Lakeview Regional Medical Center
Junior Volunteer Services

How Do I Get Started?

To become a Junior Volunteer at LRMC you must:

1. Be 14 years of age by June 1, 2016.
2. Be able to commit to volunteering for a minimum of four hours a week for 6-8 weeks (upon request, a written letter of recommendation and/or report of volunteer hours will be provided for all junior volunteers who successfully volunteer a minimum of 40 hours). **EXCEPTION: FAMILY VACATION TIME WILL BE TAKEN INTO CONSIDERATION AND THE JUNIOR VOLUNTEER WILL HAVE TO GET THEIR 40 HOURS IN BY OTHER MEANS.**
3. Complete a Junior Volunteer Application.
4. Attend **Mandatory Junior Volunteer Orientation**, before being able to volunteer.
5. Schedule an interview with our Volunteer Manager.
6. Show proof of a negative TB skin test within the last year. TB skin tests are provided by the hospital if you have not had one recently.
7. Be issued a security badge.

WHO ARE LRMC JUNIOR VOLUNTEERS?
Junior Volunteers are 14 years old by June 1, 2016 and who give their time to assist with patient and non-patient care at Lakeview Regional Medical Center. All of your kind and generous efforts add to the comfort and happiness of our patients, our staff and our visitors.

WHAT ARE THE BENEFITS OF VOLUNTEERING?
- Enjoy the satisfaction that comes from helping others
- Gain work experience
- Make friends and meet new people
- Receive a Letter of Recommendation
- Receive a free meal for a four hour shift

WHAT ARE THE REQUIREMENTS?
- Age: 14 years old by June 1, 2016
- Signed Junior Volunteer Contract Agreement
- Signed Parental Contract Agreement

WHEN DO JUNIOR VOLUNTEERS VOLUNTEER?
- Each summer a junior volunteer has his/her own schedule, arranged with the Volunteer Manager. Schedules are dependent upon the needs of the departments, as well as the availability of the Summer Junior Volunteer. Summer Junior Volunteers are required to work at least one four hour shift per week. **EXCEPTION: FAMILY VACATION TIME WILL BE TAKEN INTO CONSIDERATION AND THE JUNIOR VOLUNTEER WILL HAVE TO GET THEIR 40 HOURS IN BY OTHER MEANS.**

WHAT ASSIGNMENTS DO JUNIOR VOLUNTEERS PERFORM?
- Hospitality Host/Greeter
- Perform clerical duties
- Assist at nursing stations
- Run miscellaneous errands and much more...

SOME GENERAL INFORMATION...
- At least 6-8 weeks of commitment.
- The junior volunteer uniform consists of a red polo shirt and khaki slacks, tennis shoes or closed-in toe shoes. **NO SANDALS OR FLIP FLOPS.** The uniform red polo shirts can be purchased at Uniforms by Bayou, 13488 Seymour Myers Blvd, Covington, Louisiana (985) 893-3700 or the uniform shirt can be ordered at the parent/guardian mandatory meeting on June 8, 2016. The cost of the shirt is **$27.13 with tax** with embroidery and is tax deductible. **Please note delivery time is approximately 7-10 days to receive their uniform shirt. They should be ordered as soon as the junior volunteer has been accepted into the program.**
WELCOME!

Dear Junior Volunteer Applicant:

Thank you for your interest in volunteering with the patients and staff at Lakeview Regional Medical Center. Volunteering can be a very rewarding and fulfilling experience that will stay with you throughout your life. The deadline for applying to become a Summer Junior Volunteer is May 27, 2016. Please complete the attached forms and return them to my attention before the deadline.

There are a few things that you should consider before filling out an application.

First, evaluate your current obligations at home and school, and discuss this additional time commitment with your parent/guardian. Patients and staff will be counting on you to be present! It is very important that Junior Volunteers be dependable and they are expected to treat their assignments seriously. **EXCEPTION: FAMILY VACATION TIME WILL BE TAKEN INTO CONSIDERATION AND THE JUNIOR VOLUNTEER WILL HAVE TO GET THEIR 40 HOURS IN BY OTHER MEANS.**

Second, Junior Volunteers at Lakeview Regional Medical Center are limited to certain areas and responsibilities. You are expected to be flexible and accepting to different assignments according to the needs and requirements of the patients, staff, and Volunteer Manager.

Third, bring your energy and enthusiasm! Volunteering offers the opportunity to learn and contribute in a professional, care-giving organization. Your smile and positive attitude will help you get the most out of your volunteering experience.

Once you have successfully completed Lakeview Regional Medical Center’s Summer Junior Volunteer Program, you will receive a letter of recommendation and a copy of your hours.

As soon as we receive and evaluate your completed application we will contact you as soon as possible.

Sincerely,

Alisha Kennedy

Alisha Kennedy
Volunteer Coordinator
Lakeview Regional Medical Center

AK/jms
Junior Volunteer Application Packet 2016

Lakeview Regional Medical Center
95 Judge Tanner Boulevard
Covington, LA 70433
(985) 867-3951

Volunteers are helping hands to our staff and patients
LAKEVIEW REGIONAL MEDICAL CENTER
95 Judge Tanner Boulevard
Covington, LA 70433
(985) 867-3951

JUNIOR VOLUNTEER APPLICATION

Last Name: ___________________________________________ Date: ______________________
First Name ___________________________ Middle Name ___________________________
Address __________________________________ City: __________________ State ________ Zip Code: ______
Date of Birth: ___________________________ Social Security No.: ______________________
Home Phone: _________________________ Cell Phone: _________________________ Email: _________________________
Father’s Name: ___________________________ Employer: ______________ Work Phone _______________________
Mother’s Name: ___________________________ Employer: ______________ Work Phone _______________________

Emergency Contact Information:
Name: ___________________________ Relationship: ___________________________
Place of Employment: _______________________________________________________
Work Phone: _________________________ Home Phone: _________________________ Cell Phone: _________________________
Physician’s Name: ___________________________ Phone: _________________________

HOW DID YOU FIND OUT ABOUT OUR PROGRAM?
__________________________________________________

ACADEMIC BACKGROUND:
School: ___________________________ City: __________________ Grade: ______________
GPA __________ Counselor: ___________________________ Phone No. _________________________
Languages You Can Speak, Read or Write Fluently other than English:

EXTRACURRICULAR ACTIVITIES: List the activities you are participating and indicate DAY and TIME
Sports: ______________________________________________________________
School Clubs: __________________________________________________________
Student Government: _____________________________________________________
Church Activities: _________________________________________________________
Youth Groups: ___________________________________________________________
Part-Time Jobs: __________________________________________________________
Baby-Sitting: _____________________________________________________________
Other: _________________________________________________________________
Job, Volunteer or Community Service Experience:

Employer/Organization: ____________________________________________________________

Position/Duties: ___________________________ Total Length of Time: _______________________

Monday: ________________ Tuesday: ________________ Wednesday: ________________ Thursday: ________________

Friday: ________________ Saturday: ________________ Sunday: ________________

Transportation: If you are selected as a junior volunteer, how will you get to work?
__________________________________________________________________________________

What is your preferred location of assignment at LRMC? (Please specify your first, second and third choice) Please Note: All assignments are subject to change

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<tr>
<th>Location</th>
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<tr>
<td>ADMITTANCE</td>
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<tr>
<td>CATH LAB</td>
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<tr>
<td>CENTRAL SUPPLY – (SURGERY)</td>
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<td>EDUCATION</td>
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<td>FLOOR 2</td>
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<td>FLOOR 4</td>
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<td>FLOOR 5</td>
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<tr>
<td>HUMAN RESOURCES</td>
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<tr>
<td>MATERIALS MGT (SPECIALITY CENTER)</td>
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<tr>
<td>PLANT OPERATIONS</td>
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<tr>
<td>RADILOGY</td>
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<tr>
<td>SUBACUTE (SPECIALITY CENTER)</td>
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<tr>
<td>VISITORS LOBBY/DESK</td>
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What days and times are you available to volunteer?

<table>
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<tr>
<th>Days</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tr>
<td>Morning</td>
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<td>Afternoon</td>
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THIS IS MY FIRST, SECOND, THIRD OR FOURTH YEAR TO VOLUNTEER AT LRMC (PLEASE CIRCLE ONE)

FOLLOWING FAMILY MEMBERS ARE EMPLOYED AT LRMC: ______________________________________________________

I CAN BEGIN WORKING ON: ______________________________________________________________________________

I WILL BE ABSENT ON: ___________________________ ___________________________ ___________________________

Signature of Applicant: ___________________________ Date: ____________________

Consent for Summer Junior Volunteer Program Participation:

I authorize Lakeview Regional Medical Center to give emergency treatment to my son/daughter. I also give consent for my child’s participation in the LRMC Summer Junior Volunteer Program.

Signature of Parent/Guardian: ___________________________ Date: ____________________

I agree that the above information is correct as of the date it has been signed. I also agree to the rules and regulations of the Volunteer Department of Lakeview Regional Medical Center as they are outlined in the Summer Junior Volunteer Handbook.

Signature of Parent/Guardian: ___________________________ Date: ____________________

FOR OFFICE USE ONLY:

Date Received: ___________ Volunteer Number: ___________ Orientation: ___________

Interview Date & Time: ___________ Department/Day/Time: ___________ TB Test Taken: ___________

Picture ID Taken: ___________
LAKEVIEW REGIONAL MEDICAL CENTER
VOLUNTEER SERVICES
JUNIOR VOLUNTEER MEDICAL HISTORY

Name: __________________________ Date of Birth: _____________________
Address: __________________________________________________________
Telephone: ___________________ Cell Phone: ___________________ Email: ____________
Physician: __________________________________ Telephone: ___________________

PERSON OR PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY:
Name: __________________________ Name: __________________________
Relationship: __________________________ Relationship: __________________________
Telephone: __________________________ Telephone: __________________________

Physical and Medical Background:
Do you have any physical condition or medical problem which may hurt your ability to perform the work of a junior volunteer? ________ Yes ________ No
If “Yes” please explain ____________________________________________________________

Personal Medical History:  Immunization Record (List Dates):

<table>
<thead>
<tr>
<th>DO YOU HAVE</th>
<th>YES</th>
<th>NO</th>
<th>DESCRIBE</th>
<th>DATE</th>
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<tbody>
<tr>
<td>VISUAL DISORDERS</td>
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<td>Cataract</td>
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<td>HEARING DISORDERS</td>
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<td>Deafness</td>
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<tr>
<td>DRUG ALLERGIES</td>
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<td></td>
<td>Drug Allergies</td>
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<table>
<thead>
<tr>
<th>HAVE YOU EVER HAD:</th>
<th>YES</th>
<th>NO</th>
<th>DATE</th>
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<td>ASTHMA</td>
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<td>ALLERGIES</td>
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<td>CHICKEN POX</td>
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<td>GERMAN MEASLES</td>
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<td>MUMPS</td>
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<td>TETANUS</td>
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<td>DIPHTHERIA</td>
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<td>MEASLES/MUMPS VACCINE</td>
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<td>POLIO VACCINE</td>
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<td>TYPHOID VACCINE</td>
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<td>OTHER</td>
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<td>TB TEST: POSITIVE ( )</td>
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Is applicant presently under a doctor’s care? __________ Why? __________________________________________________________
Is applicant presently on any medication? ______ If so, what kind? __________________________________________________________
Does applicant have any chronic illnesses? __________________________________________________________
I, ____________________________________________, parent/guardian of __________________________, hereby give my consent to have my son/daughter volunteer as a Summer Junior Volunteer and to be treated by Lakeview Regional Medical Center in case of an emergency.

__________________________________________
Signature of Parent/Guardian

__________________________________________
Name of Parent/Guardian Printed

Dated: ____________________________
Name: __________________________________________ has applied to the Lakeview Regional Medical Center’s Summer Junior Volunteer Program. To help us get to know the applicant, please complete the following information. Your evaluation will be an important factor in our selection of the applicant. All information is confidential and it will not be disclosed to other parties.

Name: __________________________________________
Address: __________________________________________
Phone: ______________________ Relationship to Applicant __________________________________________

How long have you personally known the applicant? __________________________
How well do you know the applicant? _____very well _____well _____casually _____other

PLEASE CHECK THE FOLLOWING:

<table>
<thead>
<tr>
<th>General Characteristics</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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<tbody>
<tr>
<td>Cleanliness, neatness/grooming</td>
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<td>Dependability</td>
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<td>Trustworthiness</td>
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<tr>
<td>Punctuality</td>
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<td>Shows Initiative</td>
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<td>Follows Instructions</td>
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<tr>
<td>Accepts constructive criticism</td>
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<tr>
<td>Compatibility with peers</td>
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<tr>
<td>Compatibility with adults</td>
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What do you consider the applicant’s special qualities of personality or character?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

COMMENTS: (use reverse side, if needed)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: __________________________________________ Date: __________________________
LAKEVIEW REGIONAL MEDICAL CENTER
JUNIOR VOLUNTEER PROGRAM
JUNIOR VOLUNTEER CONTRACT AGREEMENT

Junior Volunteer Name: ___________________________________________________

Home Phone: ___________________________  Cell Phone: ________________________

Email Address: ____________________________________________________________

BY SIGNING THIS CONTRACT I AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

- To attend the **MANDATORY JUNIOR VOLUNTEERS ORIENTATION**, for all junior volunteers on June 8, 2016 from 9:00 am until 12:00 pm with a Mandatory Parent Meeting at the end of orientation at Lakeview Regional Medical Center, 95 Judge Tanner Boulevard, Covington, LA.

- I will accept the responsibility to set up a weekly schedule with the Volunteer Manager and participate in any training before beginning my service.

- I will always dress in the appropriate uniform for my shift.

- As a Junior Volunteer for Lakeview Regional Medical Center, I realize that I not only represent myself, but also the Lakeview Regional Medical Center and the Volunteer Department and I will perform my service with compassion, dedication and respect.

- If I fail to abide by the terms of this contract, I will not be eligible for a certificate of completion or a letter of recommendation, and may be dismissed from volunteering.

Junior Volunteer: ___________________________  Date: ________________________

Parent/Guardian: ___________________________  Date: ________________________

Volunteer Manager: ___________________________  Date: ________________________
LAKEVIEW REGIONAL MEDICAL CENTER
JUNIOR VOLUNTEER PROGRAM
PARENTAL/GUARDIAN CONTRACT AGREEMENT

Summer Junior Volunteer Name: ______________________________________________________

BY SIGNING THIS PARENTAL/GUARDIAN CONTRACT I AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

• I give my consent for Lakeview Regional Medical Center to administer and monitor Tuberculosis Screening (skin testing) and determination of immunization status through immunization records as needed to the above named minor. I understand that there is no charge for this service.
• I give my consent for Lakeview Regional Medical Center to evaluate on-the-job injuries as needed to the above named minor and treat appropriately.
• I give my consent for Lakeview Regional Medical Center to administer emergency medical treatment as necessary.
• My son/daughter is at least 14 years old by the second week of June, 2015.
• I understand that if my son/daughter misses two (2) weeks of unexcused absences he/she will be removed from the program.

Junior Volunteer: ___________________________ Date: ________________

Parent/Guardian: ___________________________ Date: ________________

Volunteer Manager: ___________________________ Date: ________________
LAKEVIEW REGIONAL MEDICAL CENTER

PHYSICIAN’S APPROVAL

Name of Patient: _________________________________________ is in good health and free
of communicable diseases.

COMMENTS: (Please include here physical handicaps or necessity for limited activity).

_________________________________________  ___________________
Physician Signature                          Date

________________________________________
Physician Name Printed

Please return to:  Alisha Kennedy
                  Staffing/Volunteer Coordinator
                  Lakeview Regional Medical Center
                  95 Judge Tanner Blvd
                  Covington, LA 70433
LAKEVIEW REGIONAL
MEDICAL CENTER
Covington, Louisiana

I ________________________________, give permission for my son/daughter ________________________________, to have the PPD (skin test for TB), CBC, VDRL (lab tests) administered at Lakeview Regional Medical Center. I also give authorization for a chest x-ray to be performed as a follow-up on a positive PPD skin test for TB.

I understand that these tests will be performed at the expense of Lakeview Regional Medical Center, and that these tests are a requirement for the Summer Junior Volunteer Program.

___________________________________________
Signature of Parent/Guardian

___________________________________________
Name of Parent/Guardian Printed

Dated: ________________________________
Confidentiality and Security Agreement

I understand that the facility or business entity (the “Company”) for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information or any information that contains Social Security Numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, “Confidential.

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information on Company systems.

General Rules

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

Protecting Confidential Information

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
5. I will not make any unauthorized transmissions, inquiries, modification, or purging of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communications, I will ensure that the Information is encrypted according to the Company Information Security Standards.

Following Appropriate Access

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Using Portable Devices and Removable Media

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards.

March 28, 2016 - jms
2. I understand that any mobile device (Smart Phone, PDA, etc) that synchronizes company data (e.g., Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
   a. Require the use of only encryption capable devices.
   b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
   c. Implement encryptions and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes Company data regardless of it being a Company or personally owned device.
   d. Remotely "wipe" any synchronized device that has been lost, stolen or belongs to a terminated employee or affiliated partner.
   e. Restrict access to any mobile application that poses a security risk to the Company network.

**Doing my Part – Personal Security**
1. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification process.
2. I will:
   a. Use only my officially assigned User-ID and password (and/or token (e.g. SecurID card).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.
3. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Company network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DSO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. My password has been seen, disclosed, or otherwise compromised;
   b. Media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

**Upon Termination**
1. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.
HCA
Hospital Corporation of America™

*This Form to be used in conjunction with the Form entitled “Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes”*

CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS

For good and valuable consideration, receipt of which is hereby acknowledged, I authorize HCA Management Services, L.P., and its affiliates (collectively, “HCA”) and its respective parents, affiliates, subsidiaries, licensees, successors, and assigns to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish any verbal or written statements, testimonials or biographical information I may provide regarding HCA and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s) (collectively, the “Materials”). I understand that for purposes of this consent, the terms “image,” “voice” and “photograph” encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

HCA shall be the owner of the results and proceeds of such taping, photography, and recording with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet, all or any portion thereof or of a reproduction thereof, free of any payment, royalty, or other compensation of any kind to me. I expressly understand and agree that the Materials and all results and proceeds derived therefrom, shall be the sole and absolute property of HCA for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf. I further represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby represent and warrant that I have not given any other person, entity or firm the exclusive right to use by name, likeness, voice or photograph, and that by signing this document I am not in breach of any other agreement to which I am a party.

I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of HCA and that HCA is under no obligation to use the Materials. I acknowledge that HCA will rely on this permission potentially at substantial cost to HCA and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby acknowledge that I am solely responsible for any statements made by me during the recording of my voice and/or likeness as described above, which statements shall consist solely of my opinions and do not necessarily represent those of HCA, which is not responsible for the content of such statements. I hereby forever release and discharge HCA, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither HCA nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above or in the execution of this Consent for Use and Disclosure of Image, Voice and/or Written Testimonials (the “Consent”).

I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the “Authorization”), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: __________________________

Print Name: __________________________ Date: __________________________

Relationship of Legal Representative to Patient (e.g., parent, guardian): __________________________

12515061.1-12/07

March 28, 2016 - jms
LAKEVIEW REGIONAL MEDICAL CENTER
Covington, Louisiana
JUNIOR VOLUNTEER PROGRAM

DATES TO REMEMBER

**MAY 27, 2016**
LAST DAY applications will be accepted at Lakeview Regional for the Summer Junior Volunteer Program.

**MAY 27, 2016 - JUNE 3, 2016**
Personal Interview with the Volunteer Manager will be made by telephone call or in person.

**JUNE 8, 2016**
MANDATORY Junior Volunteer Orientation AND MANDATORY Parent Meeting for all junior volunteers. Orientation will be held in the Pelican Room, at Lakeview Regional Medical Center, 95 Judge Tanner Blvd, Covington, Louisiana from 9:00 am until 11:45 am. The Parent Meeting will be at 11:45 am following orientation. IF YOU DO NOT ATTEND ORIENTATION, YOU WILL NOT BE ABLE TO VOLUNTEER AT LRMC.

CHECKLIST:

- _____ Junior Volunteer Application
- _____ Reference Form
- _____ All Agreement forms signed by summer junior volunteers and their parent/guardian