2026 Junior Volunteer Program

Dear Potential Junior Volunteer and Parent/Guardians(s):

Thank you for your interest in volunteering at Littleton Regional Healthcare! We trust that you will have a rewarding community service experience at the hospital, as well as an opportunity to find out more about the variety of jobs offered in the field of healthcare. Since you will be volunteering in a healthcare facility, there are rules and regulations that we are required to comply with. Please read this document in its entirety to ensure that you can meet all of the requirement of the program before applying.

Program Coordinator:	Dawn Lambert Volunteer Coordinator Littleton Regional Healthcare 600 St. Johnsbury Road Littleton, NH 03561 (603) 444-9331 dlambert@lrhcares.org
Who Can Apply:	Local students aged 16 to 18
Date of Program:	Thursday, June 25, 2026 (Orientation/First Day) to Thursday, August 13, 2026 (Program Closure) Total Length: 8 Weeks
Times of Program:	Each student will be assigned at least one 4-hour shift from 8am-12pm per week based on their availability. Assignments will be distributed after the completion of orientation.
Application Due By:	Friday, May 1, 2026

Things to know: There are limited Junior Volunteer slots available for the 2026 Summer Season. In person interviews will be scheduled for the week of May 18. Applicants will be notified no later than Thursday May 28, 2026, if they have been accepted into the program.

If you are accepted into the program, you must immediately schedule an appointment with our Occupational Health Department between June 1-June 12. The appointments are

available Monday-Friday at 9am and 2pm and your parent/guardian **must** accompany you to this appointment. The cost of this appointment will be covered by LRH and will include a physical assessment and a blood draw. The Occupational Health Department will also need a copy of your vaccination records. You can provide these, or you can complete the attached *LRH Authorization for Release of Information Form* if you are a current patient of North Country Primary Care authorizing our Occupational Health Department to access your immunization history via your medical records. If you are not a patient here, you must provide the immunization records at the time of the appointment. Occupational Health will send you a packet in advance with additional instructions and paperwork.

Our **orientation** for all junior volunteers will be held on **Thursday, June 25, 2026 from 8:00 am to 12:00 pm** at Littleton Regional Healthcare. We will meet in the **LRH Conference Center** on the ground floor outside the cafeteria. **This orientation is MANDATORY in order to become a junior volunteer.** We will cover various safety and confidentiality topics as well as provide a tour of the facility, uniform top, badge and volunteer locations.

Before you fill out this application packet, be sure to discuss this opportunity with your parent/guardian, specifically what day and time is best for both of you to volunteer so that you have transportation to and from the hospital. There is a section on your application to indicate your choice of day. The shift runs from 8:00 am to 12:00 pm. **Each student is expected to volunteer for one 4 hour shift per week for a minimum of six weeks during the program.**

Below is a list of documents you must provide or complete as part of the application:

1. **Junior Volunteer Application-** Please complete this form and have it signed by your parents at the bottom of the page. Make sure to indicate your availability during the week so that you are assigned a position that fits with your schedule.
2. A one page essay on "Why healthcare is important" or "What role(s) in healthcare interests me". This can be typed or handwritten legibly.
3. A letter of recommendation from a teacher or guidance counselor.
4. **Parking Identification Form-** If your parent/guardian will be picking you up and dropping you off, please check that box off on the form, otherwise complete the required vehicle information.
5. **Consent for Minor to Participate in the Junior Volunteer Program-** If you are under the age of 18, your parent/guardian needs to sign this form and complete the bottom of the page.
6. **NH Parental Permission Form-** If you are under the age of 18, this form must be completed by your parent/guardian.
7. **Junior Volunteer Program Student Agreement-** Please read this form carefully before signing it. You will need your parent/guardian's signature at the bottom.

8. **Written Disclosure to Volunteer Applicant and Consent to Request Background Check-** This needs to be read carefully and signed by both student and parent/guardian. You must include your social security number and date of birth as well as the other information requested. *Your social security number will not be used in any other way or seen by anyone else.*
9. **Annual Attestation Statement for Littleton Regional Healthcare.** Please print your name on the line provided, truthfully answer each of the three questions, and sign at the bottom of this page. Your parentguardian must sign this form as well. **NOTE: Please select "YES" to the answers if you have <u>NOT</u> committed a crime.**
10. **Media Release Form-**This authorizes that your photo can be utilized in social media or other LRH publications by our Marketing & Community Relations Team. Your parent/guardian must also sign this form.
11. **LRH-Authorization for Release of Information (optional)-** If you are a patient of North Country Primary Care and would like Occupational Health to access your immunization records directly, please have your parent/guardian complete the necessary sections of the LRH-Authorization for Release of Information. Some sections have already been completed for you.
12. **BAAS Form-** This online DocuSign form that will be partially filled out by LRH, sent to your parent/guardian to add your personal information, signed electronically by them, and then forwarded to the Department of Health and Human Services to ensure that you have no record on file with them for elder abuse. This will be completed once you have been accepted into the program.

All components of this application must be completed and received by the Volunteer Department <u>no later than Friday, May 1, 2026.</u>

Please submit your completed application to: Dawn Lambert, Littleton Regional Healthcare, 600 St. Johnsbury Road, Littleton, NH 03561. You can send via mail, drop off at the volunteer desk at either of our main entrances or send via email to dlambert@lrhcares.org.

If you or your parent/guardian(s) have any questions, please feel free to contact me at (603) 444-9331 or at dlambert@lrhcares.org.

Sincerely,

Dawn Lambert
Volunteer Coordinator
Littleton Regional Healthcare

LITTLETON REGIONAL HEALTHCARE

Junior Volunteer Application

Name_____

Mailing Address_____

Email Address _____

Phone Number_____ Age_____ D.O.B._____

Name of School_____ Current Grade_____

Previous Volunteer Experience_____

Parent/Guardian #1 Name_____

Phone Number_____ Relationship_____

Parent/Guardian #2 Name_____

Phone Number_____ Relationship_____

Name of family member to contact in case of emergency (if parents/guardians cannot be reached):

_____Phone number_____

Day of the week you are available from 8:00am – 12:00pm

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Area(s)/departments of interest _____

_____

Do you plan to study healthcare in the future? _____

Your signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Parent/Guardian Email Address_____

Please complete this packet and return to:

Dawn Lambert, Coordinator
Volunteer Department
Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561
dlambert@lrhcares.org
603-444-9331

Jr. Volunteer!

LITTLETON REGIONAL HEALTHCARE

PARKING IDENTIFICATION FORM

VOLUNTEER DEPARTMENT

Jr. Volunteer Program

Name: _____

☐ **I will be getting a ride to/from the Jr. Volunteer Program and no car will be parked in the lot.**

VEHICLE INFORMATION:

Vehicle #1

Make/Model: _____
Year: _____ **Color:** _____
License Plate #: _____ **State:** _____
Parking Permit #: _____

Vehicle #2

Make/Model: _____
Year: _____ **Color:** _____
License Plate #: _____ **State:** _____
Parking Permit #: _____

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VOLUNTEER SERVICES DEPARTMENT

CONSENT FOR MINOR TO PARTICIPATE IN THE JUNIOR VOLUNTEER PROGRAM

This will authorize (student's name) _____ and date of birth _____, a minor (under 18 years of age), to participate in the Littleton Regional Healthcare's Junior Volunteer Program. I understand that my daughter's/son's services are donated to Littleton Regional Healthcare without compensation.

I release Littleton Regional Healthcare and its employees and agents from any claims or liability for any losses resulting from injury or illness to said minor during his/her participation in the Junior Volunteer Program, unless such loss resulted from willful or grossly negligent conduct on the part of Littleton Regional Healthcare. I also release Littleton Regional Healthcare and its employees and agents from any and all claims related to the loss of any personal property that my child has brought with him/her to the hospital during his/her participation as a Volunteer.

In case of emergency, I authorize the Emergency Room Physicians, as our agents, to consent to x-ray examination, anesthetic, medical or surgical treatment and hospital care which is deemed advisable by the aforementioned physician in the exercise of this or best medical judgement.

This Authorization is given pursuant to the Policy and Procedures of Littleton Regional Healthcare and shall remain effective for the period of time my son or daughter is a volunteer in the Littleton Regional Healthcare Junior Volunteer Program.

Signature of parent or guardian: _____

Relationship to Minor: _____ Date: _____

STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

PARENTAL PERMISSION YOUTH AGE 16 OR 17

RSA 276-A:4,VIII & LAB 1002.02

Phone: 603.271.0127
email: inspectiondiv@dol.nh.gov

Youth's Name:_____ Date of Birth ____/____/_____
Please print *mm/dd/yyyy*

Youth's
Address:_____
Street *City* *State* *Zip*

I, _____, grant permission for my son, daughter or legal ward
Print name of parent or legal guardian

to be employed with Littleton Regional Healthcare
Name of employer

Located at 600 St. Johnsbury Road Littleton NH 03561
Street *City* *State* *Zip*

Description of work Junior Volunteer Department - NOT FOR PAY

School District_____

_____ _____
Date *Signature of parent or legal guardian*

For additional information regarding the requirements of RSA 276-A, the New Hampshire Youth Employment Law, please contact the New Hampshire Department of Labor at 271-6294 or 271-1492.

RSA 276-A:4
I. No youth shall be employed or permitted to work in any hazardous occupation, except in an apprenticeship, vocational rehabilitation, or training program approved by the commissioner…

VI. In any employer's predetermined designated work week during which school is in session for 5 days, no youth 16 or 17 years of age who is duly enrolled in school shall work more than 35 hours during that work week.

VII. No youth 16 or 17 years of age who is duly enrolled in school shall work for more than 6 consecutive days or 48 hours in any one week during school vacations, including summer vacation. For purposes of this paragraph, "summer vacation" means June 1 through Labor Day.

VIII. No youth 16 or 17 years of age, except a youth 16 or 17 years of age who has graduated from high school or obtained a general equivalency diploma, shall be employed by an employer unless the employer obtains and maintains on file a signed written document from the youth's parent or legal guardian permitting the youth's employment.

RSA 276-A:11 Certain Labor. – In addition to the prohibitions listed in RSA 276-A:4, III, IV, V, VI, and VII no youth shall be employed or permitted to work at manual or mechanical labor in any manufacturing establishment more than 10 hours in any one day, or more than 48 hours in any one week. No youth shall be employed or be permitted to work at manual or mechanical labor in any other employment, except household labor and nursing, domestic, hotel and cabin including dining and restaurant service operated in connection with such service, and boarding house labor, operating in telegraph and telephone offices and farm labor, or canning of perishable vegetables and fruit, or as a laboratory technician, more than 10- 1/4 hours in any one day, or more than 54 hours in any one week.

Hazardous Occupations are as defined in Federal Child Labor Bulletin Requirements in Nonagricultural Occupations, "Child Labor Bulletin No. 101" Order No. 1 through Order No. 17.

This form must be on file with this employer prior to the 16- or 17-year-old youth performing any work.

LITTLETON
REGIONAL HEALTHCARE

JUNIOR VOLUNTEER PROGRAM
STUDENT AGREEMENT

I understand and recognize that while volunteering at Littleton Regional Healthcare, I am not at any time intending to receive monetary compensation. Further, I understand that I will be expected to bring a good work ethic of being on time, doing what I am asked, asking questions if I don't understand something, and being courteous and positive in my demeanor.

I understand that I have a legal obligation to keep totally confidential anything I hear or observe regarding any patient's name, personal data, injury, illness, or treatment.

I understand that I am expected to dress neatly. LRH will provide a polo shirt, vest, smock, or apron that must be worn every volunteer shift. Shirts should be plain with no graphics or writing, pants should be black or khaki slacks (no jeans), and shoes should be closed toe, comfortable and in good condition. These uniforms must be returned at the end of the program.

I agree to be conservative in appearance other than earrings and one (1) small stud in the nostril OR one (1) small hoop or stud in the eyebrow may be visible while on duty, you are not permitted to wear any other facial jewelry while on duty, and no exaggerated hairstyles, make-up, perfume or aftershave. No open toed shoes are allowed – clean sneakers are recommended. We expect all students to dress and act in a professional manner. **Cell phones may not be used while volunteering**.

I understand that, if I fail to follow these regulations, I can be asked to forfeit the remainder of my tenure as a junior volunteer at Littleton Regional Healthcare.

Therefore, I agree to comply with the above regulations and with any further requests made by the Volunteer Coordinator as well as the department manager or supervisor to whom I am assigned.

_____ _____

Date Signature of the Student

_____

Signature of Parent or Guardian

LITTLETON
REGIONAL HEALTHCARE

WRITTEN DISCLOSURE TO JR. VOLUNTEER APPLICANT AND CONSENT TO REQUEST BACKGROUND CHECK

I understand that Littleton Regional Healthcare will utilize the services of a background reporting agency as part of the procedure for processing my application for volunteering. I also understand that if my application for volunteering is granted, Littleton Regional Healthcare may obtain further information through subsequent investigations by a background reporting agency so as to update, renew or extend my volunteer status.

I understand that the investigation may include obtaining information covering felony and misdemeanor criminal conviction background consistent with federal and state law.

I understand such information may be obtained by direct or indirect contact with former employers, public agencies, or other persons who may have such knowledge.

I also understand that before I am denied volunteering, based, in whole or part, on information obtained in the report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act. I understand if I disagree with the accuracy of any information in the report, I must notify Littleton Regional Healthcare within two days of my receipt of the report. If I notify Littleton Regional Healthcare within two days of the receipt of the report that I am challenging information in the report, Littleton Regional Healthcare will not make a final decision on my volunteer status until after I have had a reasonable opportunity to address the information contained in the report.

I hereby consent to this investigation and authorize Littleton Regional Healthcare to procure a report on my background as stated above from a background reporting agency.

Signature of Volunteer	Date
Printed First, Middle, and Last Name	Parent or Guardian Signature
Social Security Number	Date of Birth
Street Address	City/State/Zip

LITTLETON REGIONAL HEALTHCARE

Jr. Volunteer Program
Annual Attestation Statement

NH State law requires that every volunteer must complete this attestation form before they begin volunteering and annually thereafter. If this is the first time this form has been completed, please answer the question for any time in the past. If a statement has been completed previously, answer these questions for the time period since the previous form was completed.

I,_____ , hereby attest that I:
(Print name here)

Circle one answer for each question below:

1.	Have not had a felony conviction in any state	Yes	No
2.	Have not been convicted of a sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation or pose a threat to the health, safety or well-being of A patient	Yes	No
3.	Have not had a finding by the Department of Health and Human Services or any administrative agency in New Hampshire or any other state for assault, fraud, abuse, neglect or exploitation of any person	Yes	No

_____ _____
(Volunteer's Printed Name) (Signature date)

_____
(Signature)

If you are unable to answer **"yes"** to any of these questions (if you have experienced a conviction or finding), please provide the details of the incident to your human resources representative.

LITTLETON REGIONAL HEALTHCARE
Where good health begins.

Littleton Regional Healthcare
Media Release Authorization

On request of Littleton Regional Healthcare.

( ) For an interview: ( ) For media:

( ) For photographs/video: ( ) For testimonial:

For the purpose of: **JR. VOLUNTEER PROGRAM**

I hereby grant permission to Littleton Regional Healthcare to use my photograph and/or information (including interview, testimonial, video) in conjunction with marketing, publicity, and advertising on behalf of Littleton Regional Healthcare.

As such, I relieve and hereby agree to hold Littleton Regional Healthcare, its officers, its physicians, employees, and volunteers free and harmless from any and all liability arising out of the release of photographing or information, as stated above, interviewing and subsequent publication and broadcast or use thereof.

I understand that the release of information, interviewing and/or photographing are being carried out with my consent to the agency or person named above, and so assume full responsibility.

By signing below, I acknowledge that I will receive no compensation now or in the future for the use of my photograph.

_____ _____
(Date of Consent) (Patient or Subject Person Signature)

_____ _____
(Date of Consent) (Patient or Subject Person **PRINTED** Name)

_____ _____ _____
(Date of Consent) (Parent or Guardian *If Applicable*)

_____ _____
(Date of Consent) (Witness to Signature)

All employee photo release forms will be kept on file in the Human Resources Department office. All others will be kept on file in the Marketing & Community Relations Department office.

LITTLETON REGIONAL HEALTHCARE

Health Information Management Dept.
600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559
Email: HIMdept@LRHcares.org

Authorization for Release of Information

Please complete all sections. Missing information may cause delays or the inability to retrieve your records.
Release may take up to 30 days to process.

Please Print Patient Information Must be fully completed	Name: _____ Previous Name: _____ Date of Birth: ___/___/_____ Address: _____ Phone: _____ City: _____ State: _____ Zip Code: _____
Who has the information you want released.	**Please list the specific hospital, physician office and/or home health agency** Provider/Facility North Country Primary Care Pediatrics Address: 600 St. Johnsbury Road Phone: 603-444-7070 City: Littleton State: NH Zip Code: 03561 Fax: 603-575-6288
Who do you want to receive your information?	I hereby authorize the above-named facility/provider to: **(Please Initial)** X Release medical records, ____ Speak to/discuss with, ____ Both release medical records to and discuss medical information with Provider/Facility Littleton Regional Healthcare Occupational Health Department Address: 600 St. Johnsbury Road Phone: 603-444-9294 City: Littleton State: NH Zip Code: 03561 Fax: 603-444-9025 Email: occupationalhealth@lrhcares.org
Information to be released: **What** do you want shared? Check **Appropriate boxes**	Date(s) of service from: _____ To: _____ **We do not accept "ALL" for dates of service. If left blank the last 2 years will be sent.** **Check off the information you would like to be sent:** ____ Emergency Dept. Visits(s) (Reports, tests, consults, etc.) ____ Physician Office Visit(s) ____ Radiology Reports ____ Laboratory Report ____ Operative Report X Immunizations ____ Inpatient stay(s) ____ Nursing Notes ____ Radiology Images ***Radiology Images will be available through Nucleus Online Portal.** ____ Urgent Care ____ Cardiology Reports and Stress Tests ____ Pathology ____ Rehab PT/OT/ST ____ Billing Records ____ Other _____ _____ **Sensitive information (*INITIAL* to be released)** ____ Drug & Alcohol testing and/or treatment records ____ Psychiatric Evaluation ____ Intake Assessment ____ Treatment Plan ____ Evaluations ____ HIV / AIDS / STD testing and/or treatment records ____ Mental Health Progress Notes
Purpose of Release (Why it is needed)	☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Insurance ☐ Attorney ☐ Workers Compensation ☐ Temporary Transfer of care (school winter/away) ☒ Other (Specify) Junior Volunteer Program **Fees may be charged in accordance with State and Federal Statutes**

LITTLETON REGIONAL HEALTHCARE

Health Information Management Dept.
600 St. Johnsbury Road
Littleton, NH 03561
Phone: 603-444-9538 Fax: 603-259-7559
Email: HIMdept@LRHcares.org

FOR LEGAL USE ONLY

Discussion/Testimony/Affidavits: I authorize the following individuals to discuss with me and/or _____
And give sworn affidavits as to whatever s/he knows about my illness, injuries and treatment, as referenced on this form.
_____ Any and all practitioners _____ Other staff _____ Other: _____

I understand that:

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or adverse consequences.
- I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, except where this authorization already has been acted on for release of my protected health information. Such revocation may be basis for denial of health benefits or other insurance coverage or benefits
- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- I understand I am entitled to a copy of this authorization, upon request
- If any of the information disclosed pursuant to this request is from records protected by Federal confidentiality at 42 CFR Part 2, those rules prohibit the recipient from making any further disclosure of this information unless I expressly permit it through my written consent or redisclosure is performed as otherwise permitted in 42 CFR Part 1.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition. _____
I understand if I fail to specify an expiration date, event or condition, this authorization will expire 6 months from the date signed. I also understand it is my responsibility if I document a longer expiration date, I need to cancel by writing to Littleton Regional Healthcare if I wish to change that date.

Signature of Patient or Authorized Representative: _____

Print Name: _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date: _____/_____/_____ Time: _____

For Office Use Only

Medical Record # _____ ID Verification ___ Driver License ___ School ID ___ Other: _____
Cerner FIN _____ Paragon Visit ID _____
Number of Pages _____ Number of Pages _____
ECW # _____ Alpine # _____
Number of Pages _____ Number of Pages _____
Completed by: _____
Records to be ( ) Faxed ( ) Mailed ( ) Picked Up ( ) Handed ( ) Emailed ( ) Share File/Portal

Radiology Images to be shared ( ) Shared with Nucleus ( ) Export to CD

Date Completed: ____/____/_____

Patient Identification
Name:
DOB:
MRN:
FIN:

Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561