VOLUNTEER APPLICATION

Iredell Health System
Volunteer Coordinator, HR Department
557 Brookdale Drive, PO Box 1828
Statesville, NC 28687
(704) 878-4536 FAX (704) 878-7195
www.iredellhealth.org

An Equal Opportunity Employer

We appreciate your interest in Iredell Health System. Each application will receive consideration. Should our volunteer opportunities meet your qualifications, you may be contacted for an interview. If your background does not fit our needs at the time, your application will be held in our active files for six months.

We have committed ourselves to the recruitment and training of volunteers solely on the basis of the individual's qualifications, without regard to race, color, religion, age, sex, disability, veteran status or national origin in compliance with Federal and state equal employment laws.

Entire application must be completed and two reference letters attached (please include contact information on reference letters).

Personal Information (please print)

Name**:** _____ Date**:** _____
(LAST) (FIRST) (MIDDLE**)**

Name preferred to be called**:** _____ Date of Birth _____ Soc. Security No**.** _____

Present Address**:** _____
(STREET) (CITY) (STATE) (ZIP)

How long have you lived there? _____ Years _____Months

Previous Address**:** _____
(STREET) (CITY) (STATE) (ZIP)

How long did you live there? _____ Years _____Months

Home Phone**: (**_____**)** _____ Bus. / Cell Phone: **(**_____**)** _____ E-mail Address _____

Please indicate below the area of service you are applying for:
☐ Junior volunteer (15-17) If Jr. Volunteer, is this a requirement for school? If yes, how many hours must you volunteer? _____
☐ Adult Volunteer (age 18 and above)

What prompted you to apply for a volunteer service position with Iredell Health System?
☐ Website ☐ Employee or Volunteer (give name) _____ ☐ Other_____

Volunteer Availability (Please check all that apply. Volunteer hours are typically 9am – 1pm, 1pm – 5pm, and 5pm – 9pm):
☐ Day Shift ☐ Evening Shift ☐ Any Shift ☐ Weekends Only ☐ Substitute (as needed) ☐ Other _____

Days available to volunteer (lease check all that apply):
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Date you can start: _____

Please indicate what area(s) you would prefer to volunteer:
☐ Activities (for patients) ☐ Medical Records ☐ Outpatient Services ☐ Fundraising/Crafts ☐ Front Desk Reception ☐ Clerical
☐ Tea Room/Gift Shop ☐ ICU/CCU/Surgical Waiting ☐ Women's Health Center ☐ Outpatient Surgery ☐ Physical Therapy
☐ Mail Messenger (delivery of mail) ☐ Emergency Room Reception ☐ Other: _____

If you answer yes to any of the following questions, please list the crime(s), the date(s), the court(s), the sentence(s), and explain fully. Conviction(s) will not necessarily disqualify you from being a volunteer.

Have you ever been convicted of any crime (misdemeanor or felony) or do you have charges pending? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever paid for a worthless check in the office of a Clerk of Court and/or Magistrate's Office to resolve a summons or citation?
☐ Yes ☐ No If yes, please explain: _____

Have you ever paid a fine or restitution in the office of a Clerk of Court and/or Magistrate's Office to resolve any violation of the law?
☐ Yes ☐ No If yes, please explain: _

Have you ever been excluded from participation in or payment by any federal or state health care program? ☐ Yes ☐ No
If yes, please explain: _____

Professional Information

Have you volunteered at another hospital or organization? ☐ Yes ☐ No If yes, please fill out b

Hospital/Organization _____ Contact Name _____ Phone_____

Previous work experience:

_____
(NAME OF EMPLOYER) (TITLE) (REASON FOR LEAVING)

_____
(NAME OF EMPLOYER) (TITLE) (REASON FOR LEAVING)

_____
(NAME OF EMPLOYER) (TITLE) (REASON FOR LEAVING)

Have you ever been dismissed or forced to resign from any job held? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever been terminated from volunteering? ☐ Yes ☐ No
If yes, please explain: _____

Have you previously worked for our health system? ☐ Yes ☐ No
If yes, please list dates: _____

Do you have any relatives employed by or volunteering with our health system? ☐ Yes ☐ No
If yes, please give name(s) and relationship(s):_____

Hobbies, Skills, Special Interests, Activities or Club Memberships: _____

Do you type? ☐ Yes WPM: _____ ☐ No

Check all which you have training, skills and/or experience:
☐ Word Processor ☐ Word for Windows ☐ Excel ☐ Access ☐ PowerPoint ☐ Data Entry ☐ Word Perfect ☐ ICD Coding
☐ Switchboard ☐ Medical Terminology ☐ Other _____

PLEASE LIST NAMES AND CONTACT INFORMATION OF REFERENCES

Name: _____ Phone Number: _____ **(Reference letter must be attached)**

Name: _____ Phone Number: _____ **(Reference letter must be attached)**

PLEASE READ CAREFULLY AND SIGN BELOW:

In making an application for Iredell Health System's Volunteer Service, I understand and acknowledge the following:

1. The information given by me on this application is true in all respects and I have not failed to disclose information which Iredell Health System could consider relevant to its decision in accepting me as a volunteer. I understand that I may not be allowed to volunteer, or if accepted, may be terminated, if I give false or misleading information on my application or during the interview process.

2. Iredell Health System has my expressed authorization to thoroughly investigate my work, criminal record, or other related matters as may be necessary in making a decision. This investigation may include personal interviews with current and former employers, references, neighbors, friends and others with whom I am acquainted. Further, I hereby authorize every person or entity contacted by Iredell Health System to make any disclosure requested by Iredell Health System and release all records and information Iredell Health System may find necessary to the position I am now seeking. I encourage anyone contacted to provide complete responses to requests for information, including information which is believed to be true but not documented. I realize some information may be complimentary and some may be critical.

3. I understand that if I receive an offer to volunteer, the offer will be conditional upon the results of successfully passing a drug screen. I further understand that failure to submit to a drug screen will make me ineligible to volunteer.

4. I understand that Iredell Health System reserves the right to require a medical examination of any volunteer at any time except as may be prohibited by state or federal law.

5. I understand that, if accepted as a volunteer, my volunteer status is for no definite period of time, that I may terminate my volunteer status at any time without cause, and that Iredell Health System may terminate or modify the relationship at any time without notice and without cause.

6. I agree to hold confidential and protect all information regarding patients, former patients, employees, medical staff, volunteers, students, business matters, official documents/records and/or electronic communication of Iredell Health System. I understand that, if accepted as a volunteer, I have a specific obligation to ensure the confidential nature of patient health information (PHI) and other data, which is delineated in the Health System Confidentiality Policy. I agree to abide by all policies in place at Iredell Health System to maintain confidentiality. I will not share any information with unauthorized persons. I understand that sharing of confidential information with unauthorized persons may be grounds for termination as a volunteer and may be punishable by fine or imprisonment under certain laws and/or regulations.

7. I acknowledge and agree that should I become a volunteer with Iredell Health System, I will conform to its rules and regulations and any modification or amendments thereto. I, also, agree to preserve and/or return any property and/or money that I may be entrusted with while offering my volunteering services with Iredell Health System and/or when terminating my services.

8. I have read and understand the above and have had the opportunity to ask questions, which, if asked, were satisfactorily answered.

Applicant's Full Signature: _____ Date: _____

JR. VOLUNTEERS ONLY: All Jr. Volunteers will need to submit an application, two reference letters and a separate informational consent packet before the application will be considered for review.

Return completed application to:
Iredell Health System
Volunteer Coordinator, HR Department
557 Brookdale Drive, PO Box 1828
Statesville, NC 28687

Additional Paperwork for Jr. Volunteers Only

(must be completed and turned in with application)

Informational Consent Packet

Jr. Volunteer Essay: Please write several paragraphs about yourself and why you would like to be a Jr. Volunteer with Iredell Health System. Include aspects of your personality, educational background, family relationships, interests, hobbies, and plans for the future.

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JUNIOR VOLUNTEER COMMITMENT

I hereby apply to become a Junior Volunteer with Iredell Health System. I understand that all Volunteers represent and are part of Iredell Health System's organization and are subject to all health system rules and regulations and to proper authority.

Jr. Volunteer Signature _____ Date_____

I have read my child's completed application and concur that all information is accurate as stated. I consent to the above named child joining the Iredell Health Systems Junior Volunteer Program and understand that he/she will be expected to attend orientation training, undergo medical screenings and background investigation and to comply with the rules and regulation of the Volunteer Services Department and Iredell Health System.

Parent/Guardian's Signature _____ Date _____

CONSENT FORM

Iredell Health System provides an Employee Health Program for the protection of patients and to promote the health and safety of our employees. This program includes a routine health screening, which is required at the time of employment, as well as annually for all employees. In addition, this health screening is also required prior to beginning duties, for all volunteers, clinical educational students, or any other individuals involved in hospital activities.

The **REQUIRED** routine screenings include:

1. TB skin test, or completion of an Evaluation for PPD Reactors if TB skin test contraindicated.
2. Review of immunization record. Serological (blood) testing for immunity will be provided at no charge if unable to provide proof of immunization to Red Measles (Rubeola), Mumps, and Rubella (German Measles). If found to be non-immune, the individual will be referred to his/her physician for immunization. Documentation of receiving the vaccine must be provided prior to commencing hospital activities.
3. Drug screening test.
4. Other lab tests may be required according to the department in which the individual may perform activities.

As the parent/guardian of _____, we require your consent as well as your child's consent to provide these screenings. If you agree to our providing these services to your dependent, please sign the statement below and return with the completed application. Abnormal results of any screening tests will be reported to both the parent and the child/dependent. If you have any questions you may call the Employee Health Nurse at (704) 878-4531.

By signing below, I give permission for routine health screenings as required by Iredell Health System and the release of abnormal test/screens as explained above.

I also give permission for _____ to be treated for minor illnesses and/or work related injuries while volunteering at Iredell Health System.

I have read and understand the above information:

_____ _____

Signature of Junior Volunteer Date

_____ _____

Signature of Parent/Guardian Date