



## *Volunteer Application*

**2019 High School or College Student Summer Volunteer Program – Returning Students**

### **Deadline for Application – February 22, 2019**

#### **Checklist**

- Application
- High School or College Student Summer Volunteer Program Agreement – Returning Student
- Health Questionnaire
- Background Check Order Form (if 18 years old by May 1, 2019)
- Consent to Photography
- Vehicle Registration (if the student will be parking a vehicle on campus)

**Submit these completed and signed forms no later than February 22, 2019. Scan and email to [volunteersmca@mayo.edu](mailto:volunteersmca@mayo.edu).**

#### **I am able to attend the following mandatory 2019 program dates:**

- Return application by: February 22
- Orientation: Saturday, April 27
- Paperwork and TB check: Monday, April 29
- Student training day: Tuesday, June 4

# Volunteer Application

## 2019 High School or College Student Summer Volunteer Program – Returning Students (continued)

### Deadline for Application – February 22, 2019

Preferred Service Location

**Mayo Clinic**  
 Scottsdale Campus  
 13400 East Shea Boulevard  
 Scottsdale, Arizona 85259

**Mayo Clinic**  
 Phoenix Campus  
 5777 East Mayo Boulevard  
 Phoenix, Arizona 85054

Current School Name

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Applicant Name <i>(First, Middle, Last)</i>		Preferred Name (for badge)	
Address <i>(Street, City, State, ZIP Code)</i>			
Home Phone	Cell Phone	Email	
Birth Date <i>(mm-dd-yyyy)</i>	Current High School Grade or College Level		

Emergency Contact Name		Relationship	
Home Phone	Cell Phone	Email	

Date Available for Volunteer Service <i>(mm-dd-yyyy)</i>	Last Day Available for Volunteer Service <i>(mm-dd-yyyy)</i>
Are you able to attend a mandatory orientation session on Saturday, April 27, 2019 from 12:00 to 3:30 pm? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During June 3 through August 2, 2019, will you miss more than one week's service due to vacations, sports, camps, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Indicate below when you are available for volunteering.

Time of Day	Monday	Tuesday	Wednesday	Thursday	Friday
8 am–12 pm					
12 pm–4 pm					

# Volunteer Application

## 2019 High School or College Student Summer Volunteer Program – Returning Students (continued)

### Conflict of Interest

It is important to the integrity and success of Mayo Clinic and Volunteer Services that all volunteers strive to avoid any actual, potential, or implied conflict between their interests and the interests of Mayo Clinic. Volunteers may have access to privileged, confidential information regarding Mayo Clinic's professional, business, or research activities, and they must not use such information to derive personal benefit, either directly or indirectly, whether it be financial or otherwise.

### Confidential Information

As a Mayo Clinic Volunteer, you may have access to privileged information concerning patients or employees. When you accept an assignment, you also accept an obligation to keep confidential information precisely that—confidential. Only physicians, under certain circumstances, are authorized to release medical, surgical, or laboratory findings concerning a patient or his or her problems. Volunteers may not reveal any of this information.

Carelessness or thoughtlessness in the handling of such information is ethically unacceptable and could expose you and the clinic/ hospital to legal action. You must also understand that in the performance of your duties as a volunteer, you must hold in strict confidence any observations you may make, see, or hear regarding patients, physicians, or personnel.

I have read the above statement, I understand the contents, and I agree to conduct myself in accordance with this requirement. I will not discuss confidential information regarding patients, employees or business operations.

Applicant Signature	Date (mm-dd-yyyy)
Parent or Guardian Signature (if applicant is under 18)	Date (mm-dd-yyyy)
Parent or Guardian Printed Name	

Our volunteer positions should not be viewed as a means of obtaining employment at Mayo Clinic or Mayo Clinic Hospital. Persons seeking paid positions should apply to the Human Resources Department.

### Conditions

I understand that submission of an application does not guarantee admission to the program.

If accepted, I agree to abide by all policies and guidelines of the Volunteer Services Department. I understand that my volunteer service is "at will," meaning that it may be terminated at any time by either party.

Applicant Signature	Date (mm-dd-yyyy)
Parent or Guardian Signature (if applicant is under 18)	Date (mm-dd-yyyy)

# Volunteer Application

## 2019 High School or College Student Summer Volunteer Program – Returning Students (continued)

**If accepted as a Mayo Clinic High School or College Student Summer Volunteer:**

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. Additionally, I will not attempt to photograph or solicit an autograph from a high profile patient or visitor.
2. My services are donated to Mayo Clinic without contemplation of compensation or future employment and are given for humanitarian reasons. I realize I am never required to perform any services as a volunteer which I am uncomfortable doing or for which I have not been properly trained.
3. I shall not sell or attempt to sell good or services, request contributions, or to solicit persons to sign or distribute political petitions on Mayo Clinic property.
4. I shall submit to examinations, which may include background screening, chest x-rays, skin tests, appropriate laboratory tests, and/or immunizations that may be necessary as part of my volunteer service. I hereby authorize my health care provider(s) to furnish Mayo Clinic with information concerning my health. I also authorize the person(s) making tests or x-ray films to report the results to Mayo Clinic.
5. I shall be punctual and conscientious; conduct myself with dignity, courtesy, and consideration of others; and endeavor to make my service professional in quality. I understand that my appearance while on duty as a volunteer must be neat and clean. I shall wear the uniform designated by Mayo Clinic Volunteer Services Department and my Mayo Clinic volunteer name badge while on duty at all times.
6. I shall attempt to resolve any problems related to my volunteer activities with my supervisor or Team Leader and, if unsuccessful, I will attempt to resolve any such problems with the Director of Volunteer Services.
7. I shall make my best effort to fulfill my commitment to Mayo Clinic by completing all assignments I accept.
8. I shall, at all times, uphold the philosophy and standards of Mayo Clinic.
9. I understand that I must be available to volunteer during the required 9-week period of June 3 to August 2, 2019.

Volunteer Initials \_\_\_\_\_ Parent or Guardian Initials (if applicant is under 18) \_\_\_\_\_

10. I understand the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
  - a. failure to comply with Mayo Clinic policies, rules, and regulations.
  - b. more than one absence.
  - c. unsatisfactory attitude, work, or appearance unbecoming a member of Mayo Clinic’s High School or College Student Summer Volunteer Program.
  - d. any other circumstances which, in the judgment of the Director of Volunteer Services, would make my continued service as a volunteer contrary to my best interests as well as those of Mayo Clinic.

Volunteer Initials \_\_\_\_\_ Parent or Guardian Initials (if applicant is under 18) \_\_\_\_\_

I have read and understand each of the above conditions. I will have an opportunity to ask questions and I agree to be bound by this consent to volunteer.

Applicant Signature	Date (mm-dd-yyyy)
Parent or Guardian Signature (if applicant is under 18)	Date (mm-dd-yyyy)

# Volunteer Application

## 2019 High School or College Student Summer Volunteer Program – Returning Students (continued)

### Parent or Guardian Agreement for Returning Students (complete only if applicant is under 18)

1. I give consent for a PPD skin test (TB skin test) to be administered at Mayo Clinic for my child and, in the event of a positive result, for additional blood work to be drawn.
2. I assume full responsibility for our child's transportation to and from Mayo Clinic.
3. I give permission to Mayo Clinic to administer emergency medical treatment if necessary.
4. I hereby authorize Mayo Clinic to contact and receive information from any references given regarding my child's activities.
5. My child has permission to become a Mayo Clinic High School or College Student Summer Volunteer Program for the 2019 summer session.
6. My child will be in compliance with the High School or College Student Summer Volunteer Program Agreement, including completion of 9 weeks of service after orientation.
7. I hereby authorize my child to observe a recorded video of a Mayo Clinic surgery if the opportunity arises.
8. I hereby authorize my child to participate in the Nursing Simulation Skills Lab, including the opportunity to start IVs and administer injections on artificial patients (mannequins) which will require the use of needles.

Parent or Guardian Signature (if applicant is under 18)	Date (mm-dd-yyyy)
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# Health Questionnaire

## Volunteer Services

**Instructions:** Complete form, then return to Volunteer Services.

Applicant Name <i>(First, Middle, Last)</i>	Birth Date <i>(mm-dd-yyyy)</i>	Date Today <i>(mm-dd-yyyy)</i>
Address <i>(Street, City, State, ZIP Code)</i>		Phone
Are you currently receiving care from a physician or other health care practioner? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, explain:		
Provide us with any health- or prescription-related information that you believe is important for us to know:		
Are you allergic to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Allergies		

Can you do the following?	Yes	No	Describe any limitations.
Lift	<input type="checkbox"/>	<input type="checkbox"/>	
Bend or twist	<input type="checkbox"/>	<input type="checkbox"/>	
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	<input type="checkbox"/>	<input type="checkbox"/>	
Reach	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	
Push or pull	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>	

Describe any hearing limitations or special hearing needs:

Parent or Guardian Signature (if applicant is under 18)	Date (mm-dd-yyyy)
Parent or Guardian Printed Name	

# Background Check Order Form Mayo Clinic Volunteer Services

Please print clearly.

Fields marked with an asterisk (\*) are required.

Name* _____ <small>First Middle Initial Last</small>	Maiden Name _____
Drivers License #* _____ DL State* _____	Date of Birth* _____
SSN* _____	I.D. Number _____ <small>(I.D. Number only needed if you do not have SSN)</small>
Alias Name _____	Phone* _____
Alias Name _____	E-mail* _____

**Residences (start with current, give last 10 years)**

Address* _____ <small>Street Apt City State ZIP</small>	Dates: _____
Address* _____ <small>Street Apt City State ZIP</small>	Dates: _____
Address* _____ <small>Street Apt City State ZIP</small>	Dates: _____

**Disclosure and Authority to Release Information**

I understand that in processing my application with **Mayo Clinic**, an investigative consumer report may be conducted to obtain and verify information relating to my past activities and background. Information may include, but is not limited to: employment history, education, criminal records, motor vehicle records, personal references, and any data provided on this form, or during the interview process.

I authorize the appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosures.

I further understand and waive my right of privacy in this investigation and release and hold harmless **Mayo Clinic** and its agent Verified Credentials, Inc., from any liability.

An investigative consumer report may be generated summarizing this information. I have a right under the "Fair Credit Reporting Act" to obtain a copy of this report by providing proper identification and directing a written request to Verified Credentials Incorporated, 20890 Kenbridge Court, Lakeville, MN, 55044. 1-800-473-4934. I may also obtain a copy of this report by checking the "YES" box below.

I would like a copy of any report regarding me.  YES  NO

I hereby certify that all the statements and answers set forth on the volunteer form are true and complete to the best of my knowledge, and I understand that if any statements and/or answers are found false or the information has been omitted, such false statements or omissions may be cause for rejection or termination of my volunteership.

I authorize a photocopy of this release to be accepted with the same authority as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date  
(To be used for background information ID only)

<p><b>MayoUse Only:</b> VMS Client Code: MCV001/ Fax No. 952-985-7212 Send results to: _____</p>
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MAYO CLINIC

# Consent for Interviews/Photography/ Audiotape/Videotape/Filming

Name(s) \_\_\_\_\_

I consent to be interviewed/photographed/audiotaped/videotaped/filmed for publication, broadcast, medical instruction, patient education, electronic transmission or any other use Mayo Clinic deems appropriate (including publication in promotional materials to potential Mayo benefactors, Mayo-sponsored Web sites, and public museum-quality displays and exhibits).

Please check here if you do not wish to be featured in Mayo-sponsored Web sites.

I further agree that such information/photography/videotape/film/electronic data shall be the exclusive property of Mayo Clinic, free and clear of any claim on my part.

I consent to the above without expecting payment or royalties, and I release Mayo Clinic and its employees from any and all liabilities which may arise from the use of such information/photography/audiotape/videotape/film/electronic data.

It is understood that my name/identity, as well as any other information that I provide, may also be used for these purposes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian (if under age 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Daytime Telephone

\_\_\_\_\_  
City, State, ZIP Code



# Volunteer Vehicle Registration

Date:	Volunteer Name:
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## Vehicle Information

### Vehicle No. 1

Year:	Make:	Model:
License Plate:	State:	Color:

### Vehicle No. 2

Year:	Make:	Model:
License Plate:	State:	Color:

### For Volunteer Office Use Only

Person ID:	Parking Permit Number:
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