

VAL VERDE REGIONAL MEDICAL CENTER

VOLUNTEER APPLICATION

PERSONAL INFORMATION

NAME: _____
Last
First
M.I.

ADDRESS: _____
Street
City/State
Zip

PHONE: _____ **EMAIL ADDRESS** _____

EMERGENCY CONTACT INFORMATION

Name	Phone Number	Relationship
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HAVE YOU EVER PLED GUILTY OR NO CONTEST TO AND/OR BEEN CONVICTED OF ANY CRIME, FELONY OR MISDEMEANOR, OTHER THAN A TRAFFIC CITATION? NO YES (MUST PROVIDE DETAILS)

Details:

ARE YOU AT LEAST 18 YEARS OF AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER BEEN EMPLOYED BY VVRMC OR ITS AFFILIATE CLINICS? <input type="checkbox"/> NO <input type="checkbox"/> YES WHERE:
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WHAT ARE YOUR VOLUNTEER INTERESTS? Auxiliary Hospice Chaplaincy HOPE Cancer Room OTHER _____

PLEASE DESCRIBE WHY YOU ARE INTERESTED IN VOLUNTEERISM AT VVRMC?

ARE YOU VOLUNTEERING TO COMPLETE A PROGRAM OR COURSE OF STUDY? NO YES (Must provide details and attach documentation)

Details:

PLEASE LIST SKILLS, SPECIAL TRAINING, OR FOREIGN LANGUAGES YOU POSSESS.

WHAT HOURS AND DAYS ARE YOU ABLE TO VOLUNTEER?	SUN.	MON.	TUE.	WED.	THURS.	FRIDAY	SAT.

PLEASE PROVIDE PREVIOUS EMPLOYMENT OR VOLUNTEER WORK.	EMPLOYER	DATES	SUPERVISOR NAME
	EMPLOYER	DATES	SUPERVISOR NAME

PLEASE PROVIDE 3 REFERENCES WHO ARE NOT RELATIVES.	NAME	PHONE
	NAME	PHONE
	NAME	PHONE

I understand that willfully making false statements on this application will be sufficient cause for non-placement in volunteer service and or grounds for immediate dismissal. I authorize VVRMC to check any references listed on this application in addition to any additional background, drug and health screening. I understand that this application does not bind me or VVRMC for any specific period regarding volunteerism. I understand that my services are donated to the hospital without contemplation of compensation or future employment. I am responsible for attending any orientation and familiarizing myself with VVRMC's policies and procedures.

SIGNATURE OF APPLICANT

DATE
OVER FOR AUTHORIZATION

AUTHORIZATION (FOR INTERNAL USE ONLY)

ACTIONS	RECOMMENDED VOLUNTEER AREA	START DATE
<input type="checkbox"/> SELECTED <input type="checkbox"/> NOT SELECTED	<input type="checkbox"/> Auxiliary <input type="checkbox"/> Hospice <input type="checkbox"/> Chaplaincy <input type="checkbox"/> HOPE Cancer Room <input type="checkbox"/> OTHER _____	
SUPERVISOR/COORDINATOR SIGNATURE TO PROCEED		DATE

HR CHECKLIST

- APPLICATION
- INTERVIEW
- DRUG/BACKGROUND AUTHORIZATION
- DRUG SCREEN INITIATED
- BACKGROUND SCREEN INITIATED
- DRUG SCREEN CLEARED
- BACKGROUND SCREEN CLEARED
- HEALTH SCREENING/TB CLEARED
- NOTIFY VOLUNTEER COORDINATOR(S) TO PICK UP PACKET

VOLUNTEER COORDINATOR(S) CHECKLIST

- ORIENTATION SCHEDULED
- ORIENTATION COMPLETE – CLEAR TO START