Volunteer Application Packet

Thank you for your interest in volunteering at Memorial Regional Hospital South. The Memorial Healthcare System is recognized as one of the outstanding Healthcare Systems in the country. The volunteers are a dynamic group who everyday live the Mission and Vision of our Healthcare System.

Attached please find our volunteer application. There are also instructions attached for Teen Volunteers only.

What Is Expected Of A Memorial Regional Hospital South Volunteer

- A desire to meet the needs of our community, patients, families, visitors, physicians, and employees.

- A commitment of a four-hour shift per week and minimum 6 months and 100 hours of service.

- Purchase of a Volunteer uniform ($20.00). All fees are non-refundable.

- A completion of a Flu shot and Tuberculosis screening (two-part process).

- Completion of a background screening. (Adults 18 years old and over)

- Completion of New Volunteer Orientation.

- Please note: We do not accept court ordered community service hours.

Please call Volunteer Services at 954-518-5460 for additional information or to schedule an interview. Bring the completed application with you (along with other required documents) when you come for the interview. Thank you.

3600 Washington Street, Hollywood, FL 33021
TEEN VOLUNTEER INSTRUCTIONS

If you are a potential Teen Volunteer please have all the following prior to calling for an interview:

1. A completed Volunteer Application, with your parent/guardian's signature.
2. A character reference letter on letterhead from a responsible person other than a family member is required.
3. A complete copy of your most recent Academic Transcript/Report Card showing a 2.50 GPA or above. This is a cumulative GPA, not for one semester.
4. Proof of age, (must be at least 14 years of age) i.e., Drivers License or Birth Certificate.

If you do not have all the above or meet the above criteria please do not call and schedule an appointment.
MEMORIAL REGIONAL HOSPITAL SOUTH
VOLUNTEER APPLICATION

PLEASE PRINT

CIRCLE ONE:  ADULT  STUDENT  TEENAGER

DATE: ________________

NAME: ____________________________
  Last  First  M.I.

ADDRESS: ____________________________
  Street Address  Apartment Number
  City  State  Zip

EMAIL ADDRESS: ____________________________

PRIMARY PHONE #: ____________________  SECONDARY PHONE #: ____________________

DATE OF BIRTH: __/__/________  SEX:  FEMALE  MALE

SOCIAL SECURITY #: ____________________  DRIVER’S LICENSE #: ____________________

PLEASE LIST ALL CITIES AND STATES WHERE YOU HAVE LIVED – THIS IS FOR BACKGROUND
CHECK PURPOSES ONLY

PREVIOUS ADDRESS: ____________________________
  City  State  Zip

PREVIOUS / CURRENT OCCUPATION: ____________________________

PERSONAL OR WORK REFERENCE: ____________________________
  Name  Phone #

EMERGENCY CONTACT: ____________________________
  Name  Relationship  Phone #

NAME OF YOUR DOCTOR: ____________________________
  Physician’s Name  Phone #

SIGNATURE: ____________________________

Prospective volunteers will be subjected to a background check. Opportunities for volunteers are provided
without regard to religion, creed, race, national origin, age, sex, marital status or disability.
MONTHS AVAILABLE:
(PLEASE CIRCLE ALL THAT APPLY)

JAN  FEB  MAR  APRIL  MAY  JUNE  JULY  AUG  SEPT  OCT  NOV  DEC

PLEASE CHECK THE TIMES YOU ARE AVAILABLE TO VOLUNTEER.

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PLEASE SELECT THE AREA YOU FEEL YOU WOULD BEST BE ABLE TO SERVE

- Admitting/Regist.
- Adult Day Care
- Clerical
- Materials Mgmt.
- Outpt. Therapy
- Services
- 4th Floor Nursing
- 5th Floor Nursing
- 6th Floor Nursing
- 5th Floor - 2p-6p
- Admissions Asst.
- Inpatient Rehab-Gym
- Lab
- Emergency Dept.
- Outpatient Lab
- SBCHS Clinics
- Surgical Waiting
- Organizational
- Development
- Pet Therapy
- Deliver Mags.
- Transportation
- Women’s Imaging
- Outpatient
- Services

Other: __________________________________________

We do not place volunteers in these areas: RESPIRATORY THERAPY, BILLING & CODING, MEDICAL RECORDS, ULTRASOUND

Do you speak or write any foreign language? YES NO
(If yes, please indicate which language(s): __________________________)

PREVIOUS VOLUNTEER EXPERIENCE: __________________________________________

ARE THERE ANY VOLUNTEER DUTIES YOU WILL BE UNABLE TO PERFORM SAFELY?
(YES) (NO) IF YES, PLEASE EXPLAIN

__________________________________________

How did you learn about our volunteer program?
Newspaper _____ Newsletter _____ From a friend _____
Web site _____ Volunteer Recruitment Event _____
Ad in program or bulletin _____ School _____

Describe what you want to get from your volunteer experience with this organization, by checking all that apply:

Social interaction/fun _____
A sense of giving back _____
Networking opportunities _____
Increase skills _____
An activity different from work life _____
An activity similar to my work life _____
Other ____________________________
TEENAGE VOLUNTEERS ONLY

INFORMATION FOR PARENTS

1. All teenagers must be interviewed and approved by the office of Volunteer Services.
2. All teenagers must submit a complete application at the time of the scheduled interview.
3. It is the responsibility of the teen volunteer to provide his/her own transportation.
4. Uniforms must be worn at all times.
5. Teen uniforms consist either of white/khaki/black pants, MRHS Volunteer Polo Shirt or Jacket. Total cost for uniform is $20.00.
6. All volunteers are expected to work a four-hour shift per week and are entitled to a free meal.
7. Service hours will be awarded at the completion of their six-month commitment. Service hours letters must be requested within a month of leaving the Volunteer Services Department.

PARENTAL CONSENT FORM
MEMORIAL REGIONAL HOSPITAL SOUTH TEENAGE VOLUNTEER PROGRAM

Date: ______________

My daughter/son has my consent to become a Teenage Volunteer for Memorial Regional Hospital South. In addition, I do hereby give my consent to test to have a Purified Protein Derivative (PPD), to test for Tuberculosis, and a Flu shot as part of standard pre-employment/volunteer, physical assessment process.

Parent’s Name (please print): ______________________________________

Parent’s Signature: ________________________________________________

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Home Phone: ____________________ Work Phone: ____________________
INFORMATION FOR BACKGROUND CHECK PURPOSES
for 18 years and older only

Have you ever been convicted of a felony? Yes ______ No ______
Have you ever pled Nolo Contendre (no contest) to a felony? Yes ______ No ______
Have you ever pled guilty to a felony? Yes ______ No ______
Have you ever been found guilty of a felony? Yes ______ No ______
Have you had an adjudication withheld for a felony? Yes ______ No ______
Have a nol pros for a felony? Yes ______ No ______
Are you presently charged with a felony? Yes ______ No ______

Have you ever had to serve probation in any pre-trial intervention as a result of a criminal charge? Yes ______ No ______

NOTE: A yes response does not necessarily disqualify an applicant from acceptance as a volunteer.

PLEASE LIST ANY CITY/STATE WHERE YOU HAVE RESIDED, PLEASE INCLUDE MONTH AND YEAR.

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Due to the high cost of background checks if you fail to complete the six-month minimum commitment and minimum 100 service hours re-instatement will not be considered. Please ask for clarification if this is not clear to you.

I acknowledge that I have read and understand the commitment I am making.

Signature: ________________________________

Date: ____________________
NOTICE TO APPLICANT OR EMPLOYEE OF INTENT TO OBTAIN AN
INVESTIGATIVE CONSUMER REPORT

Dear Applicant or Employee:

In connection with your application or employment, Memorial Healthcare System would like to procure certain background information concerning you which is contained in an investigative consumer report. An investigative consumer report may contain information regarding your: creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, and/or criminal background. This information may be gathered from personal interviews with your neighbors, friends, and/or associates, e.g., former employers.

Before we may procure an investigative consumer report, you must authorize such procurement in writing. You have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report. However, if you are an applicant, we will not consider you further for employment if you so decline. If you are an employee, we may consider employment action if you decline.

We intend to ask your former employer(s) the following questions concerning you:

- What were the dates of your former employment?
- What position(s) did you hold?
- Were you ever demoted or otherwise disciplined? If so, what were the circumstances?
- Did you perform your job in a satisfactory manner?
- Under what circumstances did you leave?
- Would you rehire the individual?

On the next page of this form you will find a release which will allow us to obtain an investigative consumer report concerning the foregoing questions. Please read the release carefully before signing it and indicating your choice regarding disclosure.
RELEASE TO PROCURE AN INVESTIGATIVE CONSUMER REPORT

I have read the "Notice to Applicant or Employee" on the other side of the form.
I understand that I have the right to decline authorization for Memorial Healthcare System to
procure an investigative consumer report concerning me.

I understand that the investigative consumer report may contain information concerning my:
creditworthiness, credit standing, general reputation, personal characteristics, mode of living,
and/or criminal background. I also understand that this information may be gathered from
personal interviews with my neighbors, friends, and/or associates, e.g., former employers.

As disclosed on the back of this form, I understand the nature and scope of the investigation that is
going to be made into my background.

Understanding these rights,

☐ I **authorize** Memorial Healthcare System to procure an Investigative Consumer Report
   concerning me.

☐ I **do not authorize** Memorial Healthcare System to procure an Investigative Consumer
   Report concerning me.

(Please Print Your Name): ______________________________________________________

SIGNATURE: ________________________________________________________________

DATE: __________________________