Patient Ambassador Volunteer Agreement

IF I AM ACCEPTED AS A VOLUNTEER, I AGREE TO:

1. Keep all information regarding patients/clients and hospital business confidential.
2. Give permission for the Volunteer Services staff to discuss my work history and performance with those I have listed as supervisors and references with my potential NIH Clinical Center supervisor(s).
3. Sign in and out each day I volunteer according to the procedures defined by Volunteer Services for my particular area.
4. Volunteer a minimum of one year and 200 hours, approximately four hours every week.
5. Be punctual and regular in attendance.
6. Notify my supervisor(s) in advance if I cannot work as scheduled.
7. Wear the NIH Clinical Center Volunteer I.D. badge while on duty.
8. Not expect compensation or employment as a result of my volunteer work
9. No smoking. This is a no smoking hospital.
10. Provide my own transportation to and from the volunteer work site at my expense.
11. Comply with Federal and State Occupational Health Guidelines by:
    a) Providing proof of rubeola (measles) immunity
    b) Having a TB skin test
    c) Having a pre-placement evaluation for history of chickenpox (varicella)
12. Provide proof of health insurance.
13. Abide by all NIH policies and procedures.
14. Notify my supervisor(s) and the Coordinator of Volunteer Services of my plans to resign at least two (2) weeks in advance.
15. At the time of resignation, return my Volunteer I.D. badge to Volunteer Services.
16. Perform duties as defined by the position description or my supervisor.

I certify that:
1. I am at least 16 years old.
2. I am not volunteering as a court requirement or as an attorney referral.

Signature of Applicant _____ Date _____

PARENT/GUARDIAN OF APPLICANTS WHO ARE UNDER 18 YEARS OF AGE

1. This applicant has my permission to volunteer at the NIH Clinical Center.
2. I have read the above Volunteer Agreement.
3. I will support this applicant in fulfilling the Volunteer Agreement.
4. I give permission for this applicant to receive a TB Skin Test (PPD) and pre-placement evaluation for history of chickenpox as required by the Federal and State Occupational Health Guidelines. I release NIH of any responsibility if the applicant should have any adverse reaction as a result of the PPD skin test.

Parent/Guardian (Print) _____ Relationship _____

Signature _____ Date _____