests and availability. Regina Hospital is required to perform a background check, so please thoroughly review the application and complete the attached forms.
  - A parent or guardian must complete the consent section.
  - The recommendation section needs to be completed by a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with you in a supervisory capacity.

- Health – Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, and tuberculosis. When we meet, we will provide you with contact information for Infection Control. If your immunization record is unavailable, our infection control practitioner may arrange for a free test at an Allina Health laboratory to verify your immunity.

- General Orientation – We will schedule a time for you to attend a general orientation session to learn what you need to know about Regina Hospital before you get started.

I look forward to meeting with you and pursuing your interest in volunteering at Regina Hospital – Part of Allina Health. Please feel free to contact me if you have any questions.

Sincerely,

Maria Reis
Volunteer Services Coordinator
651.404.1104
Email: maria.reis@allina.com

REGINA HOSPITAL

YOUTH VOLUNTEER SERVICES ENROLLMENT FORM (Age 13-17)

Name ____ Birth date ______________________
Address____________________________ City________________ State _______ Zip______
Phone 1 ________________________________ Phone 2 _____________________________
Email address: ____

GENERAL INFORMATION

School presently attending ____
Grade ______________________________ Graduation year ________________________
Are you performing this volunteer service because it is required? YES NO (circle one)
If YES: 1) Reason hours are needed ______________________________________
2) Number of hours required _____________________________________
3) Completion deadline ____
How would you arrange transportation? ____
When are you available ____

AREA(S) OF INTEREST

Please indicate general area(s) that may interest you, keeping in mind that your choices may change as you discover more about us.

____ Patient experience cart (age 13-17) – pass out items (cards/crossword puzzles, Sudoku) to patients in the Medical Surgical department
____ Hospital unit helper (age 14-17) prepares ice pitchers and delivers to patients, runs errands, assists with desk duties, restocks fridge
____ Escort (age 14-17) assists in registration area (no Saturday or Sunday)
____ Garden and Labyrinth assistant
____ Other ____

SIGNATURES

The information provided in this enrollment form is true. I understand that if this information is false in any way, I will be dismissed without notice regardless of when the false information is discovered. I realize that if accepted as a volunteer, I must abide by the rules, regulations and expectations of the Volunteer Department and Regina Hospital.

Youth signature ____ Date __________________

Parent/Guardian signature ___________________________________ Date __________________

Return application to:
Regina Hospital Volunteer Services
Attn: Maria Reis
1175 Nininger Road
Hastings, MN 55033

Questions?
Call Volunteer Services at 651.404.1104

REGINA HOSPITAL

YOUTH VOLUNTEER PARENTAL CONSENT FORM

In order for your child to become a volunteer with us, we need your consent and your involvement in helping them have a productive experience. Please read and sign this parental consent form if you would like us to consider your child as a possible volunteer. Feel free to call Volunteer Services at 651.404.1132 if you have any questions, would like further information, or would like to discuss this with someone.

- Your child will receive orientation and training which is necessary for the safe and responsible performance of the duties he or she will be asked to perform.
- Your child will be expected to meet all the requirements of the position, including regular attendance and adherence to policies and procedures.

VERIFICATION OF IMMUNITY

Medical staff personnel will verify immunity to the following diseases: measles, mumps, rubella, chicken pox, and tuberculosis. If your child's immunization record is unavailable, our medical staff will provide a free test at Allina Health's laboratory to verify immunity. *Parental consent will be required for vaccination only.*

IN CASE OF INJURY

If your child is injured while performing volunteer services, it is Regina's policy to provide immediate first-aid treatment at the expense of the hospital. Your own insurance company shall be the primary carrier in the case of an injury that requires further treatment.

____ I give permission for immediate emergency medical treatment. Notify emergency contact person listed below as soon as possible.

____ I DO NOT give permission for emergency medical treatment until I have been contacted.

IN AN EMERGENCY PLEASE NOTIFY

Name ____ Relationship ___________________________

Address _____________________________ City ___________________ State _____ Zip _________

Phone 1: __________________ Phone 2: __________________ Phone 3: ____________________

I understand that my child wishes to be considered for volunteer work and if accepted by Regina Hospital, I hereby give my consent for them to serve in that capacity. I understand that my child will not receive monetary compensation for the services contributed.

____ ____________________

Parent/Guardian signature Date

Return application to:
Regina Hospital Volunteer Services
Attn: Maria Reis
1175 Nininger Road
Hastings, MN 55033

Questions?
Call Volunteer Services at 651.404.1104

REGINA HOSPITAL

YOUTH VOLUNTEER RECOMMENDATION FORM

Youth who wish to volunteer at Regina Hospital are required to submit a personal recommendation from a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with him or her in a supervisory capacity.

____ is interested in volunteering at Regina Hospital.
Volunteer candidate name

Name of person providing this recommendation ____
Please print name

How long have you known this youth? ____

What is your relationship? ____

What three words would you use to describe this youth?
1 ____________________________ 2 ____________________________ 3 _____________________

Describe how this youth gets along with people in general ____________________________________
____
____

Your recommendation ____
____
____
____
____

Signature _______________________________________ Date _____________________________
Phone ___________________ Best time to reach you _________________________________

Return form to:
Regina Hospital Volunteer Services
Attn: Maria Reis
1175 Nininger Road
Hastings, MN 55033

Questions?
Call Volunteer Services at 651.404.1104

AllinaHealth

Background Check Disclosure for Allina Health Volunteers

Allina Health, including its subsidiary and affiliate corporations, may:

- order a consumer report (a background report) on you in connection with your application to volunteer at Allina Health
- order additional background reports on you for purposes of your volunteer role if you become a volunteer, or if you already volunteer for Allina Health.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and criminal history. Information may be obtained from private and public record sources.

The current consumer reporting agencies (CRAs) are:

Verified Credentials, Inc. 20890 Kenbridge Court Lakeville, MN 55044 952-985-7200 Toll free:1-800-473-4934	Bureau of Criminal Apprehension BCA Headquarters – St. Paul 1430 Maryland Avenue East St. Paul, MN 55106-2802 651-793-2400

You have the right in most circumstances to submit a written report to the CRAs for a complete and accurate disclosure of the nature and scope of any consumer report Allina Health ordered about you. The CRAs must provide you with this disclosure form within five business days after its receipt of your request or the report was requested by Allina Health, whichever date is later.

Allina Health

Background Check Authorization for Allina Health Volunteers

By signing below, I authorize Allina Health, including its subsidiary and affiliate corporations, to obtain a consumer report in connection with my application for a volunteer role, or, as allowed by law, at any time during my volunteer role and from a consumer reporting agency (CRA) other than Verified Credentials, Inc.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, and subject to all laws protecting my information and individual privacy, I also authorize that the following information may be disclosed to the CRA as needed to compile the report: my past and present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed to the CRA, if and only as allowed by law, includes information related to my criminal background, motor vehicle history, employment and earnings history, education, personal references, character, mode of living, credit background, civil judgments or liens, military service, and professional credentials and licenses.

A volunteer opportunity with Allina Health is contingent upon a satisfactory background investigation. If I become a volunteer, I authorize Allina Health to order additional background reports while volunteering with Allina Health related to any of the above issues without asking me for my authorization again.

I may receive a copy of any consumer report obtained by Allina Health at no expense to me. I understand that I may request additional information on the nature of the report upon written request to the CRA. These searches will be conducted by: Verified Credentials, Inc., 20890 Kenbridge Court, Lakeville, MN 55044, 800-473-4934, www.verifiedcredentials.com. Check this box if you would like a free copy of your background report: ☐ Yes ☐ No

A copy of this authorization has the same validity as the original.

<table>
<tr><th colspan="6">Identity Information and Address History</th></tr>
<tr><td colspan="2">First Name</td><td colspan="2">Middle Name</td><td colspan="2">Last Name</td></tr>
<tr><td colspan="6">Former name(s) or alias you have used in the past (including maiden name):</td></tr>
<tr><td colspan="3">Date of Birth*</td><td colspan="3">Social Security Number*</td></tr>
<tr><td colspan="3">Phone</td><td colspan="3">Email Address</td></tr>
<tr><td colspan="6">Please list ALL the of the addresses where you have lived during the last 7 years</td></tr>
<tr><td colspan="6">Current:</td></tr>
<tr><td colspan="6">Previous:</td></tr>
<tr><td colspan="6">Previous:</td></tr>
<tr><td colspan="6">Previous:</td></tr>
<tr><td colspan="4">Signature:</td><td colspan="2">Date:</td></tr>
</table>

** This information is used for identification purposes only*