NORTHERN TIER INDUSTRY& EDUCATION CONSORTIUM

HOSPITAL EXTERNSHIP – APPLICATION FOR FALL 2025 PROGRAM

Wayne Memorial Hospital - Honesdale

PLEASE PRINT CLEARLY

Student Name: _____

Date of Birth: _____

Address *(Street, City, Zip Code)*: _____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

School: _____ **Grade:** 10 / 11 / 12
(Circle one)

Recommending Guidance Counselor / Teacher: _____

What healthcare profession are you most interested in? ***(Circle the number)***

1. Emergency room
2. Operating room/surgical area
3. Nursing/patient area
4. Lab/pharmacy
5. Radiology
6. Physical therapy/home health
7. Facilities (plant enginnering/food service/housekeeping)
8. Administration (leadership/medical records/accounting)
9. Other: _____

List the classes you have taken in high school preparing you for a career in healthcare.

_____

Please use the area below to describe why you are interested in participating in this externship.
(Additional room on the back)

_____

_____

_____

P.O. Box 505, Tunkhannock, PA 18657
Phone (570) 278-5038 – Fax (570) 278-2731
www.ntiec.com

NTIEC

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you are approved for the externship, will you be able to provide your own transportation to Wayne Memorial Hospital in Honesdale? Yes _____ No _____

PERMISSION

I, the parent or guardian of _____, give permission for the named participant to attend the **Wayne Memorial Hospital Externship Program.** I understand that my son/daughter will participate in this program every Tuesday from Oct 28 – Dec 9, 2025 from 9:00-12:00. I will also allow my son/daughter to drive to the Externship Program.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

TO BE COMPLETED BY THE GUIDANCE DEPARTMENT

What is students current GPA? _____

How many days absent last semester? _____ How many days tardy last semester? _____

Please return completed application to NTIEC as soon as possible via fax or e-mail to mwalker@ntiec.com to guarantee a spot as space is limited!

MUST PROVIDE PROOF OF COVID AND FLU VACCINATIONS

NORTHERN TIER INDUSTRY& EDUCATION CONSORTIUM

HOSPITAL EXTERNSHIP – EMERGENCY CONTACT

Wayne Memorial Hospital

Program: Fall 2025 *(October 28 – December 9, 2025)*

Student Name: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Number: _____

Please Print Clearly

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NORTHERN TIER INDUSTRY& EDUCATION CONSORTIUM

MEDICAL PROFILE AND RELEASE

Student Health

Student Name: _____

Date of Birth: _____ **Male/Female:** _____

Address *(Street, City, Zip Code)*: _____

Home Phone: _____ **Student Cell Phone:** _____

MEDICAL PROFILE

The following information is requested so that we can insure the health and safety of the student.

List any medical conditions which the student is currently being treated for.

_____

_____

Check any of the following that cause the student problems and explain.

_____ Asthma _____ Sinusitis _____ Bronchitis _____ Kidney Trouble _____ Hay Fever
_____ Heart Trouble _____ Diabetes _____ Dizziness _____ Upset Stomach

List any medicines and/or substances to which the student is allergic.

_____

_____

List any food allergies, special diets or needs *(as we provide lunches and snacks)*.

_____

_____

P.O. Box 200, Dimock, PA 18816
Phone (570) 278-5038 – Fax (570) 278-2731
www.ntiec.com

NTIEC

If an injury/illness occurs during a program, what hospital do you prefer your son/daughter to be taken to: _____

Family Physician: _____ **Phone:** _____

Insurance Company: _____ **Phone:** _____

Subscriber Name: _____ **Phone:** _____

MEDICATION ADMINISTRATION

I agree that my son/daughter shall bring medications which he/she is currently taking with him/her to the sponsored program, and that he/she shall consume the prescribed dosage for such medications. **NTIEC staff are not permitted to administer or supply any type of medication at any sponsored program.**

List Medications currently being taken by student *(if any)*.

_____

_____

MEDICAL RELEASE

I, on my own behalf and/or on behalf of the Minor, acknowledge and agree that such participation subjects Minor to possibility of physical illness or injury (minimal, serious, catastrophic and/or death). In the event of such illness or injury, I authorize **NTIEC program staff** to obtain necessary medical treatment of the minor and hereby, on my own behalf and on behalf of the Minor, release and hold harmless releases in the exercises of this authority. I further acknowledge and understand that I will be responsible for any and all medical and related bills that may be incurred on behalf of the Minor for any illness or injury that the Minor may sustain during the program.

Student Name: _____

Address: _____

Signature: _____ **Date:** _____

If subject is a minor or lacks capacity, a parent or personal (legal) representative must sign.

Witness signature: _____ **Date:** _____

NORTHERN TIER INDUSTRY& EDUCATION CONSORTIUM

STUDENT MEDIA CONSENT AND RELEASE FORM

Throughout the year, student may be highlighted in efforts to promote Northern Tier Industry & Education Consortium (NTIEC) activities and achievements. Students may be featured in materials to promote and/or increase public awareness of our programs through newspapers, radio, TV, the web, DVDs, displays, brochures and other forms of media.

I, as the **parent/guardian** of _____ hereby give NTIEC and its employees, representatives and authorized media organizations permission to print, photograph and record my child for use in audio, video, film or any other electronic, digital and printed media.

a. This is with the understanding that neither NTIEC nor its representatives will reproduce said photograph, interview or likeness for any commercial value or receive monetary gain for use of any reproduction/broadcast of said photograph or likeness. I am also fully aware that I will not receive monetary compensation for my child's participation.
b. I further release and relieve NTIEC, its Board of Directors, employees and other representatives from any liabilities, known or unknown, arising out of the use of this material.
c. I understand that I have the right to ask NTIEC to stop the production of any photographs, films or other images. I also understand that I have the right to cancel this Permission before the photograph, film or other image is used.

I certify that I have read the Student Media Consent and Release form and fully understand its terms and conditions and any questions I may have had have been answered.

PLEASE PRINT CLEARLY

Student Name: _____ **Grade:** _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Parent/Guardian signature: _____ **Date:** _____

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NORTHERN TIER INDUSTRY& EDUCATION CONSORTIUM

HOSPITAL EXTERNSHIP – EXTERN GUIDELINES

Wayne Memorial Hospital (WMH)

Welcome to the Wayne Memorial Hospital (WMH) Externship Program. In a cooperative effort between NTIEC and WMH, students will be provided with an educational work experience in areas of the healthcare occupation. The purpose of this program is to assist students in setting educational and/or career goals.

The externship experience with be conducted at WMH every Tuesday from October 28– December 9, 2025 from 9:00 am – 12:00 pm. Students will receive a safety orientation and expectations of conduct on the first day along with a tour of the hospital. After orientation and the remaining weeks, student will spend time rotating through various departments.

General Rules:

- If the student will be absent, he/she **MUST** call their educational coordinator by 7:30 am and leave a message. This is mandatory!
- Notify the worksite internship coordinator if you are feeling sick on site.
- Respect EMHS property, employees, and patients.
- Follow staff instructions at all times.
- Follow all guidelines regarding CONFIDENTIALITY.
- Cell phones **MUST** be turned off while in the hospital.
- Dress Appropriately:
    - Wear your name tag – if one is provided
    - Slacks or Khakis – with shirt/blouse are preferred and closed-toed, comfortable shoes
    - Unacceptable clothing
        - No shorts, jeans, sweatpants, leggings, or spandex
        - No halter/tube tops or t-shirts with writing on them
        - No dangling earrings or necklaces
        - No open-toed shoes
        - No perfume/cologne
- Ask, ask, ask questions; no question is a bad question. This is how we all learn!

We hope you enjoy your externship experience. Hopefully this experience will assist you with your career decision.

If you have any questions, please do not hesitate to contact Megan Walker at 570-278-5038 or via e-mail at mwalker@ntiec.com.

Student Signature: _____ Date: _____

Student Name: _____

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Wayne Memorial Hospital – Special Notes/Instructions

1. Several forms require a "Witness" signature (highlighted in yellow). If any required signature are missing, the hospital will reject the application.

2. By signing the "Medical History" form, you give permission to get the Tuberculosis Test. This test is mandatory to participate in the program.

3. Copies of your immunizations record must be submitted with the application. You can get this record from your school nurse.

4. The hospital requires everyone to secure background checks.
    a. PA Criminal Record Check
    b. PA Child Abuse History Certification
    c. Federal Background Check
        i. If you have been a resident of PA for the entirety of the previous ten (10) years, you can sign the attached affidavit.

Any questions, please reach out to Joyce Malicky at 570-253-8737 or via email at malicky@wmh.org.

WMH VOLUNTEER SERVICES

570-253-8737

Special Project Participant Registration Form

Name _____ **Phone** _____

Address _____

Date of Birth _____ Email Address _____

Emergency Contact _____ Phone _____

Relationship _____

Physician Contact _____ Health Insurance Info (Plan & #) _____

Education High School 9 10 11 12 College 1 2 3 4 Post Grad
(Please circle current or highest completed grade)

School _____

Field of Study: _____ Degree(s) _____

Occupation/Employer _____

Work Phone _____ Cell Phone _____

Special project affiliated with _____
(Institution, Agency, School, etc.)

Department/Placement Preference 1) _____

2) _____

3) _____

General Health/Medical Conditions _____
Medications _____
Allergies _____
Date of last TB Skin Test _____ Result _____

Both Department of Health and Center for Disease Control Guidelines recommend annual TB skin testing of staff and volunteers in healthcare settings. WMH will provide this testing as a courtesy with parental permission (for participants under age 18). See enclosed Authorization for TB Skin Testing form.

Have you ever been convicted of a crime? YES NO
If yes, when and for what crime? _____
(Record of conviction does not necessarily disqualify you from volunteer services, observation and/or special project opportunities.)

_____ _____
Project Participant's Signature **Date**

(For Youth/Student Participants under the age of 18)

Parent/Guardian Name: *(Please Print)* _____

Parent/Guardian Phone: *(Daytime)* _____ *(Evening)* _____

_____ _____
Parent/Guardian's signature *Date*

WAYNE MEMORIAL HOSPITAL
EMPLOYEE HEALTH

GENERAL INFORMATION for STUDENTS, VOLUNTEERS and OTHERS

Date: _____

NAME_____ **Soc.Sec #**_____

Address: _____

City: _____ **State:** _____ **Zip**_____

Phone # _____ **Alternate #** _____

Sex: ☐ **Male** ☐ **Female** **Race:** _____ **Birth date:** _____

Family Physician: _____

Medical Record #: _____ **ID #:** _____

Department: _____

School/College: _____

Dates of service: _____

EMERGENCY CONTACT

Name: _____**Relationship:** _____

Address: _____

Phone #: _____

Wayne Memorial Hospital

MEDICAL HISTORY FORM (for students, volunteers, agency, NTIEC, Project SEARCH)

Name _____ Date of Birth _____

Address _____

Phone # _____ Alternate # _____

Emergency Contact _____ Relationship _____

Physician _____ Health Insurance Information _____

_____

Do you have any past medical history? ☐ YES ☐ NO If yes, please explain.

_____

_____

Are you under a physician's care? ☐ YES ☐ NO If yes, please explain.

_____

Do you have allergies? ☐ YES ☐ NO If yes, list.

_____

_____

Do you take any medications? ☐ YES ☐ NO If yes, list.

_____

_____

Is there any reason that you should or must limit physical activity? ☐ YES ☐ NO

_____

Date of last TB test (Skin test of TSPOT)? _____ Result _____

WMH will provide this testing as a courtesy (with parental permission for participants under age 18).

Immunizations Information - Please provide a copy of your Immunization Record to include the following:

- Tetanus, Diphtheria & Pertussis (Td/Tdap) Tdap once and then Td booster every 10 years
- Measles, Mumps & Rubella (MMR)
- Varicella (Chicken Pox)
- Tuberculosis Test (PPD) (within 1 yr)
- or Documentation of Positive Titers for above
- Drug Screening (current)
- Hepatitis B Vaccine or Signed Waiver
- Influenza (Flu) Vaccination or Declination

According to the Department of Health Guidelines, TB tests must be current within one year. WMH will provide a TB GOLD test as a courtesy with your authorization through the Employee Health Office. Any changes in a volunteer's health status/history should be reported to the Employee Health Office. It is the responsibility of each applicant to update the Employee Health Nurse with any changes or updates to this form. I give permission to administer a TB GOLD as a requirement to become a WMH volunteer.

Volunteer Signature: _____ Date: _____

6/24/14, 1/10/17, 8/6/19, 1/10/20 jkm

WMH
Employee Health

T.B. HEALTH QUESTIONNAIRE

The Annual Tuberculosis Questionnaire is used to evaluate your current TB status.

Name: (Print) _____

Department: _____ ID# _____

YES	NO	
☐	☐	Have you ever had a positive TB test? When _____
☐	☐	Have you ever been told you have Infectious Tuberculosis? When _____
☐	☐	Have you ever been treated for TB or to prevent TB? When_____
☐	☐	Was treatment completed?
☐	☐	Have you ever had an abnormal chest x-ray? When_____
☐	☐	Have you ever received the vaccine BCG? When _____
☐	☐	Have you been exposed to anyone with known TB in the past year?
☐	☐	Do you currently have a cough that lasted longer than three weeks?
☐	☐	Do you cough up blood or mucous?
☐	☐	Have you had a decrease in your appetite?
☐	☐	Have you lost weight (over 10 pounds) in the past 2 months without trying?
☐	☐	Do you have night sweats? (Not associated with menopause)
☐	☐	Do you have a persistent Fever (especially in the evening)?
☐	☐	Do you have chills?
☐	☐	Do you have excessive weakness/fatigue?
☐	☐	Do you have Dyspnea (shortness/difficult breath)?
☐	☐	Do you have chest pain?
☐	☐	Do you have Hoarseness?
☐	☐	Do you live with or have close contact with someone who was recently diagnosed with TB?
☐	☐	Current or planned immunosuppression including HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist, chronic steroids, or other immunosuppression medication.
☐	☐	Temporary or permeant residence of one month or longer in a country with a high TB rate (any Country other than USA, Canada, Australia, New Zealand, Northern Europe or Western Europe).

Employee's Signature_____ Date_____

Northern Europe

1. Aland Islands
2. Denmark
3. Estonia
4. Faroe Islands
5. Finland
6. Guernsey
7. Iceland
8. Ireland
9. Isle of Man
10. Jersey
11. Latvia
12. Lithuania
13. Norway
14. Sark
15. Svalbard and Jan Mayen
16. Sweden
17. United Kingdom (Great Britain and Northern Ireland)

Western Europe

1. Austria
2. Belgium
3. France
4. Germany
5. Liechtenstein
6. Luxembourg
7. Monaco
8. Netherlands
9. Switzerland

WMH/WMCHC
Employee Health Office

Drug Test Authorization and Release Form

I hereby agree, in response to a request made under the drug/alcohol testing policy of Wayne Memorial Hospital, to submit to a drug or alcohol test and to furnish a sample of my urine, breath and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under Wayne Memorial Hospital's policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate termination from employment. I further authorize and give full permission to Wayne Memorial Hospital and/or its designated agent(s) to send the specimen(s) so collected to a laboratory to test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to Wayne Memorial Hospital. I understand that a positive result will be forwarded to a certified Reference Laboratory to perform any testing necessary to confirm the result. Positive results will also be reviewed by the hospital's Medical Review Officer.

I hereby release Wayne Memorial Hospital and any persons involved in the collection and testing of my specimen from any and all claims, losses, damages, and any other liability relating to the collection of specimen(s) and drug/alcohol testing and release of information to Wayne Memorial Hospital.

I understand Wayne Memorial Hospital's Drug and Alcohol policies and procedures, and this authorization and release form and the drug testing process have been explained to me. I have been provided the opportunity to ask all questions relating to this form and the drug testing process, and all my questions have been answered

If Employee is Under the Age of 18

I understand the foregoing provisions, and hereby give my consent and authorization for Wayne Memorial Hospital or its designee to conduct the drug/alcohol test(s) indicated herein on my minor child or dependent. I also understand and agree that the results of the test will be provided to my minor child or dependent, and not to me.

Name (print) _____ Date: _____ Badge#:_____

Signature Employee/Guardian _____

Test to be performed. ☐ Urine Drug

Witness: _____ Date: _____

Wayne Memorial Hospital
Volunteer Services
(570)253-8737

RELEASE/CONSENT FOR PARTICIPATION IN WMH VOLUNTEER ACTIVITIES

CONSENT FOR EMERGENCY TREATMENT

This will authorize _____, a minor, to participate in volunteer activities at Wayne Memorial Hospital as may be prescribed by the hospital's Volunteer Coordinator and/or designated representative. I understand that my daughter's or son's services are donated to the hospital without contemplation or expectation of compensation or future employment, and given for humanitarian, educational, or charitable reasons.

We release the hospital and its employees from any claim of liability for any damages, injury, or illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities.

We authorize the Emergency Room Physicians as our agents to consent to any *emergency* x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of the hospital.

This authorization is given in advance of any specific diagnosis, treatment, or hospital care required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

_____ _____

Parents'/Guardians' Signature(s)

_____

Date

volforms\consent.doc 4/95, Reviewed/Revised: 1/99, 4/03pb, 8/1/19jk*m*

Affidavit to Claim Exemption from the Federal Background Check (Fingerprinting) Requirement

Read fully and sign to claim an exemption from the requirement for submission of a federal criminal background check (fingerprinting) ONLY per Pennsylvania state regulations applying to volunteers. The applicant will still need to provide copies of the two state clearances (PA State Police criminal background check and PA Child Abuse check).

1. I have been a resident of the Commonwealth of Pennsylvania for the entirety of the previous ten (10) years from the date of this Affidavit.
2. I swear that I am not disqualified from service as a volunteer as a result of a conviction of one or more of the following offenses listed under Title 18 of the Pennsylvania crimes code (or equivalent crime under federal law or law of another state), or the attempt, solicitation or conspiracy to commit any of these offenses:
   a. Criminal homicide (Chapter 25)
   b. Aggravated assault (Section 2702)
   c. Stalking (Section 2709.1)
   d. Kidnapping (Section 2901)
   e. Unlawful restraint (Section 2902)
   f. Rape (Section 3121)
   g. Statutory sexual assault (Section 3122.1)
   h. Involuntary deviate sexual intercourse (Section 3123)
   i. Sexual assault (Section 3124.1)
   j. Aggravated indecent assault (Section 3125)
   k. Indecent assault (Section 3126)
   l. Indecent Exposure (Section 3127)
   m. Incest (Section 4302)
   n. Concealing death of a child (Section 4303)
   o. Endangering Welfare of Children (Section 4304)
   p. Offenses relating to infant children (Section 4305)
   q. Felonies related to prostitution (Section 5902 (b))
   r. Obscene materials/performances (Section 5903(c))
   s. Corruption of minors (Section 6301)
   t. Sexual abuse of children (Section 6312)
   u. Felony violation of Controlled Substance, (35 P.S. Section 780-101 et seq.) Drug, Device and Cosmetic Act within preceding five-year period. (5-year limitation applies to this item, item u, only.)

Signed _____ Date _____

Print Name _____

Employer _____

EMPLOYEE DISCLOSURE STATEMENT
APPLICATION FOR PROVISIONAL EMPLOYMENT
Required by the Child Protective Service Law, 23 Pa. C.S. Section 6344

I swear/affirm that I have mailed or filed the requests for clearance to Childline, the Pennsylvania State Police, and the Federal Bureau of Investigation.

I swear/affirm that I have not been named as a perpetrator of a founded report of child abuse or as an individual responsible for a founded report as defined by the Child Protective Services Law.

I swear/affirm that I have not been convicted of any of the following crimes or the attempt, solicitation or conspiracy to commit any of the following crimes under Title 18 of the Pennsylvania Consolidated Statues or equivalent crimes in another state or under Federal law:

Chapter 25 (relating to criminal homicide)
Section 2702 (relating to aggravated assault)
Section 2709.1 (relating to stalking)
Section 2901 (relating to kidnapping)
Section 2902 (relating to unlawful restraint)
Section 3121 (relating to rape)
Section 3122.1 (relating to statutory sexual assault)
Section 3123 (relating to involuntary deviate sexual intercourse)
Section 3124.1 (relating to sexual assault)
Section 3125 (relating to aggravated indecent assault)
Section 3126 (relating to indecent assault)
Section 3127 (relating to indecent exposure)
Section 4302 (relating to incest)
Section 4303 (relating to concealing death of child)
Section 4304 (relating to endangering welfare of children)
Section 4305 (relating to dealing in infant children)
Section 5902(b) Felony (relating to prostitution and related offenses)
Section 5903(c)(d) (relating to obscene and other sexual material and performances)
Section 6301 (relating to corruption of minors) Section 6312 (relating to sexual abuse of children)

I have not been convicted of a felony offense under Act 64-1972 (relating to the controlled substance, drug device and cosmetic act) committed within the past five years.

I understand that I must be dismissed if I am named as a perpetrator of a founded report of child abuse within the past five (5) years or have been convicted of any of the crimes listed above.

I understand that my employment may be terminated if I have been named as the perpetrator of an indicated or founded report of child abuse or as an individual responsible for the injury or abuse in a founded or indicated report.

I understand that my employment may be terminated if I have been convicted of a felony offense or have been convicted of a crime involved child abuse, child neglect, physical violence or moral corruptness.

I hereby swear/affirm that the information as set forth above is true and correct to the best of my knowledge and belief. I have read and understand the foregoing. I understand that the penalty for false swearing is a misdemeanor of the third degree pursuant to Section 4903(b) of the Criminal Code.

Name:_____ Signature:_____ Date:_____

Witness: _____ Signature:_____ Date:_____

WMH Conduct and Appearance/Dress Code

The appearance and behavior of all volunteers/observers/participants should reflect the hospital's professional standards. The following are guidelines:

* The volunteer should keep him/herself clean and neat;
* In patient care areas, long hair should be pulled back;
* Avoid extremes in fashion; dress professionally. Khaki pants are preferred, ***NO JEANS***! A polo shirt may be issued if what is being worn is inappropriate for the work setting. The shirt must be returned;
* Comfortable, low-heeled shoes or sneakers are recommended, NO open-toe shoes;
* Stockings or socks must be worn at all times;
* Jewelry should be kept to a minimum and any type of long, dangling jewelry must be avoided for safety reasons;
* Avoid perfumes, colognes, etc., as patients may have sensitivities and/or allergies to them;
* Be courteous, considerate and friendly to employees, volunteers, visitors and patients;
* Nail polish should not be worn in patient care areas as chipped/cracked nail polish has been shown to promote the spread of infection.

Examples of unacceptable attire include, but are not limited to:

* Jeans;
* Exposed midriffs
* Open-toe shoes/sandals;
* Form fitting or low cut clothing;
* Shorts (except city/walking shorts);
* Sweatsuits, tank tops, sleeveless tops/shirts;
* Over-sized T-shirts or T-shirts with inappropriate designs/slogans.

Many areas of the hospital are warm, so dress with these points in mind. You will be informed if there are any other types of dress code requirements that may be necessary for certain placements. Inappropriate attire will be addressed.

I have read and agree to comply with the codes as described above.

_____ _____

Signature of Participant Date

10/1/08, 6/15/11, 1/2/12, 6/2/14, 8/12/19 jkm

Release of Photographic Authorization

Authorization is hereby granted Wayne Memorial Hospital to photograph and release such pictures of the individual(s) listed below for the purpose of medical education, public information or publicity in the interest of the Hospital.

Individual(s) to be photographed:

Name	Address
Name	Address
Name	Address

_____
Signature of person granting authorization

_____
Address

Identity of signature, circle one
Self
Wife
Husband
Mother
Father
Guardian

Witness: _____

Date _____

Volforms 12/11 jkm

WAYNE MEMORIAL HOSPITAL
Volunteer Services
Summary of Possible Volunteer Assignments

BUSINESS OFFICE CLERICAL ASSISTANT: Provide general clerical assistance within the department. May include: filing of forms, answering phones, alphabetical and/or numerical ordering, preparing files, preparing mailings, photocopying, running errands, and/or light computer data entry; according to skill level. Weekdays.

CENTRAL SERVICES DEPARTMENT: Provide general assistance in preparing, stocking and delivering sterile supplies/equipment for use in various hospital departments; sterile gowns/caps/booties will be supplied and must be worn; weekdays only.

CLERICAL and/or GENERAL DEPARTMENT ASSISTANT: Provide miscellaneous clerical and/or general assistance within the Administrative, Business or other department offices located within the main facility or ancillary buildings; may include filing, alphabetical and numerical ordering, preparing files, preparing mailings, photocopying, shredding, running errands, answering phones, etc; according to skill level, may include typing, computer data entry; weekdays.

EMERGENCY DEPARTMENT: Assist patients, visitors and staff by performing non-professional tasks related to patient care and miscellaneous department support. May include greeting and assisting family members of patients, informing family of available hospital services, i.e., Cafeteria, Gift Shop, Chapel, etc.; provide supportive conversation as the situation allows; provide patient support and/or general assistance at the nursing station; prepare patient beds, restock supplies; run errands for staff; weekdays or weekends.

FAMILY/PATIENT SUPPORT (ER, ICU): Provide a supportive environment within the ICU and/or ER areas; assist family members with courtesy hospital services, i.e., Cafeteria, Gift Shop, Chapel, etc.; provide supportive conversation as the situation allows; occasionally provide patient support and/or general assistance at the nursing station; varied shifts and "on call" opportunities.

GOOD SHEPHERD SUPPORT: Assist staff, patients and family members with errands; interact with patients, i.e., socialization, play games, read to patients.

HOME HEALTH HOSPICE: Provide visitation and caring support to hospice patients and their families in their home environment, and/or provide clerical assistance within home health hospice office. Specialized training required and provided.

INFORMATION DESK: Greet and direct patients/visitors as needed to various areas of the facility; according to time of day, distribute patient mail; occasionally assist with miscellaneous clerical support work for various hospital departments (i.e., mailings, alphabetizing forms, assembling patient charts, etc.); allows for weekend and evening participation.

MAINTENANCE DEPARTMENT: Provide general assistance related to certain grounds-keeping and facility care duties; requires minimum age of 16 to operate certain types of equipment; weekday/weekend participation.

MATERIALS MANAGEMENT: Provide general assistance within the materials management department to possibly include unpacking and labeling stock items, compiling orders, etc.; main stock area is located in the Stourbridge Mall hospital annex; loading dock/stock area is located in main facility; weekday or weekend morning participation.

MEDICAL RECORDS DEPARTMENT: Provide general assistance in various tasks related to the filing of forms/medical records in second floor department location and also in lower level medical records storage room; weekdays only.

continued...

NUTRITION & FOOD SERVICES DEPARTMENT: Provide general assistance within the kitchen/ cafeteria areas to possibly include limited food preparation, stock work, serving, etc.; possibly assist in delivering/retrieving food trays from various patient floors; weekdays.

"ON-CALL" VOLUNTEER: Assist in numerous departments with various tasks as requested on a day-to-day basis as needed; may include clerical tasks, preparing mailings, etc; weekdays.

O.R. FAMILY LIAISON: Provide general assistance to family members in the OR Family Waiting area; maintaining/organizing refreshments, reading material, etc.; assist staff by providing information to family, escorting family to recovery area, tracking whereabouts of family members, etc.

OUTPATIENT GREETER: Provide general assistance to patients and staff at the Outpatient Information Desk area by greeting incoming patients, directing or escorting them to areas and summoning them as the registration personnel become available; requires weekday afternoon shifts.

PRE-ADMISSION ESCORT: Provide assistance to patients and staff by greeting and escorting pre-admission patients to various departments/offices during the pre-admission testing process; may involve walking with or pushing patients in wheelchairs; requires weekday morning shifts.

PRINT SHOP: provide miscellaneous assistance to possibly include collating, stapling, delivering, etc. of printed materials; weekday mornings.

REHABILITATION SERVICES TRANSPORTER: Provide general assistance to the patients and staff in the wheelchair transport of patients to/from the therapy department; weekday morning and afternoon shifts. Weekend placement is possible for Good Shepherd Unit.

SDS/CHEMO RECEPTIONIST: Greet and direct patients/visitors in the Same Day Surgery/Chemotherapy waiting areas; requires morning weekday participation.

SOCIAL SERVICES: Provide assistance to patients as assigned by Social Services, i.e., verbalization and one-on-one interaction with patients, i.e., socialization, play games, read to patients.

****ADDITIONAL PLACEMENTS*** may be possible based on career interests, school requirements, etc. Please feel free to discuss your interests or needs with the Volunteer Services Department staff.

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Reviewed/Revised: 1/96, 4/97, 8/98, 9/98, 7/00, 12/02, 10/03, 5/05, 1/18/06, 6/15/09, 8/3/18, 1/1/23 jkm

Please note that some of these placements are not available at this time due to COVID.