Community Hospital Anderson

OFFICE USE ONLY / Date received _____

INTERVIEW Date & Time _____

1515 N Madison Ave, Anderson IN 46011
T 765.298.1025
anne.runyan@eCommunity.com

VOLUNTEER APPLICATION

DATE: _____

NAME: _____
Last First Middle (or Middle Initial)

ADDRESS: _____
Street City State Zip

EMAIL ADDRESS: _____

TELEPHONE Home: _____ Cell: _____

Work: _____

SPOUSE'S NAME: _____ EMERGENCY CONTACT Phone: _____

FAMILY PHYSICIAN NAME: _____ Phone: _____

TEEN VOLUNTEERS (14-17 years of age)
School Name: _____ Year of Graduation_____ Grade: ☐8 ☐9 ☐10 ☐11 ☐12
As a parent/guardian I consent to let Community Hospital Anderson administer a TB skin test (Mantoux) to my son/daughter _____ Date _____ Phone _____

PERSONAL INFORMATION

Tell us why you have an interest in volunteering: _____

_____

How did you find out about our program? _____

_____

Education: ☐completed High School/GED ☐some College/Spec Training ☐completed College/Spec Training

If you are a college student, what is your major or field of study? _____

_____

Do you have a current Indiana Driver's License? ☐Yes ☐No

Do you have your own transportation? ☐Yes ☐No

Have you ever been convicted of or pled guilty to a felony or misdemeanor other than a minor traffic violation? If yes, explain: _____

Hospital employees/Auxiliary members at Community Hospital acquainted with: _____

_____

List any limitations: _____

Have you ever been employed by Community Health Network or Affiliate? ☐ Yes ☐ No
If Yes, position(s) _____

PERSONAL REFERENCES
Do NOT list relatives or former employers:

1._____
Name Address City/State/Zip Phone# Yrs. Known

2. _____
Name Address City/State/Zip Phone# Yrs. Known

JOB, VOLUNTEER OR COMMUNITY SERVICE EXPERIENCE and AFFILIATIONS:

List below most recent employment or volunteer experience.
Be sure to include previous employment with Community Hospital Anderson and any military experience.

_____/____to ____/_____
Name and Address From Mo./Yr. to Mo./Yr.

_____
Reason for Leaving

_____
Position(s) Held Type of Business

_____
Immediate Supervisor's Name and Title

PREFERENCES / AVAILABILITY

Please check all special skills and interests:

SKILLS

☐Good people skills
☐Calm under stress
☐Computers/typing
☐Cashier
☐Public reception area
☐Courier service
☐Sewing/crafts
☐Bookkeeping
☐Fundraising
☐Music
☐Art
☐Tour guide
☐Foreign language/sign language skills
☐_____(other)

SERVICE PREFERENCES

☐Gift Shop
☐Guest Services
☐Same Day Surgery
☐Physical Therapy
☐Pharmacy
☐Emergency Room
☐X-Ray/Imaging
☐Courier
☐Medical Records
☐Cancer Center
☐Employee Health
☐Farm (and Gardening)

Days available to Volunteer (*Circle Preferences*):

Monday Tuesday Wednesday Thursday Friday

Saturday Sunday Open Available to Substitute

Hours available to Volunteer:

8:30am – 12:30pm

12:30pm – 4:30pm

4:30pm – 7:00pm

PLEASE READ CAREFULLY

I will consider as confidential all information which I may hear directly or indirectly concerning a patient, a doctor, or any member of hospital personnel. I will not express curiosity in regard to a patient beyond the carrying out of my duties.

The facts contained in this application are true and complete. I understand that if I became a volunteer, any false statements on this application will be cause for release from the program. I authorize Community Hospital Anderson to contact my current and/or former employers or volunteer agencies and any other person who may have information bearing on my suitability for volunteer work. If accepted as a volunteer, I will fulfill my commitment of service and maintain annual education and health testing. I authorize Community Hospital Anderson to complete the Criminal History Check.

_____*Signature* _____*Date*

APPLICATION PROCESS CHECK SHEET FOR VOLUNTEER OFFICE STAFF:

- ☐ Interview appointment scheduled for _____
- ☐ Interview completed
- ☐ Confidentiality Waiver signed
- ☐ Orientation scheduled for _____
- ☐ Volunteer assigned to _____
- ☐ First day on the job training _____
- ☐ Handbook given
- ☐ TB test completed
- ☐ Reference checked
- ☐ Criminal background check recorded
- ☐ Smock/shirt given
- ☐ Name badge issued
- ☐ File recorded in computer
- ☐ Birth date _____

VOLUNTEER EXIT CHECKLIST:

- ☐ Exit interview given
- ☐ Smock and name badge returned
- ☐ Termination recorded in computer
- ☐ Application archived

General Information for Volunteer Applicants

Health Screening: TB screening is required with the Employee Health Department located at Community Hospital Anderson. A flu shot is also required. These are provided at no cost to the volunteers.

Criminal History Check: All new volunteers over the age of 18 must pass a criminal history background check by the Indiana State Police.

Orientation: all volunteers are required attend volunteer orientation. You will be given important resources that should be studied. Additional training will occur, depending on your specific volunteer assignment. In some cases, you will shadow a current volunteer or hospital employee in your designated area.

Uniforms: Uniforms are provided to each volunteer. A name badge will be provided and is to be worn on your uniform at all times. Uniforms must be worn while volunteering. The dress code consists of black, khaki or white pants, the under shirt of your choice, with your Community Hospital Anderson smock, vest or polo shirt over it. Shoes must be closed toed and heel covered. When a volunteer ends their service to the hospital, they are required to turn in their name badge to the Volunteer Services office.

Parking: Parking is free. You will be instructed on where to park in Orientation.

Meal: One free meal (totaling $7 or less) will be provided on the day you volunteer.

Sign in/out: Volunteers sign in and out using a touch screen computer. You will be trained on this procedure. Service hours are tallied from these records, as well as annual hospital reports and are available for you for scholarship applications, tax purposes, etc.

Attendance: Volunteers and staff have a better experience if volunteers commit to a consistent schedule. If you cannot volunteer due to illness, vacation, etc., please contact the Auxiliary office at 765-298-5100 or the CHA employee with whom you volunteer.

Again, welcome to our team and thank you for helping us always create exceptional experiences for our patients, families, staff and guests at Community Hospital Anderson. If you have any questions, please don't hesitate to contact us. We look forward to working with you!

Sincerely,

Lorie Staehler

Volunteer Services Director

Community Hospital Anderson

CRIMINAL HISTORY CHECK AUTHORIZATION & ACCESS CONTROL REQUEST FORM

CRIMINAL HISTORY CHECK AUTHORIZATION

APPLICANT'S LEGAL NAME _____
(Last) (First) (Middle Initial)

ADDRESS_____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

GENDER (circle one) M F

RACE _____

I authorize Community Hospital Anderson to perform a criminal history check on my record.

Applicants Printed Name _____

Applicants Signature _____

Date _____

ACCESS CONTROL REQUEST

PRIMARY WORK SITE: CHA

DEPARTMENT NAME AND COST CENTER: Volunteer Services 94000

DEPARTMENT PHONE NUMBER: 765-298-1025

SUPERVISOR: Lorie Staehler

It is the responsibility of each approved user to take every precaution to ensure the security of the access control card and information relevant to its use and prevent it from its use by unauthorized individuals. The borrowing of the access control card by another (authorized or unauthorized) is strictly prohibited. It is the responsibility of the user to report lost or stolen cards to security immediately at 83301.

Failure by a volunteer to take such precautions will be grounds for disciplinary action in accordance with policy PER-20, Employee Disciplinary Action. The offense will be classified as a Major Offense, as defined in PER-20, or may be reclassified as a Major Offense, or an Intolerable Offense, depending of the circumstances.

In such cases as an employee transfer to another department or leaves CHA as a volunteer, the volunteer is required to return the access control card to his/her department Supervisor. Failure to return the access control card will result in a charge of **$30.00**. This fee will also be applied to any lost cards. Damaged of non0-working cards will be dealt with on an individual basis.

I agree to the terms herein. I will take all responsible precautions to ensure the security of the access control card.

Signature_____ Date _____

Card # Issued _____

Community Hospital Anderson

Permission to Photograph/Videotape

I consent to and authorize Community Hospital Anderson/Community Health Network and its representative to take photograph(s) and/or videotape(s) of

Name of subject _____ with the full understanding that such photograph(s) and/or videotape(s) may be used for publication, for media broadcast, for educational or research purposed or for insurance or legal purposes. In addition, I consent to the use of my name and quotation for such purposes, as well.

The offices, employees and trustees of Community Hospital Anderson/Community Health Network and its appointed representative are hereby released without recourse from any liability arising from the taking and used of such photograph(s), videotape(s), name or quotation.

The undersigned also hereby transfers and assigns to Community Hospital Anderson/Community Health Network the exclusive right to authorize others to use all or any part of such photograph(s), videotapes(s), or name or quotation for publication, for media broadcast, for educational or research purposes or for insurance or legal purposes and to copy the material onto all other formats and media.

I have read the above and od sent on this _____day of _____(month), 20____.

_____ _____

Signature of subject or parent/guardian of subject *Witness*