

LAST NAME: \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

Washington Adventist Hospital  
Application for Office of Volunteers  
7600 Carroll Avenue  
Takoma Park, MD 20912  
(301) 891-5444

*Please Print Clearly – Use Black Ink Only*

**PERSONAL INFORMATION**

Name	Male or Female	Date
Telephone (Home)	(Work)	(Cell)
Address	(E-Mail Address)	
City	State	Zip Code
S.S. #	(or) Provide I-94 Card (Original)	Date of Birth

**WORK EXPERIENCE**

Currently Employed: Yes \_\_\_ No \_\_\_ Full-Time \_\_\_ Part-Time \_\_\_ Dates: \_\_\_\_\_

Place of Employment \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Previous Employment \_\_\_\_\_

Previous Volunteer Experiences \_\_\_\_\_

**EDUCATION**

Currently Enrolled in School? Yes \_\_\_ No \_\_\_ Highest Level Completed? \_\_\_\_\_

Name of School \_\_\_\_\_

Address of School \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Degrees/Majors \_\_\_\_\_ Fluent in what languages? \_\_\_\_\_

**VOLUNTEER INFORMATION**

Why did you select Washington Adventist Hospital as a site to volunteer?

Spare Time \_\_\_ School Requirement \_\_\_ Internship Requirement \_\_\_

Court Mandated \_\_\_ Other reason: \_\_\_\_\_

Desired Choice of Volunteer Position (check choice(s) from the following basic categories)

Patient Care \_\_\_ Office/Clerical Support \_\_\_ Gift Shop \_\_\_ Reception Desks \_\_\_

Desired Schedule: (circle choices)

1. Sunday Monday Tuesday Wednesday Thursday Friday Saturday

2. Mornings Afternoons Evenings

3. How many hours per day would you be interested in volunteering? \_\_\_\_\_

4. What time of day would you like to start? \_\_\_\_\_

NOTE: Recommended shift is 4 hours in length, times as follows: 8a – 12n \ 12n – 4p \ 4p – 8p

**IN CASE OF EMERGENCY**

Please Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

## REFERENCES

Please choose two people who have known you longer than one (1) year.  
Please do not use the name of a relative.

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_

May we have your permission to contact the two references you have listed? Y \_\_\_ N \_\_\_

## HEALTH INFORMATION

Do you have any health restrictions do we need to be aware of? \_\_\_\_\_

Do you have any special needs do we need to make provision for? \_\_\_\_\_

Do you have any chronic illnesses, diseases or disabilities that might interfere with your service?

Y \_\_\_ N \_\_\_ If (yes), please explain briefly and state what accommodations you feel will be necessary:  
\_\_\_\_\_

Have you had a TB Test/Chest X-Ray within the last six (6) months? Y \_\_\_ N \_\_\_

(If yes, please provide a Xeroxed copy of the results for our records before your start date.)

## VOLUNTEER PLEDGE

Believing that Washington Adventist Hospital has a real need for my services as a volunteer, I pledge to:

- Conduct myself with dignity and courtesy at all times;
- Work harmoniously with others, using tact, understanding and compassion;
- Treat all information concerning patients as confidential;
- Be dependable in attendance, punctuality and performance of duties;
- Exhibit loyalty to the hospital, upholding standards, attitudes, vision and mission which influence the reputation of Washington Adventist Hospital in the community;
- Maintain a neat and clean professional appearance, keeping make-up and jewelry to a minimum and abiding by the volunteer dress code;
- Abide by all hospital safety requirements.

I agree to:

- Donate a minimum of 100 Hours of service to Washington Adventist Hospital within one calendar year;
- Abide by all the guidelines in the volunteer manuals;
- Perform my volunteer assignments without remuneration.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

I understand any omission or misrepresentation of information in this application may result in refusal of or separation from my volunteer service at the hospital. I certify that I am NOT volunteering as a court referral or attorney referral.

I certify that I am at least 15 years of age.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Days/Times of availability for second interview: \_\_\_\_\_

## VOLUNTEER HEALTH SERVICES INFECTION CONTROL QUESTIONNAIRE

Please answer the following questions. If you do not know the answer to a question, please try to find the answer by contacting your parent or physician. Since most of the diseases of concern are "childhood" diseases, you may have to contact your pediatrician if available. If you are unable to obtain information, check the "unknown" square. If you were born after 1956, you will be required to provide a copy of your MMR and Chicken Pox Vaccines. All schools require these vaccinations. Your cooperation in this matter is greatly appreciated.

NAME:	DOB:	AGE:	RACE:
ADDRESS:			
COUNTRY OF BIRTH:	SS# :	PHONE #:	
POSITION: Hospital Volunteer			
DATE OF LAST TB SKIN TEST:	RESULTS: (circle one) Negative (or) Positive		
HAVE YOU EVER HAD A CHEST X-RAY? (circle one) YES (or) NO      If Yes, WHAT YEAR:			

Have you ever had any of the following diseases or been vaccinated against them?

DISEASE	Have you ever had:		Been Vaccinated Against:		
	Yes	No	Yes	No	Unknown
Chicken Pox / Shingles					
Measles (M)					
Mumps (M)					
Rubella (R) German Measles					
Pertussis					
Diphtheria					
Tetanus					
Tuberculosis (TB)					
Hepatitis B					
Polio					

Have you ever donated blood and then were told not to donate again? \_\_\_\_\_

If you have any brothers or sisters, have they ever had Chickenpox? \_\_\_\_\_

Have you done any foreign traveling within the past year? \_\_\_\_\_ If "Yes", where? \_\_\_\_\_

Have you ever been treated for pulmonary tuberculosis (INH) \_\_\_\_\_

Are you currently taking any immunosuppressive drugs such as prednisone? \_\_\_\_\_ If "Yes", what? \_\_\_\_\_

**Application Questionnaire**

(Please complete all questions and return this form with your application)

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Why did you choose Washington Adventist Hospital to volunteer?

\_\_\_\_\_

Who referred you to our hospital?

\_\_\_\_\_

Please describe any previous volunteer experiences.

\_\_\_\_\_

Are you currently employed? What type of work?

\_\_\_\_\_

Why would you like to volunteer?

\_\_\_\_\_

Are you currently seeking employment?

\_\_\_\_\_

Why did you leave your last employment?

\_\_\_\_\_

What type of work do you enjoy?

\_\_\_\_\_

What are your spare time activities, hobbies or talents?

\_\_\_\_\_

What do you consider your greatest strength and weakness?

\_\_\_\_\_

Do you have a specific position in mind?

\_\_\_\_\_

Would you rather work with people or working alone?

\_\_\_\_\_

What makes you feel good about your work at the end of the day?

\_\_\_\_\_

Would you enjoy a fast-paced volunteer position or a calmer atmosphere?

\_\_\_\_\_

Do you have any computer experience?

\_\_\_\_\_

(continued on back)  
**Application Questionnaire Continued**

When would you like to start volunteering?

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Do you have any special needs or health restrictions we need to accommodate?

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Have you ever been convicted of a felony?

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Are you volunteering as a court or attorney referral?

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If requested, are you willing to submit to a drug test prior to your acceptance into the volunteer program?

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Are you willing to submit to a criminal background check?

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Do you have any questions or concerns?

*(These will be addressed during your interview with the Director of Volunteers.)*

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Can you agree to the below program requirements?

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1. A commitment to a minimum of 100 hours of service
2. Complete Self-Study Preparation Materials (provided by Office of Volunteers)
  - 4 hours of Hospital Volunteer Orientation
  - On-the-job training
  - A Tuberculosis Screening Test
  - Abide by Hospital Uniform, always wearing jacket and I.D. badge while volunteering
3. Treat all customers of the hospital with respect and care. Customers often receive their first impression of the hospital through interaction with the volunteer. It is important that all volunteers take their role seriously.

Thank you for applying to volunteer at Washington Adventist Hospital!

**Background Screening Disclosure and Consent**

In connection with my application for volunteering with Washington Adventist Hospital, I understand that investigative inquiries may be obtained on my self and that any such report will be used solely for volunteer related purposes. I understand that the nature and scope of this investigation will include a number of sources including, but not limited to, criminal convictions, motor vehicle, and other reports. These reports will include information as to my character, general reputation, personal characteristics, mode of living, and work habits. Information relating to my performance and experience, along with reasons for termination of past employment from previous employers, may also be obtained. Further, I understand that you will be requesting information from various Federal, State, County and other agencies that maintain records concerning my past activities relating to my driving, criminal, civil, education, and other experiences.

I understand that if the Office of Volunteers at Washington Adventist Hospital accepts me, it may request an investigative report about me for volunteer-related purposes during the course of my service. The scope of this investigation will be the same as the scope of a pre-employment investigation, and that the nature of such an investigation will be my continuing suitability for volunteering or whether I possess the minimum qualifications necessary for promotion or transfer to another position. I understand that my consent will apply throughout my volunteer service, unless I revoke or cancel my consent by sending a signed letter or statement to the Office of Volunteers at Washington Adventist Hospital at any time, stating the I revoke my consent and no longer allow the Office of Volunteers at Washington Adventist Hospital to obtain investigative reports about me.

I understand that I am being given a copy of the “Summary of Your Rights Under the Fair Credit Reporting Act” prepared pursuant to 15 U.S.C. Section 1681-1681u. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Office of Volunteers at Washington Adventist Hospital.

I authorize without reservation any party or agency acting on the behalf of Washington Adventist Hospital to furnish the above-mentioned information. I hereby consent to your obtaining the above information from:

Accurate Background, Inc.  
 6 Orchard, Suite 200  
 Lake Forest, CA 92630  
 800.216.8024

I understand to aid in the proper identification of my file or records the following personal identifiers, as well as other information, is necessary.

Your Legal Name:		
Last	First	Middle
List other names used (including maiden names, nicknames):		
E-mail address:		
Social Security Number:      --      --	Home Phone:	
Date of Birth*:	Other Phone:	
Address:		
City:	State:	Zip:
Please list all United States Cities and States you have lived in for the past seven (7) years:		
Signature:		Date:

\*DOB is used only if identification purposes by Accurate Background, Inc.