Mass General Brigham
Cooley Dickinson Hospital

30 Locust St., PO Box 5001
Northampton, MA 01061-5001
T 413-582-2000
cooleydickinson.org

SUMMER HIGH SCHOOL VOLUNTEER
Program Overview

Program Description Students commit to 12-15 hours per week over 6-8 weeks of the summer. We gladly accept students who want to support their community in a variety of ways including supporting patients and helping staff and fundraising.

Program Requirements

Summer volunteers must be 15 years old by June 1, 2025.

Before you apply, make sure that you can volunteer for three shifts per week for at least **6 weeks** between **June 30 and August 22, 2025**. We cannot accept volunteers who cannot make at least a 6-week commitment to the program.

Application Process

Step 1: Application, Parent Forms, References

- Complete and sign the application
- Have your parent(s)/guardian(s) read and sign the Parent Permission Form
- Reach out to two people to write references for you. They may write a letter on your behalf, or they may use the form provided here. They should submit the letter or completed form to you.
- Email to rkline4@mgb.org or drop off or mail the Application, Parent Permission Form and References by Friday, May 16, 2025 at 5pm to:

  CDH Volunteer Department/Cooley Dickinson hospital
  30 Locust Street
  Northampton, MA 01060
  Attn: High School Volunteer Program

Step 2: Interview

We will contact you if you are among the approximately 20 applicants invited to be interviewed. If contacted, you must schedule and complete the interview by June 6, 2025.

You must bring the following items with you to your interview:

- Completed Summer Volunteer Immunization Documentation Form, signed by a health care provider
- A negative TB test is part of the Immunization Documentation. The TB test must be taken 3 months or less prior to June 30, 2025
- Vacation schedule for the summer

Step 3: **Orientation and Training**

If accepted into the Summer Program you will need to attend an Orientation and Training session on **Thursday, June 26 from 8:30pm – 12:30pm.**

Participation in the Program

The CDH Summer Volunteer Program will start on Monday, June 30, 2025 and end on August 22, 2025.
You must be able to commit to 6 of the 8 weeks.

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SUMMER HIGH SCHOOL VOLUNTEER
Application Form

It is the intent of the CDHCC to conform to Federal and State Laws pertaining to non-discrimination.

Mr. Miss. Last Name	First	Middle	Home Phone:
			Business/Cell Phone:
Address: No. Street	City	State Zip	Date of Birth:
Email:			

In case of emergency notify:

Name:	Address:
Relationship:	**Phone:**

Extracurricular, Personal, Paid Work and Volunteer Activities		
Activity	Approximate Time Spent (Hours per week and how long)	Position Held, Honors won

Please note best days and times:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8am-12	☐	☐	☐	☐	☐	☐	☐
12-4pm	☐	☐	☐	☐	☐	☐	☐
4-7:30pm	☐	☐	☐	☐	☐	☐	☐

Please rate your **TOP FOUR** interests on this form by putting a number, 1-4, in the box.

PATIENT CONTACT

☐ **Information Desk (CDH and off-site)**

Escort visitors to appointments, give directions, learn to assist with wheelchairs, create a warm and welcoming environment. Looking for friendly, out-going, active workers. Great place to learn the hospital.

☐ **Rehabilitation—Northampton, Hadley or Southampton (all locations are off-site)**

Stock shelves, collate packets, prepare rooms, clean equipment. Observe some treatments with permission. Looking for mature students interested in healthcare

☐ **Surgical Day Care or Endoscopy**

Stock shelves, collate packets, prepare rooms, escort patients, and give comfort measures. Looking for mature students interested in healthcare.

☐ **Patient Support**

Assist on Patient Units by serving meals, answer call bells, provide comfort measures and help with clerical tasks.

☐ **Coffee Shop**

Provide needed meals and treats to patients, visitors, and staff. Looking for caring individuals who want to make a difference to others. This department raises funds for critical hospital areas.

☐ **Nutrition Department**

Work with a great team that serves over 300 meals daily. Load trays, clean dishes, equipment, deliver meals to patients. Looking for active, enthusiastic helpers.

Personal Statement:
What interests you about volunteering at Cooley Dickinson Hospital? What characteristics and skills would you bring to your experience here? In your response, please reflect on any past volunteer or work experience you have had.

Previous Employment: List most recent first.

Name & Address:	Position & Duties:	Dates:
1.		From To
2.		From To
3.		From To

Name of School	Level (Sophomore, Junior, etc.)	Year of graduation
High School:		

Have you ever volunteered at CDH before? If yes, when?	☐ Yes ☐ No

References

Please provide **2 letters of reference**. These can be from supervisors, teachers, neighbors, or others who know you well. They can't be from people related to you. Your references may use the Reference Form.

Vacation Dates

I plan to be out for Vacation the following dates:
(NOTE: Only 2 weeks absence is allowed. Volunteers MUST commit to a minimum of 6 of the 8 weeks.)

_____

_____

Have you ever been sanctioned or excluded or been the subject of a sanction or exclusion proceeding by Medicare, Medicaid or other federal health care program? ☐ Yes ☐ No

Please Read Carefully

All of the above statements are true to the best of my knowledge. Any misstatements are sufficient cause for my dismissal.

I authorize The Cooley Dickinson Health Care Corporation to verify any information presented in this form and to request statements from references. In the event of my volunteering for the Cooley Dickinson Health Care Corporation, I agree to comply with all of The Cooley Dickinson Health Care Corporation's rules and regulations as they may be changed from time to time.

Signature: _____

Date: _____

Please Remember to SIGN your Application Form.

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Cooley Dickinson Hospital

SUMMER HIGH SCHOOL VOLUNTEER
Immunization Documentation Form

Please Print:
First Name _____ Last Name_____

Date of Birth / / Assigned Department: ____Volunteer Services_____

Dear Medical Provider,

Cooley Dickinson Hospital (CDH) is committed to providing a safe environment for its patients from communicable illnesses. Your patient, identified above, is going to be working at CDH and must meet the following requirements. **Please provide/verify the dates as requested below.**

1. Covid-19: Covid Vaccine #1 date: _____ Covid Vaccine #2 date: _____ Covid Vaccine #3 date: _____
(Minimum Covid Vaccine requirement is the initial series or a Bivalent booster)

2. TB screening ***within 3 months of start date:***
Date Planted _____ Date Read _____ Result in mm _____

OR

Date of TSpot/Quantiferon test: _____ Result _____

- If hx of positive TB test: Date of positive test: _____
- Date of last Chest x ray: _____ and Result: _____ (***Please attach X-Ray report.)***
- Does the above patient have any current symptoms of active TB? Yes _____ No _____
- Has the patient completed treatment? Yes _____ No _____ ***(Please attach certificate of completion.)***

3. Measles, Mumps, Rubella: MMR Vaccine #1 date _____ MMR Vaccine #2 date _____

OR

Date of ***Positive*** Titer for Measles IgG _____
Date of ***Positive*** Titer for Mumps IgG _____
Date of ***Positive*** Titer for Rubella IgG _____

Provider Signature: _____ Date: / /

MUST BE RN, NP, PA, or Physician Provider

Provider Printed Name or Office Stamp: _____

Work Address: _____

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SUMMER HIGH SCHOOL VOLUNTEER
Parent/Guardian Permission Form

Your son or daughter has applied to become a Cooley Dickinson hospital Volunteer. We are looking for teen volunteers, age 15 or older, who will honor the commitments they make, who will treat information about patients as strictly confidential, who are enthusiastic, pleasant, considerate, and honest.

In return we can provide:

- The opportunity to learn work skills
- An environment with interesting people
- A chance to support their community and learn responsibility
- A chance to learn more about health care

For many of our High School Volunteers, the commitment they make to us is also a commitment for you. They count on their parents/guardians to:

- **Provide transportation to and from the hospital**
- **Help ensure their timely arrival**
- **Expect them to do their best in jobs assigned**
- **Not schedule family events or duties at the time they are scheduled to work**

We understand there will be times they can't come, due to illness, emergencies, or vacations. We ask that volunteers call their supervisor when they are ill or have an emergency and that they give us as much notice as possible for vacations. High School Volunteers in the summer program are required to attend 6 of the 8 weeks of the program.

- I hereby give permission for my child,

  _____,

  to perform volunteer services at Cooley Dickinson Hospital.

_____

Name of family physician:

_____ _____

Located at: Phone

I grant the hospital permission to provide emergency treatment to my child in the event he/she becomes ill or sustains an injury while serving as a High School Volunteer.

_____ _____

Parent/Guardian Signature Phone

_____

Parent/Guardian – Print Name

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SUMMER HIGH SCHOOL VOLUNTEER
Reference Form

Date_____ Applicant's Name_____

Please be specific when answering the following questions. If you need more room, please use the back of this form.

1. In what capacity have you known the applicant?_____
2. How long have you known the applicant?_____
3. How would you describe the applicant's interactions with people? _____

   _____
4. What would you consider the applicant's strengths or best skills?_____

   _____
5. What would you consider an area of needed growth for the applicant?_____

   _____
6. Please rate the applicant in the following areas:

	Excellent	Good	Fair	Poor	Not Applicable
Customer Service					
Independence/Initiative					
Maturity					
Reliability					
Patience					
Flexibility					
Positive Attitude					
Sensitivity to Others					

7. Do you have any concerns about this person volunteering at Cooley Dickinson Hospital?_____

   _____
8. Please add anything about the applicant you feel is important or would help us to know this person better

   _____

   _____

Your Name (*please print*)_____Phone Number_____

Signature_____Date_____

Please return to:
Volunteer and Guest Services **|** Cooley Dickinson Hospital | 30 Locust Street, Northampton, MA 01060

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Patience					
Flexibility					
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Sensitivity to Others					

9. Do you have any concerns about this person volunteering at Cooley Dickinson Hospital?_____

   _____
10. Please add anything about the applicant you feel is important or would help us to know this person better

    _____

    _____

Your Name (*please print*)_____Phone Number_____

Signature_____Date_____

Please return to:
Volunteer and Guest Services **|** Cooley Dickinson Hospital | 30 Locust Street, Northampton, MA 01060