Volunteer Application

All fields must be completed prior to becoming a Hope Health Volunteer/Extern/Intern.
Incomplete applications will not be processed.

PERSONAL INFORMATION *(please print in all sections of the document)*		
Last Name:	**First Name:**	**Middle:**
Date of Birth:	**Social Security Number:**	
Mailing Address:	**City/State/Zip:**	
Cell Phone:	**Email:**	

EMERGENCY CONTACT INFORMATION		
Primary Emergency Contact		
Last Name:	**First Name:**	
Relationship:	**Cell Phone:**	**Work Phone:**
Secondary Emergency Contact		
Last Name:	**First Name:**	
Relationship:	**Cell Phone:**	**Work Phone:**

EDUCATION *(please answer according to your current level of education)*

I have completed: *(check one)*

☐ High School ☐ Some College ☐ College (Associate Degree) ☐ College (Bachelor's Degree) ☐ Master's Degree

If applicable, please list the college you are attending now: _____

College Grade Level: (check one)

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

If applicable, please list the college/university you graduated from:

Name of College/University: _____ Month/Year of Graduation: _____

I need volunteer hours for school/college credit: (circle one) YES or NO If yes, how many? _____

Note: If you are currently taking classes, please submit a copy of your most recent transcript.

EMPLOYMENT INFORMATION	
Current Employer:	**Phone:**
Business Address:	**City/State/Zip:**
Current Position:	**Date of Hire:**
Supervisor:	**Supervisor Phone:**

HEALTH INFORMATION	
Physician's Name:	**Phone:**

Is there any health reason that might limit your ability to volunteer? ☐ **YES** ☐ **NO**

If yes, please describe: _____

_____

Please check any illnesses you have had:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Whooping Cough

Please check the illnesses you have been immunized for:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Whooping Cough

VOLUNTEER INFORMATION

Please describe in detail why you are interested in volunteering at Hope Health:

_____

_____

_____

_____

Interests / Skills / Availability

What areas are you interested in volunteering?

☐ Directly with Children

☐ Directly with Families

☐ Other: _____

Continued on next page.

VOLUNTEER INFORMATION (continued)

Please list your experiences or skills that relate to the preference indicated on the previous page:

_____

_____

_____

Current/Previous Volunteer Roles

Please complete current/previous volunteer experience by listing: company name & location/volunteer position/roles & responsibilities.

Current Volunteer Role(s):

_____

_____

_____

Previous Volunteer Role(s):

_____

_____

_____

Select your availability below *(place a check mark next to each shift/day you are available)*

Mornings: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Afternoons: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Evenings: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Are you interested in supporting Hope Health at special events/projects? ☐ YES ☐ NO

If yes, when: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

PROFESSIONAL/PERSONAL REFERENCES: *Please provide three professional references (excluding relatives). By providing the references below, you are authorizing us to contact them.*

Name:	Relationship:
Cell Phone:	Position/Title:
Work Phone:	Email:
Name:	Relationship:
Cell Phone:	Position/Title:
Work Phone:	Email:
Name:	Relationship:
Cell Phone:	Position/Title:
Work Phone:	Email:

CONFIDENTIALITY AGREEMENT

During the course of your activity at Hope Health, you may have access to information which is confidential and may not be disclosed except as permitted or required by law and in accordance with Hope Health policies and procedures. In order for Hope Health to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information can cause irreparable damage to Hope Health. Confidential information includes,but is not limited to:

- *Medical and certain other personal information about patients*
- *Medical and certain other personal information about employees*
- *Medical Staff records and committee proceedings*
- *Reports, policies and procedures, marketing or financial information, and other information related to the business of services of Hope Health which has not previously been released to the public is confidential. If you have any questions at any time concerning the confidentiality or disclosure of information, you should contact Hope Health's CEO.*

By initialing each section and signing this Confidentiality Acknowledgment, you acknowledge and agree that:

_____ **1.** I will only access business information for which I have a legitimate business purpose.

_____ **2.** Medical information is confidential and my access is restricted to my legitimate medical need to know for diagnosis, treatment and care of a particular patient.

_____ **3.** I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of Hope Health.

_____ **4.** I will print information from any hospital information system only when necessary for a legitimate purpose and I am accountable for this information until it is destroyed. I understand that patient medical information may only be stored in authorized locations such as the hard copy medical record jacket. Exceptions may be incorporated into departmental policy so long as the exception is approved in writing by Administrative Staff.

_____ **5.** All patient identifiable information must be shredded or disposed of in a designated locked, confidential disposal bin.

_____ **6.** Patient medical information available from any hospital information system may not be in final form. Therefore, I will not release printed hard copy to third parties, including parents/guardians.

_____ **7.** My access and use of any Health information system information is subject to routine, random, and undisclosed surveillance by Hope Health.

_____ **8.** Failure to comply with my confidentiality obligation may result in disciplinary action or termination, or corrective action in conformance with current medical staff bylaws, rules and regulations.

_____ **9.** Impermissible disclosure of confidential information about a person may result in legal action being taken against me by or on behalf of that person.

_____ **10.** If I am issued a unique user code, it is my responsibility to maintain this code in a confidential manner. This user code is my signature for accessing authorized on-line computer systems. My user code will ensure that the data for which I am responsible will not be available to anyone else; therefore, it is mandatory that my user code and access data be kept strictly confidential.

_____ **11.** My confidentiality obligation shall continue indefinitely, including at all times after my association with Hope Health, such as termination of my employment or affiliation with Hope Health.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT, HAVE HAD MY QUESTIONS FULLY ADDRESSED, AND HAVE RECEIVED A COPY FOR MY PERMANENT PERSONAL RECORDS.

Volunteer's Printed Name: _____ Date: _____

Volunteer's Signature: _____

HOPE HEALTH RESERVES THE RIGHT TO CONDUCT STATE/FEDERAL BACKGROUND CHECKS ON ALL EMPLOYEES/VOLUNTEERS/INTERNS AND EXTERNS.

Have you ever been arrested for conducting or attempting to conduct a sexual offense? ☐ YES ☐ NO

If yes, please list the date(s) of the arrest(s) as well any facts and circumstances surrounding the arrest(s). Being arrested does not automatically exclude you from consideration. If you meet the requirements, you will be able to explain the circumstances of your arrest. If you are subsequently arrested for conducting or attempting to conduct a sexual offense during the course of your volunteer services at Hope Health, you agree to notify Human Resources. Failure to do so may result in termination.

_____

_____

_____

Have you ever been convicted, plead no contest, or plead guilty to a felony or misdemeanor? ☐ YES ☐ NO

Volunteer Privacy Information and Release Authorization - *Please read the following carefully*

Application information
I certify that all information in this application is true and complete. I understand that any false information or omission may disqualify me from further consideration for volunteer service and may result in my dismissal, if discovered, at a later date.

References
I understand that Hope Health requires information from me to evaluate my qualifications for volunteer service. I authorize and release personal references, employers (past and present), and, if necessary, other applicable entities to answer questions in regards to volunteer work, employment, ability, character, medical and emotional background and, if applicable, driving history.

Background Investigation
I understand, in consideration of my application, a background investigation will be conducted. I understand this investigation may include, but is not limited to, a criminal background check in the files of any Federal, state or local justice agency, driving history, performance of medical examinations, drug screening or reference verification. I authorize Hope Health to conduct the background investigation and release Hope Health from responsibility for this investigation.
I understand the requested information is for the sole purpose of gathering accurate information for volunteer services at Hope Health. I have read and understand the above and by my signature consent to these statements.

Drug Screening
I understand that Hope Health, in consideration of my application, a drug screening will be conducted. I authorize Hope Health and/or the agency it acquires/contracts to conduct the drug screening and release Hope Health from responsibility for this screening.

Volunteer's Signature:_____ **Date**: _____

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