Conemaugh Memorial Medical Center
Fall 2018 Career Day Packet

Thank you for your interest in Conemaugh Memorial Medical Center Fall 2018 Career Day on Thursday October 11, 2018 from 9 AM to Noon.

Completed packets can be mailed directly to Conemaugh Memorial Medical Center
Volunteer Services, 1086 Franklin St., Johnstown, PA, 15905, Faxed to 814-534-9431, or scanned and emailed to VolunteerServices@conemaugh.org

If you have any questions or concerns, please contact the Volunteer Services Office at 814-534-9129.

PLEASE SEE CRITERIA AND DOCUMENTATION REQUIRED BELOW:

Career Day Participant Criteria:
• Student must be enrolled in grades 11 or 12 and 16 years of age or older
• Student must have an overall GPA of 3.0 or higher on a 4.0 scale in most recent semester
• Student must demonstrate a strong interest in pursuing a career in the medical field

Documentation To Be Submitted With Request:

1. Completed and signed Career Day Packet materials which include:
    - Career Day Application Form (***all highlighted lines must be completed***)
    - Student Information document (***all highlighted lines must be completed***)
    - Career Day confidentiality agreement and acknowledgement (***all highlighted lines must be completed***)
    - Emergency Protocol document (***all highlighted lines must be completed***)
    - Authorization to use or disclose certain information for marketing, public relations, and external communication form. (***Fill out Section I and III–In Section I, enter Conemaugh Health System as the Provider, PRINT the student's name and date of birth; and check I am not a patient of Provider. In Section III, the student or a parent/guardian (if the student is under 18) must sign and date. If under 18, the student's parent or guardian must also PRINT their relationship to the student)***.
2. Copy of school transcript documenting current GPA.
3. Recommendation (brief email or letter) from a teacher or guidance counselor.
4. A statement fully addressing all of the points listed below. Statements may be in bulleted or narrative format.
    a. Specific health career area of interest
    b. Specific reasons for choosing this career path
    c. Research describing the occupation and how this profession serves the patient
    d. The academic and clinical training required
    e. The tuition and related expenses
    f. Anticipated future job market in PA and nationally for this specific career

Requests are filled on a first come, first serve basis. The capacity is set to 40 participants. Students who have participated in past Conemaugh Career Days are not eligible to attend. **PLEASE BE SURE THAT ALL THE DOCUMENTATION REQUIRED IS SUBMITTED, ENTIRELY COMPLETE, AND RECEIVED NO LATER THAN FRIDAY SEPTEMBER 28, 2018.**

Conemaugh Memorial Medical Center has the right to terminate any Career Day experience at any time for any reason.

Conemaugh Career Day October 11, 2018 Application

Today's Date: _____

Student's Name: _____ **Student's Home Phone**: _____

Student's Email: _____ **Student's Cell Phone:** _____

Student's Address: _____

Emergency Contact: _____ **Phone:** _____

Referring School: _____ **Grade Level:** _____

School Contact: _____ **Phone:** _____

School Contact Email: _____

Will you be 16 years old on or before October 11, 2018? : Yes: _____ No: _____

Have you taken part in a past Conemaugh Career Day? Yes: _____ No: _____

Career Interest(s):

1. _____

2. _____

Have you ever been convicted of a felony? Yes: _____ No: _____

I hereby confirm that all of the information provided above is accurate. If this information changes prior to my Career Day experience, I understand that it is my responsibility to notify Volunteer Services of any changes regarding the above information. In consideration and participation of this event, I hereby WAIVE, RELEASE, AND DISCHARGE from any and all liability for the death, disability or personal injury or lost or damaged property as the participant, the Conemaugh Health System, including but not limited to Conemaugh Memorial Medical Center and its employees.

_____ _____

Student's Signature **Date**

_____ _____

If minor, Parent/Guardian Signature *ALSO* required **Date**

Student Information

DRESS/APPEARANCE GUIDELINES - **Inappropriately attired students will be refused.**

- Student must wear a collared shirt/blouse. **No novelty shirts**.
- "Docker" like slacks strongly recommended. **No jeans.**
- Comfortable shoes or clean tennis shoes recommended. **No open-toe or open-back shoes.**
- Unusual facial "piercings" are not permitted.
- No large purses or backpacks.
- **Cell phones are <u>not</u> to be out or visible at any time.** Cell phones may be on your person or in a small purse.
- **Photography and video of any kind are strictly prohibited.**

<u>Individuals who do not comply will be sent home immediately!!!!!!!!</u>

PARKING
Free parking is available in the North Parking Garage- located across from the Good Samaritan Building with the entrance on Valley Pike Road. Participants who present a parking ticket to Volunteer Services staff will be issued a parking token.

LOCATION
Conemaugh Career Day will take place on the Campus of Conemaugh Memorial Medical Center. Details including the exact location and directions to the room will be shared with the student and the school approximately a week before Career Day.

NO SOLICITATION
Career Day participants are not permitted to solicit or to distribute materials of any kind unless approved by Volunteer Services.

SUBSTANCE-FREE and TOBACCO-FREE WORKPLACE
Possession or use of alcohol or drugs, or reporting to Career Day in an intoxicated condition is strictly prohibited. This does not apply to over-the-counter or physician-prescribed medication used according to directions. Conemaugh Memorial Medical Center is tobacco-free. Tobacco use of any kind is prohibited on any Conemaugh Memorial Medical Center property at any time. Participants will be held to the same **Smoke-free Shift Policy** as employees. Use of all tobacco products are prohibited during the entire Career Day session.

NO WEAPONS
Possession of any type of weapon on hospital property is strictly prohibited.

SICKNESS OR EMERGENCY
In the event of an illness, injury, or an emergency, please notify Volunteer Services immediately at 814-534-9129.

SPECIAL NEEDS
If you have a disability or need any auxiliary aids or services identified in the Americans with Disability Act or have additional questions, please contact Volunteer Service at (814) 534-9129.

I have read and agree to the terms of the student information sheet.

Student's Signature	**Date**
If minor, Parent/Guardian Signature *<u>ALSO</u>* required	**Date**

Conemaugh Health System

Career Day confidentiality agreement and acknowledgement

Career Day is an academically motivating event designed to provide qualifying local high school students with an introduction to healthcare careers as a basis for career planning.

By signing this agreement, I acknowledge that the Conemaugh Memorial Medical Center 2018 Spring Career Day event is for educational purposes only and that I will not in any way be considered an employee of Conemaugh Health System (CHS).

By signing this agreement, I acknowledge that I may have access to confidential information concerning CHS business and operational activities during the course of this experience. This confidential information may include, but is not limited to, information that relates to CHS patients, employees, technological activities, medical and scientific research, business activities (including marketing of services and recruiting staff and employees), business plans, purchasing, accounting, data processing/management information systems, licensing of patents, trademarks or service marks and copyrights and all other information or material that CHS considers confidential, proprietary or a “trade secret” as that term is used in the law.

I agree that during my Career Day experience with CHS and at any time thereafter, I will not discuss, relay, or deliver and/or communicate in any way any confidential information gained during my experience to any person or entity, in any form, including verbal, written, or online through such social media sources such as, but not limited to, Twitter, MySpace, Facebook, or Blogs. I agree that, unless I am specifically directed in writing or approved in writing by an authorized representative of CHS, I will not disclose any confidential information and I further understand that any disclosure not so authorized will result in termination of my Career Day experience and/or legal corrective actions in accordance with the law.

I understand that taking photos and/or videos are prohibited.

I agree to return all property of CHS upon request or on the date my Career Day experience ends.

I voluntarily assume all risks of illness and injury associated with my Career Day experience and knowingly release CHS, its directors, officers, employees and agents, from any and all claims by me or on my behalf, in conjunction with or resulting from my Career Day experience.

Date this day of, _____, 20___

_____
Student’s Signature

_____
Student’s Print Name

_____
If minor, Parent/Guardian Signature *ALSO* required

_____
Parent/Guardian Print Name

_____
School Guidance Counselor or Principal Signature

_____
School Guidance Counselor or Principle Print Name

_____
School Name

Created 03/14
Revised: 02/16; 08/17; 01/18

Conemaugh Health System

EMERGENCY PROTOCOL

1. In the event of an emergency, pick up any of the hospital issued phones and **dial 222**.
2. **Loud Speaker Emergency Codes**

Type of Emergency	**Call**
EMERGENCY ON-CAMPUS	**222**
EMERGENCY OFF-CAMPUS	**911**
MEDICAL EMERGENCY (unconscious)	**Code BLUE**
MEDICAL EMERGENCY (conscious)	**Rapid Response**
FIRE (Internal Disaster)	**Code RED**
UTILITY FAILURE (flooding, total electrical failure, etc.)	**Code BROWN**
UNCONTROLLABLE SITUATION w/ Patient (Crisis Intervention, physical threat)	**Code GREEN**
UNCONTROLLABLE SITUATION w/ Staff or Visitor	**Code ORANGE**
ACTIVE SHOOTER	**Code GREY**
EXTERNAL DISASTER	**Conval Alert**
INFANT/CHILD ABDUCTION	**Code PINK**
EVACUATION- Follow instructions of person responsible for evacuation	**Code AMBER**
BIOHAZARD/BIOTERRORISM ALERT- chemical, biological other incident in which patients may need to be contaminated hospital goes into a lockdown.	**Code WHITE**

3. **FIRE**

CODE RED is the code for an internal disaster- fire, explosion, etc. Dial 222 to report an internal disaster. In the event of a fire, follow **RACE** as the emergency response in a fire and **PASS** which explains how to use a fire extinguisher:

R **Rescue**
Rescue persons if in immediate life threatening danger without placing yourself in danger

A **Alarm**
Pull nearest fire alarm and dial 222, tell the operator your location and the nature of the emergency.

C **Contain**
Close all doors and windows.

E **Extinguish**
Extinguishers are located on each floor. Know their location and remember PASS

P **Pull**
Pull the locking pin or release lever.

A **Aim**
Aim the extinguisher by holding the nozzle firmly. Hold extinguisher firmly.

S **Squeeze**
Squeeze the handle.

S **Sweep**
The nozzle back and forth, slowly, aiming at the base of the flames.

SUMMARY:
Know how to work an extinguisher. If you don't use the extinguisher correctly, a small fire can easily become a big fire. Fight only a small fire. Make sure you have access to an exit. If you have the slightest doubt about whether to fight or not to fight—don't. Make sure that you have sent for help or dialed 222 to report a Code Red and the location.

If the fire is in another area of the hospital: 1. Close all windows and doors 2. Clear all hallways 3. Restrict elevator and phone traffic 4.Stay calm 5. Await further instructions. (An "all clear" announcement will be made when the event is resolved and departments will return to their normal duties).
**This information is only meant to be a guide. For specific information or questions, call Security at 534-9730.*

I have read, understand and will abide by the information contained in this Emergency Protocol sheet.

_____ _____ and _____ _____
Student's Signature **Date** **If Minor, *ALSO* Parent/Guardian Signature** **Date**

AUTHORIZATION TO USE OR DISCLOSE CERTAIN INFORMATION FOR MARKETING, PUBLIC RELATIONS, AND EXTERNAL COMMUNICATIONS

SECTION I:

I authorize _____ and any of its affiliates and their representatives to use
(Provider)
or disclose the name and photographic or video images of _____ DOB: _____
(Name)
for promotional, educational and informational purposes (i) in any printed publication, advertisement, or website of Provider and its affiliates; (ii) to local, state, and national government officials; reporters for local, state, and national media publications, including newspapers, magazines, and on-line media; and to reporters for local, state, and national television broadcast stations; and or (iii) as otherwise specifically described:

_____

I acknowledge that my participation pursuant to this Authorization is voluntary and that I will receive no financial compensation for the use of my name or images as provided by this Authorization. I further agree that the use of my name or images as provided by this Authorization confers upon me no rights of ownership whatsoever. I agree that Provider and its affiliates may use images of me with or without my name and for any lawful purpose, including but not limited to publicity, education, illustration, advertising, or web content. I release Provider and its affiliates from liability for any claims by me or any third party in connection with my participation pursuant to this Authorization.

I am: □ a patient of Provider **(Complete Section II and Section III)**.

I am: □ **not** currently a patient of Provider **(Skip Section II and Complete Section III)**.

SECTION II:

Date(s) of Relevant Service or Encounter:	

PROVIDER USE ONLY:

□ **Provider may receive payment from third parties for marketing activities allowed pursuant to this Authorization.**

□ **Provider does not receive payments from third parties for marketing activities allowed pursuant to this Authorization.**

The type and amount of information to be used or disclosed regarding the above-referenced date(s):

□ Patient's name and/or image
□ Name and specialty of physician(s)
□ Medical Record (specify portion for use or disclosure): _____
□ Diagnosis and/or type(s) of treatment received
□ Description of treatment experience
□ Other (Describe): _____

The format in which such information may be used or disclosed:

□ Interview and/or use of quote from patient or physician
□ Photographic or video images

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. I may refuse to sign the Authorization.
2. This Authorization includes information relating to behavioral or mental health services, alcohol and drug treatment, sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus, if any.
3. I have the right to revoke this Authorization at any time in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance on my prior authorization. Unless I revoke this Authorization, it will expire five (5) years after the date I sign this Authorization or, if shorter, the maximum period allowed by state law.
5. By signing below, I recognize that the health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of this disclosure.
6. Treatment or payment will not be conditioned on my signing this Authorization.
7. I have received a copy of this Authorization.

SECTION III:

I have read the above and authorize the use or disclosure of information about me as stated herein.

_____ _____
Signature of Individual or Individual's Personal Representative Date

_____
Relationship of Personal Representative to Individual