Adventist HealthCare
White Oak Medical Center

ADULT VOLUNTEER APPLICATION

Name	Male/Female	Date
Telephone (Home)	(Cell)	(Preferred)
Address		
City	State	Zip Code
E-Mail Address		Want to receive our email newsletter? Y/N
S.S. #	(or) Provide I-94 Card (Original)	Birth Month & Day

WORK EXPERIENCE

Current or most recent employer:	
Position held:	Full-Time ____ Part-Time ____ Dates:
Supervisor's name:	Telephone:
Reason for leaving:	
Previous or current volunteer experience:	

EDUCATION

Name of Institution:		Highest Level Completed:
Address:		Degree/Major:
City:	State:	Zip Code:
Currently enrolled: Yes_____ No_____		Fluent in what languages?

VOLUNTEER INFORMATION

Why would you like to volunteer? Select all that apply.
Spare Time ____ School Requirement ____ Internship Requirement ____ Court Mandated ____
Personal Enrichment _____ Interest in Healthcare _____Other reason: _____

Desired Choice of Volunteer Position (**Select all areas of interest)**

I would like to work with:
Computers_____ Patients_____ Public_____ Office Environment_____ Customer Service_____
I would **not** like to work with:
Computers_____ Patients_____ Public_____ Office Environment_____ Customer Service_____

Availability and Schedule (Indicate available time blocks)*

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.							
P.M.							

How many hours per day would you be interested in volunteering? _____ How many times/week? _____
*NOTE: Minimum shift of 4 hours is preferred.
What time of day would you like to start? _____ Finish? _____

EMERGENCY CONTACT

Name:	Relationship:
Telephone: Home ( )_____	Work ( )_____Cell ( ) _____

FOR OFFICE USE

Appointment:_____
Orientation:_____
Placement:_____
ID Check:_____

REFERENCES

Please choose two people who have known you longer than one (1) year that may be contacted. Please do not use relative.

Name _____ Phone ( ) _____
Relationship _____

Name _____ Phone ( ) _____
Relationship _____

HEALTH INFORMATION

Do you have any health restrictions we need to be aware of? _____
Do you have any special needs 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 within the last six (6) months? Y ___ N ___
Have you had a Chest X-Ray within the last five (5) years? Y ___ N____
(If yes, please provide a copy of the report for our records before your start date. This can serve in lieu of a TB skin test.)

VOLUNTEER PLEDGE

Believing that White Oak Medical Center 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 White Oak Medical Center 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 including volunteer uniform jacket & badge;
- Abide by all hospital safety requirements;
- Donate a minimum of 100 Hours of service to White Oak Medical Center within one calendar year;
- Abide by all the guidelines in the volunteer manuals;
- Contact my department if unable to make regularly scheduled shift;
- Perform my volunteer assignments without compensation.

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 18 years of age.

SIGNATURE: DATE:

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
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

Why are you applying to volunteer at White Oak Medical Center?

_____

_____

What have you gained from previous volunteer or work experiences?

_____

_____

Are you currently seeking employment?

_____

_____

What type of work do you enjoy?

_____

_____

Do you have a specific position in mind?

_____

_____

Would you rather work with people or work alone?

_____

_____

Do you need to begin volunteering by a specific date?

_____

_____

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

_____

Have you ever been convicted of a felony? Y_____ N_____

Are you volunteering as a court or attorney referral? Y_____ N_____

If requested, are you willing to submit to a drug test

prior to your acceptance into the volunteer program? Y_____ N_____

Are you willing to submit to a criminal background check? Y_____ N_____

Do you have any questions or concerns? *(These will be addressed during your interview.)*

_____

White Oak Medical Center Volunteer program requires the following:

1. A commitment to a minimum of 100 hours of service
2. Complete Self-Study Preparation Materials (provided by Office of Volunteers)
   Minimum of 4 hours 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 an interaction with a volunteer. It is important that all volunteers take their role seriously.

If you agree to these requirements listed above, please sign below.

Name:_____ Date:_____

Thank you for applying to volunteer at White Oak Medical Center!

Human Resources Department
Adventist HealthCare
1801 Research Boulevard, Suite 100
Rockville, MD 20850
Website: www.adventisthealthcare.com

Background Screening Disclosure and Consent

In connection with my application for employment (including contract for service) with Adventist HealthCare, I understand that investigative inquiries may be obtained on myself by a consumer reporting agency, and that any such report will be used solely for employment-related purposes. I understand that the nature and scope of this investigation will include a number of sources including, but not limited to, consumer credit, 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, credit, criminal, civil, education, and other experiences.

I understand that if the Company hires me, it may request a consumer report or an investigative consumer report about me for employment-related purposes during the course of my employment. 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 employment, or whether I possess the minimum qualifications necessary for promotion or transfer to another position. I understand that my consent will apply throughout my employment, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time, stating that I revoke my consent and no longer allow the Company to obtain consumer or investigative consumer 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. If I am applying for employment in the State of California or if I am a resident of California at the time of applying for employment, a summary of the provisions of California Civil Code section 1786.22 is also being provided to me with this form. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Company.

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

Certiphi Screening, Inc.
1105 Industrial Highway
Southampton, PA 18966
888.260.1370

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):	
Social Security Number: -- --	Home Phone:
Date of Birth*:	Other Phone:
Address:	
City: State: Zip:	
Please list all U.S. Cities and States you have lived in for the past seven (7) years:	
Signature:	Date:

*DOB is used only for identification purposes by Certiphi Screening, Inc.