Wamego Health Center
Volunteer Services
Pre-Professional Application

Date Received: _____

Please include the following with your application:

- □ One referral letter from an adult non-family member who has worked with you in a supervisory capacity or school counselor/advisor/teacher/professor that has known you for at least one year.
- □ One referral letter from an adult non-family member who has known you for at least two years.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____/_____/_____
(LAST) (FIRST) (MI) (MM) (DD) (YY)

Address: _____ Home Phone: _____

Email Address: _____ Cell Phone: _____

EMERGENCY CONTACT

Name: _____ Home Phone: _____

Relationship to you: _____ Cell Phone: _____

INTEREST

(Wamego Health Center has a limit of 20 hours total for shadowing time per student)

Please check the areas you are interested in:

□ Health Information □ Radiology □ Heritage - Senior Behavioral Health

□ Dietary □ Laboratory □ Physician (Family Practice) *requires prior approval

□ Nursing (Clinical) □ Nursing (Medical floor) □ Cardiac Rehabilitation

□ Speech Therapy □ Occupational Therapy □ Physical Therapy

□ Other: _____

Please circle days and times you are available:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING	MORNING	MORNING	MORNING	MORNING
AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON

Date you are able to begin shadowing: _____

PLACEMENT

For High School Students

School: _____ Grade Level: _____

School Counselor: _____ Phone Number: _____

Address: _____ Email: _____

Anticipated graduation date: _____

Is this a class requirement? □ YES □ NO

If yes: Course: _____ Teacher: _____

Activities: (clubs, sports, hobbies, etc.) _____

_____

For College Students

College / University: _____ Major: _____

Academic Advisor: _____ Phone: _____

Address: _____ Email: _____

Grade Level: □ Freshmen □ Sophomore □ Junior □ Senior □ Other: _____

Is this a class requirement? □ YES □ NO Anticipated graduation date: _____

If yes: Course: _____ Professor: _____

Activities: (clubs, sports, hobbies, etc.) _____

_____

Have you observed, volunteered, or worked in a medical facility before: □ YES □ NO

If yes: Name of facility: _____

Department: _____ Approx. number of hours: _____

How did you hear about Wamego Health Center?

□ Friend □ Church □ WHC webpage

Who? _____ Which one: _____

□ Employer / School □ Poster / flyer □ Via Christi webpage

Who: _____ Where: _____

Have you worked / volunteered / shadowed for Wamego Health Center before? □ YES □ NO

If yes: Department: _____ Dates: _____

Reason for leaving: _____

IMPORTANT INFORMATION

PLEASE READ CAREFULLY!

I understand that the Pre-Professional program at Wamego Health Center is designed to allow students the opportunity to observe/ shadow a medical setting. I understand that this opportunity does **NOT** allow for patient interaction of **ANY KIND**. The program allows for **shadowing/ observation ONLY**. I understand that failure to comply will result in immediate termination and no credit will be given.

Applicant's Signature: _____ **Date:** _____

CONFIDENTIALITY AGREEMENT

Wamego Health Center recognizes the importance of protection of confidential information concerning patients, their families, medical staff and co-workers and the operations of the hospital. It is the intent of Wamego Health Center and the undersigned to protect the privacy and provide for the security of Protected Health Information (PHI) disclosed to the undersigned in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy regulations published by the U. S. Department of Health and Human (DHHS) and other applicable laws. It is the obligation of the undersigned to maintain the confidentiality and privacy of PHI or other confidential information and to relay facts pertinent to the treatment of a patient only to those who are involved with the patient's treatment program or for quality

All patient and health center information including protected health information in any form (oral, written, or electronic) is considered confidential. Computer systems allow qualified individuals to access, from authorized terminals, restricted and confidential patient and hospital information. The hospital shall issue a confidential password and security code to authorized individuals. It is the authorized individual's ethical and legal responsibility to maintain and comply with all the confidentially requirements. Wamego Health Center requires that all agree to the following:

1. I will protect the confidentiality of patients and health center information
2. I will not release protected health information or other confidential information to any source unless authorized
3. I will not access or attempt to access information other than necessary information which I have been authorized to
4. I will not use another person's security code
5. I will not write down passwords or security codes that would make them accessible to other individuals
6. I will report breeches of this confidentiality agreement by others to the Wamego Health Center privacy office. I understand that failure to report breeches is an ethical violation which will subject me to civil and/or criminal penalties

I HAVE READ AND AGREE TO ADHERE TO THE CONDITIONS OF THIS CONFIDENTIALITY AGREEMENT. I ACKNOWLEDGE THAT ANY VIOLATION OF THE ABOVE CONDITIONS CAN RESULT IN DISCIPLINARY ACTION OR CONTRACT TERMINATION, SEVERENCE, OR CIVIL PENALTIES.

Applicant's Signature: _____ **Date:** _____

(Continued on next page)

APPLICANTS UNDER 18 YEARS OF AGE MUST OBTAIN PARENTAL CONSENT

(Applicant's Name) _____ has my permission to serve in a Student Pre-Professional capacity at Wamego Health Center. I understand that, if accepted as a Pre-Professional Applicant, my son or daughter may be working within various departments and may at times be in close contact, but NOT direct with patients. He or she will receive instruction and orientation concerning the types of duties assigned. I understand that this is a volunteer activity and is performed at the patient's own risk.

Parent/ Guardian's Signature: _____ **Date:** _____

CRIMINAL BACKGROUND

Have you ever been convicted of a felony for violation of any federal, state, county, or municipal law, regulation, or ordinance? (Do not include traffic violations) □YES □NO

If yes, date of conviction or plea: _____/_____/_____ State or County: _____
(MM) (DD) (YY)

Describe circumstances: _____

_____

Please disclose all of the convictions or pleas that have been requested, even if the conviction or plea has been discharged, expunged, or otherwise removed from your record. Convictions and pleas are not an automatic bar from placement. We will consider relevant factors such as, the recency and nature of the violation, in the placement process.

Applicant's Signature: _____ **Date:** _____

AGREEMENT

I certify, to the best of my knowledge, that all information given by me in this application is true and correct. I authorize Wamego Health Center to utilize this information in determining my Pre-Professional placement. I understand that false or misleading statements made by me or consequential omissions of any kind in the application process are sufficient causes for my not being accepted as a pre-professional or for my dismissal from the WHC Pre-Professional Program. I understand that I will not be paid for my services as a Pre-Professional.

Applicant's Signature: _____ **Date:** _____

HEALTH INFORMATION

In accordance with Via Christi's Volunteer Policies, acceptance of an applicant is based upon successful completion of:

- □ ~~Background check~~

- □ Verification of vaccinations:
  - □ Hepatitis B
  - □ MMR
  - □ Varicella
  - □ Tdap

- □ Current on:
  - □ TB skin test (within the past year)
  - □ Flu shot (within the current flu season)

Wamego Health Center Volunteer Services
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