Sparks Auxiliary
Volunteer Services

**Please select desired area:**

_____ Auxiliary
_____ Hospital Volunteer
_____ Chaplain Volunteer

Name _____

Address _____

Cell Phone _____ Home Phone _____

Email_____ Social Security no._____

DOB _____ Aliases _____Male _____ Female_____

Emergency Contact _____ Phone number _____

Relationship _____ Work number_____

Previous volunteer experience _____

Contact person to verify experience _____ Phone no _____

## Day of Week/Time of Day

Days available: MON TUES WED THURS FRI SAT SUN

Morning _____ Afternoon _____ Evenings_____ Hours desired _____

Please describe any special needs you may have in regard to the day of the week or time of day you volunteer _____

Volunteer assignment preference: _____

Available: Days per week _____ Days per month _____

## Current Employment (If Applicable)

Current employer _____ Start date_____

Address of employer _____

Previous employer _____ From _____ To _____

## Work Experience or Interest
## (check all that apply)

Chaplain _____ Visiting Clergy _____ Foreign Language _____ Nursing _____

Accounting/Booking _____ Cashiering _____ Computer/Word Processing _____

Clerical/Office _____ Fitness Center _____ Arts & Crafts _____ Musical _____

Sewing _____ Reading _____ Photography _____ Other _____

_____ _____
Volunteer Signature Date

_____ _____
Interviewer Date

_____ _____
Volunteer position Orientation date

## Health Information

Physician's name _____ Phone number _____

Address _____

Health limitations _____

Allergic to _____

Have you ever had a tuberculosis skin test? **Yes/No** If you have had test in the last twelve months, please provide documentation.

I hereby certify that the above is true and complete to the best of my knowledge. I realize this information is confidential and may be used to determine my eligibility to volunteer. I authorize Sparks to make inquiry to my physician regarding the state of my health.

I agree to submit to examinations which may include appropriate immunizations, chest x-rays and/or laboratory tests which may be necessary as part of my volunteer services. I hereby authorize my doctor(s) to furnish Sparks information concerning my health. I also authorize the person(s) making tests or x-ray films to report the results to the hospital.

**Applicants signature**_____ Date _____

Believing that Sparks has need of my services as a volunteer, I agree to:

Hold as absolutely confidential all information which I may obtain directly or indirectly concerning patients, doctors or associates and I will not seek confidential information in regards to a patient.

My services are donated to Sparks without contemplation of compensation or future employment and are given with humanitarian or charitable reasons.

**Applicants Signature** _____ Date _____

To help establish my eligibility to volunteer, I hereby authorize Sparks Regional Medical Center, its subsidiaries and affiliates to conduct a background check and to request and receive appropriate report(s) which may include information as to my character, general reputation, personal characteristics. The request of an applicant's social security number is to verify identity, employment history and eligibility under immigration laws.

I authorize any former employer, or medical provider to release information and documentation which is deemed relevant to my application to volunteer.

I understand that any offer to volunteer is conditioned on the satisfactory completion of all relevant aspects of my background check.

If accepted as a volunteer, I agree to observe any and all policies, practices, and rules of the organization, which may be amended from time to time. Violation of any such policy, practice or rule may subject me to disciplinary sanctions including dismissal.

If accepted, I hereby consent to any required security investigation. Refusal to cooperate with or submit to any lawful security investigation may be grounds for dismissal.

I understand that any volunteer relationship with the organization, its subsidiaries or affiliates is an at-will relationship, meaning that the relationship can be terminated at any time for an reason by either myself or the organization, as stated in the Sparks Bylaws and policies.

I certify that the information provided in this application is correct to the best of my knowledge. I understand that if any statements made by me, either in this application or otherwise, are found to be false or misleading in any way, either because of the nature of the statement themselves or because of omitted information which makes any such statements false or misleading, my application may be excluded from further consideration or, if accepted, I may be subject to dismissal.

Have you ever been convicted, or pleaded "no contest" to a felony and/or misdemeanor?
_____No _____Yes

If yes, Where _____ When _____ Explain _____

**Applicants signature**_____ Date _____

It is the policy of Sparks Regional Medical Center, its subsidiaries and affiliates, that equal employment opportunity be available to all without regard to race, color, religion, national origin, sex, age, disability or marital status.

## Chaplains Section

PRESENT CHURCH _____
Name of Church, Years

PREVIOUS CHURCH _____
Name of Church, Years

PREVIOUS CHURCH _____
Name of Church, Years

What do you feel should be your role as a volunteer chaplain? _____

_____

Which of your spiritual gifts could be used here at the hospital? _____

_____

Where do you draw the line concerning witnessing, or proselytizing while on duty?

_____

How do you know when someone does not want to talk, or is tired, or is ill? _____

_____

Why is it important to keep patient information confidential? _____

_____

_____ _____
Signature Date