Volunteer Services Application

Name: Mr. Mrs. Ms. Dr. _____ **Suffix:** _____
Print First Name Print Last Name Credentials

(Optional) Spouse & Children's Names: _____

Local Address: _____
No. Street Apt. City Zip

Local Phone Number: ( ) _____ **Local Email**: _____

Off-Season Address: _____
No. Street City State Zip

Off-Season Phone Number: ( ) _____ Off Season Email: _____

Emergency Contact: _____ (_____) _____
Print Name Relationship Phone Number

Are you 18 or older? Yes☐ No☐ If not, what is your date of birth? _____

__ Clinical Nursing: FL License? Y☐ N☐ License # _____

__ Clinical Medical Doctor: FL License? Y☐ N☐ License # _____

The type of volunteer positions I am applying for (please check all that you are interested in):

☐ Clinical Volunteers (Drs, RNs, DDS, other certified professionals)
☐ Clerical Support Volunteer Staff
☐ Ronald McDonald Care Mobile® Volunteer *Staff*
☐ Special Projects
☐ Other \Explain: _____

I am looking for Required Volunteer Service Hours / internship / Preceptorship for Graduation: Y☐ N☐

If Yes, please tell us your grade : ☐ High School ☐ Higher Education (vocational , college, etc.)

Name of School _____ Major _____

****Shadowing does not meet the criteria for Volunteer Service Hours ****

Requested Work Hours: (*Please fill in the blank or circle the options*)

I can commit to working ___ hours-per-week from _____ to _____ .
Month / Date Month / Date

Preferences (circle): weekday mornings☐ / afternoons☐ / Comments: _____

Rev. 12/2/2013

Please provide three character references (non-relatives) that would be willing to talk to us about you.

1. _____ (_____)_____
   PRINT: First & Last Name | Address | Phone Number

2. _____ (_____)_____
   PRINT: First & Last Name | Address | Phone Number

3. _____ (_____)_____
   PRINT: First & Last Name | Address | Phone Number

Healthcare Network of Southwest Florida. is a smoke free, drug free, violence free employer with a zero tolerance policy for its Volunteer Program prohibiting any type of discrimination based on age, race, sex, sexual orientation, religion, national origin, veteran's status or disability.

Healthcare Network reserves the right to take all appropriate steps to maintain the safety and health of our patients, visitors, volunteers and staff at all times. Honesty and integrity are important values of our programs.

Do you have any current or pending investigations? Y☐ N☐ (Please attach explanations for all investigations.)

Have you ever been convicted *of* / entered a plea of nolo-contendre *to* a crime against person or property? Y☐ N☐
If yes, please attach a separate sheet of paper explaining the situation. Applicant's Initials: _____

I pledge that the statements and information provided herein are truthful and accurate to the best of my knowledge, understanding that any intent to mislead via omission or misrepresentation of the facts provided herein is grounds for immediate dismissal from the Healthcare Network Volunteer Program. All offers of volunteer placement are contingent upon receipt of all necessary materials, successful completion of training, successful job performance and the maintenance of good moral and ethical character.

_____
Volunteer Applicant Signature — Today's Date

_____
Parent/Legal Guardian Signature — Phone — Today's Date

Healthcare Network Volunteer Program Space

Application Received By: _____ ____/____/____
Healthcare Network Representative — Date

Applicant Contacted: ___/___/____ By: _____
Date — Healthcare Network Representative

Volunteer is being placed at : _____ ***Under the supervision of:*** _____

Received and Filed:

- ☐ Copy of Current Driver's License
- ☐ Copy of Current Inoculation Record
- ☐ Copy of Resume
- ☐ Copy Medical Questionnaire
- ☐ Copy of License(s)
- ☐ Copy of Confidentiality Form
- ☐ Copy of Explanation: Investigation / Conviction
- ☐ Other:

NOTE

_____

Rev. 12/2/2013

Medical Screening

We ask that you complete this form upon acceptance of a Conditional Offer of Employment. You are also asked to provide any evidence of immunization you have (see reverse side). **This form and evidence of immunization should be faxed or mailed promptly to Healthcare Network of Southwest Florida, Attn Human Resources at FAX: 239-658-3078** or 1454 Madison Avenue, Immokalee FL 34142. You may do this yourself, or you may ask the manager with whom you interviewed to return it to HR.

Our purpose is to assure that you are not placed in a job that would pose undue risk of infection to yourself, other personnel, patients or visitors. All health records are confidential and will be kept in locked file in the HR office.

Name _____ SS# _____

Preferred Phone Number (for Occupational Health Nurse Use) _____

Date of Birth _____ Job Title/Position/Duties _____

Date Screen Completed _____ Jobsite _____

Do you currently have:	**Yes**	**No**
Conjunctivitis (drainage or symptoms of eye infection)		
Herpetic Lesions – On hands (whitlow) or Mouth (fever blisters)		
Diarrhea or Vomiting		
Sore Throat		
Sores in Mouth		
Persistent Cough		
Rash		
Draining Skin Lesion		
Herpes Zoster (Shingles)		
Chronic or Acute Hepatitis B		
Hepatitis A		
Recent exposure to any of the following diseases:	**Yes**	**No**
Meningococcal Infect		
Measles		
Mumps		
Rubella (German Measles)		
Varicella (Chicken Pox)		
Scabies		
Tuberculosis		
Having any of the following conditions or treatments may put you at greater risk for contracting an illness on the job. It may also influence your vaccine requirements.	**Yes**	**No**
Do you have diabetes		
Are you pregnant		
Are you HIV positive		
Do you have leukemia		
Do you have lymphoma		
Do you have generalized malignancy		
Are you immune suppressed as a result of:		
Steroid Therapy (15 mg or more daily)		
Chemotherapy		
Radiation		
Asplenia or Persistent Complement Compound Deficiencies (i.e., lupus)		
Do you have hypersensitivity to latex		
Do you feel you are physically and mentally capable of performing your job requirements?		

I attest that I have answered all the above questions honestly and to the best of my ability.

Signature: _____ Date _____

Reviewer's Name: _____

Reviewer's Signature: _____Date _____

Job Required Vaccines and Tests

In order to comply with company policy, all persons working in company facilities must be able to prove immunity to several vaccine preventable diseases. Please provide the Occupational Health Nurse or designee with proof of immunity to the following diseases:

DISEASE	ACCEPTABLE PROOF
MEASLES	1. Documentation of 2 doses of live vaccine on or after your 1st birthday 2. Lab evidence of immunity or disease
MUMPS	1. Documentation of having received 2 doses of mumps vaccine 2. Lab evidence of immunity or disease
RUBELLA	1. Documentation of live vaccine on or after 1st birthday 2. Lab evidence of immunity or disease
VARICELLA ZOSTER	1. Documentation of physician diagnosed varicella or herpes zoster 2. Evidence of 2 doses of varicella vaccine 3. Lab evidence of immunity or disease
PERTUSSIS	1. Documentation of Tdap vaccine
INFLUENZA	1. Documentation of vaccine during most recent influenza season
HEPTATITIS B	For those individuals who provide medical care, or who may be exposed to blood and body fluids, proof of immunity to Hepatitis B must be provided. 1. Documentation of Hepatitis B vaccines 2. Lab evidence of immunity or disease
TUBERCULOSIS	1. Documentation of a tuberculin skin test in the past year or 2. Documentation of previous treatment for Latent Tuberculosis Infection (LTBI) or Tuberculosis Disease (TB). 3. If previous history of treatment for LTBI or TB, an interpretable copy of a chest x-ray done in the past 6 months.

If you are unable to provide any of the required documents, the necessary lab test and procedures will be ordered by the occupational health nurse prior to your first day on the job.

If you have any questions, please contact the occupational health nurse.

Volunteer Program / Confidentiality Form

As a volunteer at Healthcare Network, I understand and agree that I must abide by the same standard of patient confidentiality as all Healthcare Network employees, including the standards of HIPAA (the Health Insurance Portability and Accountability Act).

I understand that all patient information is confidential by law. Patient information *includes but is not limited to* the following:

Patient Name	Patient Contact Information
Patient Date of Birth	Patient Medical Information
Patient Address	Patient Prescription Information
Patient Phone Number	Name of Patient's Doctor
Patient Social Security Number	Reason for Patient's Visit

Volunteers are prohibited from discussing patient information with persons other than those directly involved in the patient's care. As permissible, all conversations should be held in the utmost private manner, away from others who could overhear information.

Breach of confidentiality is very serious and carries with it the possibility for disciplinary action, legal and financial penalties. ***Please keep all patient information confidential.***

_____

Volunteer Signature

_____

Date