Dignity Health.
St. Elizabeth Community Hospital
Auxiliary

Volunteer Application

Personal Information – Please Print Clearly

Last Name _____ First Name _____ Middle Initial (Name to appear on badge) _____

Address _____ (Apt. #) _____ (City) _____ (State) _____ (Use 9-Digit Zip Code) _____

Home Phone: _____ E-Mail: _____

Cell Phone: _____ Birthday Month/Day/Year: _____ / _____ / _____

Education – Check all that apply

High School ☐ College ☐ Post Graduate ☐

Degrees: _____ GPA: _____

Work Status

Employed ☐ Unemployed ☐ Retired ☐ If employed, current employer: _____

Skills/Work Experience

Accounting ☐ Leadership ☐ Nursing ☐ Computer ☐ Teaching ☐ Public Speaking ☐ Clerical ☐

Sports ☐ Graphic Design ☐ Writing ☐

Other (please list): _____

In An Emergency – Please Notify

First Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

How did you hear about the program?

Friend ☐ Newspaper ☐ Brochure ☐ Bulletin Board ☐ Web Site ☐ Facebook ☐

Other (Please Specify): _____

Volunteer Availability: (Please indicate the days and times you are available)

A.M. Hours 8:00 - 12:00
P.M. Hours 12:00 - 4:00
Breakfast OR Lunch included with every 4-hour shift.

Monday:	A.M. ☐	P.M. ☐	
Tuesday:	A.M. ☐	P.M. ☐	
Wednesday:	A.M. ☐	P.M. ☐	
Thursday:	A.M. ☐	P.M. ☐	Weekly: ☐
Friday:	A.M. ☐	P.M. ☐	Alternate Weeks? ☐

What is appealing to you about volunteering in a healthcare setting?

Service Area Opportunities: (Please check any that would interest you)

Working with patients ☐ Prefer no patient contact ☐ Retail ☐ In the community ☐ Coffee Cart ☐

Behind the scenes *(Administrative/Clerical)* ☐ Reception/Front Desk ☐ Special Interests/Events ☐

Have you ever committed, been convicted of, pled guilty to, or pled no lo contendre to a felony or misdemeanor?

No ☐ Yes ☐ If "Yes," where and when: _____

Do you have any Volunteer experience?

No ☐ Yes ☐ If "Yes," where and when: _____

Personal References: Please list two references. Do not use your relatives:

Name: _____

Phone Number: _____ Relationship: _____

Name: _____

Phone Number: _____ Relationship: _____

The information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way I will be dismissed without notice regardless of when the false information is discovered.

As a volunteer, I...

- Agree to complete the volunteer orientation and train until I am competent to perform the required duties.
- Agree to complete an ANNUAL education review and TB screening, as well as any additional service-specific training that may be deemed necessary.
- Agree to comply with all the rules and regulations of St. Elizabeth Community Hospital and uphold the Standard & Procedures and bylaws of its Volunteer Auxiliary.
- Understand that I may be dismissed from my duties for willful wrongdoing or negligence and/or performing duties outside of my service guidelines.
- Agree to call for a substitute when I have scheduling changes.
- Contact our Membership Manager or Volunteer Coordinator if I will be absent and cannot find a substitute for my shift.
- Agree to accept assignment to a new service area if absent for an extended period of time.
- Agree by submitting this document electronically that it will be considered as an electronic signature.

Confidentiality:

It is the belief of this hospital that all medical, financial, and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion, and disclosure. Therefore, Volunteers may look at, use, or disclose patient information ONLY as it relates to the performance of their duties. Any unauthorized viewing, discussion, or disclosure will provide grounds for immediate dismissal. Whenever it is questionable as to what information is confidential, it is your responsibility to discuss that matter with the Volunteer Coordinator before any breach of confidentiality occurs. I acknowledge and have read the statements above and agree to abide by the expectations of St. Elizabeth Community Hospital and Department of Volunteer Services.

Signature: _____ Date: _____ /_____ /_____

Parent or Guardian Signature (if 17 and years old and under)

For further information, please contact the Volunteer Office at 529-8002 and leave a message or email at Linda.Ezzat@CommonSpirit.org