ValleyCare HEALTH SYSTEM

VOLUNTEER APPLICATION

(Circle one) Mr. Mrs. Ms. Miss.

Last Name _____ First Name _____ Initial _____

Address _____

City _____ State _____ Zip _____ Home phone _____

Cell phone _____ Email address _____

Are you 18 or older? ❑ Yes ❑ No (If under 18 – Birthdate: Month _____ Date _____ Year _____)

Parent or Guardian Name _____ Phone _____

In case of emergency, person to notify: _____ Relationship _____ Phone _____

Do you have any physical condition or medical problem that may require special accomodation?

❑ Yes ❑ No If yes, please explain: _____

CATEGORY: (Check all that apply)

❑ Adult Volunteer

❑ College Student Name of College _____ Degree/Major _____

Will you be receiving academic credit? ❑ Yes ❑ No

❑ High School Student Name of School _____ Graduation Year _____

❑ Freshman ❑ Sophmore ❑ Junior ❑ Senior ❑ Other

Is volunteering required for school credit? ❑ Yes ❑ No If yes, hours required? _____

WORK EXPERIENCE

Current or Last Employer _____ Occupation _____

Work Phone _____ May we contact you at work? ❑ Yes ❑ No

Are you or have you ever been an employee of any ValleyCare Health facility? ❑ Yes ❑ No

If yes, where do you or did you work? _____

VOLUNTEER EXPERIENCE

Please describe your volunteer experience (if any): _____

_____

Have you ever been a volunteer for ValleyCare Health before? ❑ Yes ❑ No

If yes, please give the dates and department in which you worked. _____

HOBBIES, SKILLS, SPECIAL INTERESTS _____

CLUBS AND ORGANIZATIONS _____

HOW DID YOU HEAR ABOUT VALLEYCARE HEALTH'S VOLUNTEER PROGRAM, AND WHY ARE YOU INTERESTED IN VOLUNTEERING AT VALLEYCARE HEALTH? _____

VOLUNTEER INTEREST

I want to volunteer:

❑ In a clinical unit
❑ In a waiting room
❑ To greet/escort patients
❑ To deliver flowers/mail
❑ Other _____
❑ With Pastoral Care
❑ To help in an office, Library, Information Desk
❑ With the Gift Shop/Gift Cart/Art Cart
❑ At Hospital Events
❑ No Preference

Day(s) and time(s) you would like to volunteer: _____

Do you have transportation? _____ Car _____ Bus _____ Other

REFERENCES

1. Name _____
   Relationship _____
   Address _____
   City/State/Zip _____
   Day Phone _____

2. Name _____
   Relationship _____
   Address _____
   City/State/Zip _____
   Day Phone _____

3. Name _____
   Relationship _____
   Address _____
   City/State/Zip _____
   Day Phone _____

STATEMENT OF UNDERSTANDING

I wish to become a volunteer at ValleyCare Health System with an understanding of the following:

- I understand that the completion of an application, interview and background check (students under 18 are exempt) and a drug screening is required of all applicants.
- I understand that I will commit to a designated time schedule to volunteer and will complete an orientation and training.
- I understand that state and national hospital regulatory agencies require that ValleyCare Health Volunteers receive an annual review of orientation and training each year and have an annual TB test. Failure to do so will result in temporary suspension from the Volunteer Services program until completed.
- I understand that I am obligated to comply with the responsibilities, rules and procedures as outlined in the volunteer handbook and to perform the duties expected of me to the best of my ability.
- I understand that a prerequisite to volunteer service is the ability to hold as absolutely confidential all information relating to patients and/or staff that I may hear, see, read or otherwise acquire except what is appropriate to discuss with staff in a private setting. State and federal laws prohibit any unauthorized release of personal information. Any breach of confidentiality is immediate grounds for dismissal.

I certify that the information on this application is true and complete and I understand that false statements may be considered grounds for termination. My signature indicates approval for ValleyCare Health System to contact references. I understand that ValleyCare Health is not obligated to provide a placement, nor am I obligated to accept the position offered. If I do accept a position I agree to follow the established policies of ValleyCare Health System and the volunteer department and that my work is without benefit of monetary compensation.

Applicant's Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Please return application to hospital perference:

❑ Hillside Rehabilitation Hospital
8747 Squires Lane NE
Warren, Ohio 44484
Phone: 330.841.3784
Fax: 330.841.3517

❑ Trumbull Memorial Hospital
1350 E. Market St.
Warren, Ohio 44482
Phone: 330.841.9427
Fax: 330.841.1915

For Volunteer Office Use Only

Date Application Received: _____
Background Check Received: _____
TB Testing completed on: _____
Drug Screen received: _____
Interview Date: _____ By: _____
Orientation Date: _____ By: _____

Starting Date: _____
Assigned to: _____
Schedule Day & Hours: _____

Comments:

Qualified applicants are considered for all positions without regard to race, color, religion, national origin, sexual orientation, age, gender or handicaps.