Prosser
Memorial Health

# Health Occupations Application Packet

A cooperative learning experience between Prosser Memorial Health and Prosser High School.

---

Prosser Memorial Health (PMH)· Health Occupations Class Coordinator
Phone: (509) 786-4669 · kgreene@prosserhealth.org
723 Memorial Street · Prosser, WA 99350

## Application due to counseling office by Friday, March 6, 2020

Prosser Memorial Health is honored to once again work with students from PHS in offering our Health Occupations Program. This is a yearlong course for select high school seniors, although juniors may be considered, who are interested in pursuing health related careers or have general health care interests. This is a unique class that combines hands on learning, classroom course work in anatomy and real life observation and job shadowing. The goal of this course is to help students make an informed choice about their career path by exploring many health care careers and developing an understanding of the health care system. Please review the course criteria and return completed application to the counseling office. Applications will be reviewed for completeness and fit for the program. Interviews will be scheduled for finalists with a panel of employees and students. Final selection will be made based upon GPA, application and interview. Course only accepts 10 students a year. Course curriculum is graded with half of the grade coming from attendance. The rest of the grade evaluation is based upon case studies and anatomy classwork. Having access to a cell phone and car are helpful but not required. Two of the rotation sites are located on Chardonnay drive, all others are on the main hospital campus site. Should you have questions about the program, please feel free to talk with current students or contact the Health Occupations Class Coordinator at kgreene@prosserhealth.org.

### Health Occupations Criteria for Consideration:

- ✓ Completed application turned in by deadline
- ✓ Cumulative high school GPA at least 3.0
- ✓ Attach copy of high school transcript.
- ✓ Attach copy of high school attendance record
- ✓ Will be a junior or senior in high school for class year, preference to seniors
- ✓ Pass a Washington State Patrol Background check
- ✓ Available to have this class 1st period during 2020-2021 school year.

Prosser
Memorial Health

# HEALTH OCCUPATIONS APPLICATION

*All fields are required - applications with missing information will be considered incomplete.*

## PERSONAL

| Last Name | First Name | Middle Name | |
|---|---|---|---|
| | | | |
| Address | City | State | Zip |
| | | | |
| Student's Email | | Date of Birth | |
| | | | |
| Student Cell Phone Number | Alternate Contact Number | | |
| | | | |
| Emergency Contact | | Emergency Contact Number | |
| | | | |
| Parent/Guardian Name (required if under 18 years of age) | | | |
| | | | |
| RUNNING START? | CURRENT GRADE LEVEL | CURRENT CUMULATIVE GPA | |
| | | | |

## List potential career areas of interest

## List science classes that you have taken in high school

## REFERENCES

Please list two references (other than relatives) that we may contact

| Name | |
|---|---|
| | |
| Phone and or email | Relationship |
| | |
| Name | |
| | |
| Phone and or email | Relationship |
| | |

Prosser
Memorial Health

**As a potential Health Occupations student at Prosser Memorial Health, I agree to:**

- Hold as absolutely confidential all information, which I may obtain directly or indirectly, concerning patients, doctors or personnel, and I will not seek out confidential information in regards to a patient.
- My experience at Prosser Memorial Health is held in contemplation without compensation or future employment and given with the understanding that the program is for educational purposes only.
- I have provided the above information as honestly and to the best of my ability, under perjury or penalty of law.

| *Student applicant's Signature* | *Date Signed* |
|---|---|
| | |

## CRIMINAL DISCLOSURE

Background checks are now required of all prospective employees/volunteers who are directly responsible for the care, supervision, or treatment of children under 16 years of age, or developmentally retarded persons, under a law passed by the Washington State Legislature (RCW 43.43 and 70.125.030) and under the provisions of a 1987 Washington statute. Likewise, such checks are also now required of volunteers who may have regularly, unsupervised access to children under 16 years of age, or groups of children under certain circumstances, or developmentally disabled persons.

Background inquiries will be made to Washington State Patrol, or other state or federal law enforcement agencies. Each new volunteer/student is required at the time of the initial interview, or application process, to complete a disclosure form (in addition to the attached Disclosure Statement).

Child/Adult Abuse Information Act Chapter 486, Laws of Washington, 1987. Second Senate Substitute Bill 5063.

AUTHORIZATION

I hereby give permission to Prosser Memorial Health to conduct a background check through the Washington State Patrol in accordance with the Child/Adult Abuse Information Act, Chapter 486, Laws of Washington, 1987, Second Senate Substitute Bill 5063 and Washington State Legislature (RCW 43.43 and 70.125.030).

| DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|
| | |

| Health Occupations Applicant Signature | Date signed |
|---|---|
| | |

## Disclosure Statement

Prosser
Memorial Health

I consent and authorize Prosser Memorial Health to check with the Washington State Patrol Crime Records Division for record of convictions for crimes against children or other persons, crimes relating to financial exploitation of a vulnerable adult, and crimes relating to drugs (manufacture, delivery, or possession with intent to manufacture or deliver a controlled substance) as prescribed by RCW 43.43.830, 43.43.834, and 70.125.030.

I affirm under penalty of perjury that the following responses are true: (please mark yes or no)

| | | |
|---|---|---|
| ❒ Yes | ❒ No | Have you been convicted of any crime against children or other persons? This means conviction of any of the following offenses: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, third degree statutory rape; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; or first or second degree criminal mistreatment. |
| ❒ Yes | ❒ No | Have you been convicted of crimes relating to financial exploitation if the victim was a vulnerable adult? |
| ❒ Yes | ❒ No | Have you been convicted of crimes relating to drugs (manufacture, delivery, or possession with intent to manufacture or deliver a controlled substance)? |
| ❒ Yes | ❒ No | Have you been found in any dependency action under RCW 13.34.030(2)(b) to have sexually assaulted or exploited any minor or to have physically abused any minor? |
| ❒ Yes | ❒ No | Have you been found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused any minor? |
| ❒ Yes | ❒ No | Have you been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult? |
| ❒ Yes | ❒ No | Have you been convicted of custodial sexual misconduct in the first or second degree? |
| ❒ Yes | ❒ No | Have you been found by a court in a protection proceeding under Chapter 74.34 RCW, to have abused or financially exploited a vulnerable adult? |

You will be notified of the state patrol's response within 10 days after receipt by the hospital. A copy of the response is available from the Human Resources Office and/or the Credentialing Office.
The hospital will use this record in making the initial volunteering decision. Further dissemination or use of the record is prohibited.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am offered a volunteer position, I can be discharged for my misrepresentation or omission in the above statement. I hereby authorize Prosser Memorial Health to request information relating to my background.

Applicant's Signature _______________ Date: _______________

## MINOR CONSENT FORM

I, as the parent /guardian of ______________________________________________ understand that my child would like to participate in the volunteer/ student program at Prosser Memorial Health (PMH). I understand that volunteers/ student are not employed by PMH and that there will be no financial remuneration for services contributed by volunteers. I understand that in order for my child to participate this parental consent form must be signed and returned to the Community Relations Department. I agree that my child may participate in the volunteer/ student program at PMH and that he/she will abide by all policies, procedures, and regulations that will affect her/him as a volunteer/ student intern.

Additionally, I understand during my child's volunteer or student experience they may be exposed to nudity while observing the delivery of healthcare services. My determination regarding these types of procedures is noted below:

- ❒ My son/daughter may be included during healthcare procedures where they may be exposed to nudity.
- ❒ My son/daughter must be removed from healthcare procedures in which they may be exposed to nudity.

________________________________________________ ________________________________

Signature Parent/Guardian: Date:

## AUTHORIZATION OF EMERGENCY TREATMENT FOR A MINOR

In the event your child is injured while volunteering at PMH and we are unable to reach you, do you want your child treated at PMH?

- ❒ YES, I, hereby authorize PMH to provide hospital care to my child, 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 of the medical staff of PMH. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the parent/guardian to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.
- ❒ NO, I do not want my child treated at PMH.

  I wish my child be treated at ___________________________________

________________________________________________ ________________________________

Signature Parent/Guardian: Date:

## IMMUNITY TITERS BLOOD WORK CONSENT AND INFLUENZA VACCINE CONSENT

- ❒ YES, I, as Parent/Guardian, authorize PMH staff to draw blood, free of charge, to test immunity to Measles, Mumps, Rubella, Varicella, Hepatitis B and Tuberculosis, on my child, as required by Washington State law and PMH policy.
- ❒ YES, I, as Parent/Guardian, authorize PMH staff to administer an Influenza vaccine to my child, as required by PMH policy.

________________________________________________ ________________________________

Signature Parent/Guardian: Date:

**Date of applicant's last tetanus/diphtheria/pertussis (Tdap) vaccine: ________________________________**

Prosser
Memorial Health

**Please share any extracurricular or community activities you participate in or any interests or hobbies you have.**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Please share what has inspired you to apply for this program and why you would be a good candidate for the program. You may handwrite in the space below, type a statement or add a paper if needed.**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Prosser
Memorial Health