HOW TO BECOME A JUNIOR VOLUNTEER

Welcome, and thank you for your interest in volunteering with Casa Colina. We appreciate the support and contributions volunteers make to our organization.

The “Casa Colina Family” is comprised of many members and the volunteers at Casa Colina are very special. You will become part of a team that takes pride in the way we serve our community. Offering excellent healthcare and concern to our patients and their family members in a professional, friendly and courteous manner is of the utmost importance to us. If you join us, you will represent Casa Colina and we know you will set a good example. Please note: Junior Volunteers must be at least 16 years of age and the application does require a parent or guardian’s signature.

Following, is the process to becoming a volunteer. This process must be completed within one month of your attendance at orientation. We hope you will enjoy volunteering at Casa Colina.

- The completed application is to be returned to the Human Resources Department via US Mail or hand delivered. Human Resources will review and determine if the volunteer meets the requirements.
- Once, the application has been turned into Human Resources, the potential volunteer must attend an orientation. Orientation dates will be emailed to the volunteer approximately two weeks before the orientation.
- At the orientation the volunteer will receive the first TB test.
- The volunteer will return to Casa Colina within 24-72 hours of orientation to have the TB test read.
- Once the TB test is cleared the volunteer can return to Human Resources to receive his/her badge, volunteer assignment and purchase the volunteer jacket.
- Additionally the volunteer will be responsible for receiving a second TB test once the volunteer assignment begins (this is required by the Department of Health and Casa Colina policy due to the high incidence of TB in our geographical area).

*Casa Colina volunteers are required to volunteer a minimum of 6 months and 100 hours. Volunteers must work a minimum 1 hour per week.*
VOLUNTEER APPLICATION

JUNIOR VOLUNTEER

(For volunteers between the ages of sixteen & eighteen years of age)

*Parental consent is required throughout this application*

Today’s Date ____________

Name ____________________________________________

Address ____________________________________________ Apt# ____________

City ____________________________________________ State ____________ Zip _______

Home # ____________________________________________ E-mail ____________________

Work # ____________________________________________ Work Extension ____________

Driver’s License # ____________________________________________ Cell/Pager # ____________

How were you referred to Casa Colina Centers for Rehabilitation? ____________________________

Employment History

Current:
Position/Title ____________________________________________

Company Name ____________________________________________

Supervisor’s Name ____________________________________________ Phone Number (____ ) -

Dates of Employment ____________________________________________

Previous:
Position/Title ____________________________________________

Company Name ____________________________________________

Supervisor’s Name ____________________________________________ Phone Number (____ ) -

Dates of Employment ____________________________________________

Position/Title ____________________________________________

Company Name ____________________________________________

Supervisor’s Name ____________________________________________ Phone Number (____ ) -

Dates of Employment ____________________________________________

Vocational and/or Special Trainings: ____________________________

__________________________________________________________

Volunteer Services • 255 East Bonita Avenue, Pomona, CA 91769 • (909) 596-7733 x2154
Educational History

Current:
Study Emphasis ___________________________ School ___________________________
Highest Grade Achieved ___________________________ Degree/Certificate? __________
Dates of Attendance ___________________________

Previous:
Study Emphasis ___________________________ School ___________________________
Highest Grade Achieved ___________________________ Degree/Certificate? __________
Dates of Attendance ___________________________

References

Name ___________________________ Relationship ___________________________
Phone Number (____) - ___________ Years Known __________

Name ___________________________ Relationship ___________________________
Phone Number (____) - ___________ Years Known __________

Name ___________________________ Relationship ___________________________
Phone Number (____) - ___________ Years Known __________

Special Skills/Experience

Special Skills and/or Knowledge: ____________________________________________
________________________________________________________________________

Hobbies and Interests: ___________________________
________________________________________________________________________

Community and/or Club Affiliations:
________________________________________________________________________

Previous Volunteer Experience:
________________________________________________________________________
________________________________________________________________________

Reason(s) For Volunteering:
________________________________________________________________________
________________________________________________________________________

Events For Which You Would Like To Volunteer (please list names and dates):
________________________________________________________________________
________________________________________________________________________

Volunteer Services • 255 East Bonita Avenue, Pomona, CA 91769 • (909) 596-7733 x2154
1. Do you speak any language(s) other than English? □Yes □No
Language(s): ______________________________

2. If yes, would you be willing to act as a translator while on duty as a volunteer? □Yes □No

3. Is volunteer work a requirement for school credits? □Yes □No

4. Do you have any physical disability/condition which may interfere with your work? If yes, explain: _______________________________________________________________

5. _______________________________________________________________

6. Do you require any special accommodations? □Yes □No
If yes, please describe: ______________________________________________

__________________________
Signature of parent, or legal guardian:

__________________________
Date

__________________________
Signature of parent, or legal guardian:

__________________________
Date

Photo Release
I hereby give my authority to Casa Colina to photograph me and use the photos for educational and/or commercial purposes, such as human-interest stories, advertisements, promotions, etc., at the discretion of the corporation.

Date: ____________________ Signed: ____________________

__________________________
Signature of parent, or legal guardian:

__________________________
Date

Volunteer Expectations
If accepted as a volunteer, I understand that my services are donated to Casa Colina without contemplation of remuneration or future employment.

Date: ____________________ Signed: ____________________

__________________________
Signature of parent, or legal guardian:

__________________________
Date

Background

Have you ever been convicted of, plead guilty or nolo contendere to a crime? Do not identify traffic infractions, or misdemeanor marijuana convictions occurring more than two years ago, or convictions for which the criminal record has been expunged, sealed, or eradicated, or misdemeanor convictions for which any probation has been completed and the case dismissed by the court. □Yes □No

If yes, state the nature of the crime(s), when and where convicted and disposition of the case(s).

____________________________________________________________

No applicant will be denied the opportunity to volunteer solely on the grounds of the conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position applies may, however, be considered.

I hereby certify that the above is true and complete to the best of my knowledge. I realize that this information is confidential and may be used to determine my eligibility to

Volunteer Services • 255 East Bonita Avenue, Pomona, CA 91769 • (909) 596-7733 x2154
CONFIDENTIALITY AGREEMENT

It is likely that your volunteer work assignments may involve or expose you to work of a confidential nature. In some or all of its aspects, your volunteer work may involve contact with trade secrets and confidential information of Casa Colina, or confidential information which has been entrusted to us regarding our patients, clients, residents, employees, volunteers or vendors.

You are expected to protect the interests of Casa Colina and our patients, clients, residents, employees, volunteers or vendors by not disclosing to anyone who does not have a legitimate need to know, any information that is considered as trade secrets or other proprietary information of Casa Colina or our vendors, or confidential information of our patients, clients, residents, volunteers, or employees. Information which we may consider trade secrets, confidential or proprietary includes:

- Information about patients, clients, residents, employees, volunteers or vendors;
  What is ‘individually identifiable health information’ or protected health information’? Any health information relating to a person’s health, care received or payment for services. This includes diagnosis, treatment received or prognosis. It also includes demographic information, such as, name, address, social security number, medical record number, zip code, phone number, etc. It includes protected health information in any form, including written, oral, or electronic.
- Information about current or future program or product design (other than that which is typically shared during market or sales efforts);
- Financial data (of Casa Colina, patients, clients, residents, employees, volunteers or vendors);
- Marketing strategies;
- Prototypes, plans, designs or blueprints (i.e., plan or proposal for expansion or curtailment of operations, mergers, acquisitions or joint ventures, as well as information relating to increasing or decreases in business, unusual management developments, litigation or purchases or sales of substantial assets).
- Technological data or prototypes, computer software and/or programming codes (i.e., all communication systems, including electronic mail, internet, voice mail, phone system); and,
- Any information that may be used by competitors against us or our patients, clients, residents, employees, volunteers or vendors.

As a condition of your volunteer service, you agree that you will not, except as required in the conduct of Casa Colina’s business or as authorized in writing by the President/CEO of Casa Colina, disclose, either during the time you provide volunteer services, or any time thereafter, any trade secret or confidential information relating to Casa Colina, our patients, clients, residents, employees, volunteers or vendors that you may in any way acquire by reason of your volunteer service by Casa Colina, including the identity of current and prospective patients, clients, residents, employees, volunteers or vendors.
The confidentiality of all patients, clients, residents, volunteers and employees shall be maintained at all times by all personnel and volunteers. Discussions concerning a patient’s, client’s or resident’s condition or other related information shall take place in treatment areas or private areas, and only with those people involved in care of the individual(s).

You are expected to respect the confidence and trust placed in us by our patients, clients, residents, employees, volunteers or vendors by keeping their information confidential. The professional relationship between each patient, client, resident, employee, volunteer or vendor and Casa Colina requires that there be no disclosure of information about the affairs of either party to others. This includes responses to inquiries from salespeople, the press, contractors, other companies or the public. Should anyone make inquiries about our relationship with, or the affairs of a patient, client, resident, employee, volunteer or vendor, immediately report the inquiry to the Foundation office or the person supervising your work. Violations to medial privacy laws will result the organization with administrative penalties.

To further protect the interests of Casa Colina, you must secure permission from the Foundation Director, before making a public presentation as a representative of Casa Colina.

By signing below, I hereby agree to abide with all legal policies and practices of Casa Colina, Inc. and Subsidiaries, including the confidentiality agreement.

_________________________  ____________________________  ____________________________
Date                       Signature                                 Date

Signature of parent, or legal guardian: ____________________________
Volunteer Application – Medical Questionnaire

Today’s Date _____________________________

Name ____________________________________________

Address ____________________________________________ Apt# _____________

City ____________________________ State ___________ Zip __________

Home # ____________________________ E-mail ____________________________

Work # ____________________________ Work Extension _____________________

Driver’s License # ____________________________ Cell/Pager # _____________

Date Of Birth _______ Height _______ Weight _______ □ Male □ Female

Date of last tetanus shot: ___________ Date of last tuberculosis test: ___________ Result: ________

How were you referred to Casa Colina Centers for Rehabilitation? ____________________________

5. Do you have any food allergies or dietary restrictions? □ Yes □ No

6. Are you currently under the care of any medical specialist or doctor? □ Yes □ No

7. Are you currently taking any medications? □ Yes □ No

Have you experienced any of the following? Please check all that apply.

☐ Allergies-Any
☐ Arthritis
☐ Asthma/Respiratory Problems
☐ Back Conditions
☐ Bowel/Urinary Issues
☐ Chronic Colds or Cough
☐ Communicable Disease
☐ Diabetes

☐ Ear Perforation
☐ Ear/Throat Infections
☐ Fainting/Blackouts
☐ Headaches
☐ Heart Defect/Disease
☐ Hemophilia
☐ Hernia/Ruptures
☐ High Blood Pressure

☐ Kidney Stones/Infection
☐ Knee/Joint Conditions
☐ Lung Disease
☐ Seizures/Convulsions
☐ Shortness Of Breath
☐ Skin Infections
☐ Surgeries
☐ Tuberculosis

If you answered, “Yes” to any of the questions above or if there are conditions not listed, please elaborate on the next page or on the back page including date[s] of occurrence.
Please complete all information below as it is necessary for us to have should you require medical care.

Health Insurance Company ___________________________ Policy Number ___________________________
Personal Physician ___________________________ Physician’s # ___________________________
Physician’s Address ________________________________________________________________
Emergency Contact Name ___________________________ Relationship ___________________________
Home # ___________________________ Alternate # ___________________________

- If the volunteer is under 18 years of age, the signature of a parent, spouse or legal guardian is required.
- Volunteers, while on duty, are covered by liability insurance.

Consent For Treatment
1. IN CASE OF EMERGENCY, the Undersigned authorizes Casa Colina staff and personnel to provide such medical assistance as they determine to be necessary. The Undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the participant, including anesthetics, which they determine necessary or advisable, pending receipt of a specific consent from the Undersigned. The Undersigned authorizes necessary care by paramedics.

   Date: ___________________________ Signed: ___________________________
   Signature of parent, or legal guardian: ___________________________ Date ___________________________

2. I hereby give permission for my son/daughter to have the required test(s) for TB screening (PPD or Chest X-Ray) at Casa Colina. This permission extends to their annual test if and when required.

   Signature of parent, or legal guardian: ___________________________ Date ___________________________

3. I hereby certify that the above is true and complete to the best of my knowledge. I realize that this information is confidential and may be used to determine my eligibility to volunteer in patient areas. I authorize Casa Colina Centers for Rehabilitation to make inquiry to my physician regarding the state of my health. The name and address of my physician are provided above.

   Date: ___________________________ Signed: ___________________________
   Signature of parent, or legal guardian: ___________________________ Date ___________________________

Use this space or the back for additional information or explanations:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
I ____________________________, have read and acknowledge the requirements and expectation of my duties as a volunteer. I understand and agree that I must volunteer a **minimum of 100 hours and 6 months** with Casa Colina. I further understand that I must volunteer a minimum 1 hour per week.

_name: _______________________________

Signature: __________________________ Date: ________________

**IF THE VOLUNTEER IS UNDER 18 YEARS OF AGE A PARENT OR GUARDIAN MUST ALSO SIGN:**

_PARENT/GUARDIAN NAME: _______________________________

Signature: __________________________ Date: ________________

*Casa Colina will not sign-off on any hours or complete any school required paperwork if this agreement is not fulfilled*
### Health Questionnaire

#### Volunteer Information
- Name
- Address
- City/State
- Social Security number
- Phone number
- Date of birth
- Age
- Marital Status
- Department

#### Since completing your last questionnaire have you had or do you have any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone joint or other ailments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest or Lung Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Back Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness or Unconsciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or Narcotic Addiction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Infection/Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye, Ear, Nose, Throat Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy: Convulsions or seizure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent or Painful Urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder Trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia/Rupture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High or Low Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase or Decrease in Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worn Glasses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worn a Hearing Aide?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worn a back brace or support?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Additional Questions
- Tiredness
- Fever
- Headache
- Cold/Flu
- Cough
- Sneezing
- Runny nose
- Nasal congestion
- Voice changes
- Chest pain
- Shortness of breath
- Change in urine color
- SOB
- Pain
- Urinary tract infection
- Pneumonia
- Tension headache
- Migraine
- ...
Do you take medicine?  □ Yes  □ No
Type: ___________________ Dosage: ___________________ Frequency: ___________________
Type: ___________________ Dosage: ___________________ Frequency: ___________________

Have you had any illness or injuries during the past year?  □ Yes  □ No
Describe: ______________________________________________________

Have you been under a doctor’s care within the last year?  □ Yes  □ No
Describe: ______________________________________________________

Have you been advised to have any operations?  □ Yes  □ No
Describe: ______________________________________________________

Have you been hospitalized?  □ Yes  □ No
Why: __________________________________________________________

Are you receiving or have you received in the past, compensation or pension as a result or injury or illness?  □ Yes  □ No
Describe: ______________________________________________________

Have you been rejected for life insurance, military service or employment?  □ Yes  □ No
Explain: _________________________________________________________

<table>
<thead>
<tr>
<th>Have you ever:</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had prior positive TB skin test</td>
<td></td>
<td>Night sweats/chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received INH</td>
<td></td>
<td>Persistent cough for more than 2 weeks (TB)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received the BCG vaccine</td>
<td></td>
<td>Blood streaked sputum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unusual fatigue for more than 2 weeks</td>
<td></td>
<td>Fever associated with cough for more than 1 week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss unrelated to dieting</td>
<td></td>
<td>Other unusual symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite for more than 2 weeks</td>
<td></td>
<td>List:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I declare the above information is true and I am aware that misrepresentations of omission may be cause for disfavor from the organization. I am aware of the physical requirements of the position for which I am applying. I will permit physicians or health facilities that have treated me to furnish information to Casa Colina upon request. I understand that results of this assessment may be shared with administration, supervisors and or case managers.

__________________________  ___________  ____________________________
Signature of Volunteer   Date      Signature of Conservator/Parent

(If volunteer is under 18) for 1st & 2nd TB Tests

1 step PPD Vitals: ____________________________ This requires that a second skin test be done 30 days after initial PPD
_________ Employee can provide proof of negative PPD reading prior to hire Total Charges:

2nd Step PPD Vitals: ____________________________ ONLY REQUIRED IF THE EMPLOYEE HAS NEVER HAD A PPD READING BEFORE
Date test given: ___________ Time: ___________ Given By: ___________
Right Arm: ___________  Left Arm: ___________ TST,5TU: ___________ Lot#: ___________
Expires: ___________

Date test read: ___________ Time: ___________ Read By: ___________
Reaction: ___________ Induration Size: ___________mm Erythema Size: ___________mm
Follow up: ___________