



Volunteer Services Adult Application

- € Mercy Anderson
- € Mercy Clermont
- € Mercy Fairfield
- € The Jewish Hospital
- € Mercy Mt. Airy
- € Springfield Regional Medical Center
- € Mercy Western Hills
- € Mercy Memorial Hospital

PERSONAL INFORMATION:

Last Name	First Name	Middle Initial	Name to appear on badge
Address	(Apt/lot #)	City	Zip code
Phone: _____		E-mail: _____	
Birthday: _____ / _____ / _____ (month/day/year)			

Are you a year-round resident? Yes No
 If not, what months are you available? _____

CITIZENSHIP

Are you a U.S. citizen? Yes No If not a U.S. citizen, does your alien status or visa prohibit working in the U.S.? Yes No

Type of Visa _____ Expiration date: _____

IF YOU WERE BORN IN A FOREIGN COUNTRY AND ARE NOT A CITIZEN OF THE UNITED STATES, YOU WILL BE REQUESTED TO PROVIDE DOCUMENTATION OF IMMUNIZATION TO MEASLES, MUMPS, CHICKEN POX, AND RUBELLA. IF YOU ARE UNABLE TO PROVIDE THIS DOCUMENTATION, YOU WILL BE REQUIRED, AT YOUR OWN EXPENSE, TO HAVE BLOOD TITERS DRAWN TO PROVE IMMUNITY TO THESE DISEASES. IF THE TITER PROVES YOU ARE NOT IMMUNE TO ANY OF THESE DISEASES, YOU WILL BE REQUIRED, AT YOUR OWN EXPENSE, TO BE IMMUNIZED AS APPROPRIATE PRIOR TO BECOMING A HOSPITAL VOLUNTEER.



EDUCATION:

Check highest level completed: ___ High School ___ College ___ Post Graduate

Level	Name	Major	Dates Attended	Degree
High School				
College				
Other Training				

WORK STATUS:

___ Employed ___ Retired ___ Unemployed ___ Student

If employed, current place of employment: _____ Phone: _____

SKILLS/WORK EXPERIENCE:

___ Accounting ___ Leadership ___ Computer ___ Teaching
___ Nursing ___ Public Speaking

EMPLOYMENT HISTORY

Former Employer Name	Street Address	Supervisor's Name	Business Phone
Dates Employed	Type of Work You Did	Your Job Title	

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Dates Employed	Type of Work You Did	Your Job Title	

HOW DID YOU HEAR ABOUT OUR PROGRAM?

___ Friend ___ Newspaper ___ Brochure ___ Bulletin Board
___ Web Site _____ Other (please specify)



IN AN EMERGENCY, PLEASE NOTIFY:

Emergency Contact #1				
Last Name	First Name	Relationship	Home Phone	Other Phone
Daytime address (residence or co.)	Apt #	City	State	Zip Code

Emergency Contact #2				
Last Name	First Name	Relationship	Home Phone	Other Phone
Daytime address (residence or co.)	Apt #	City	State	Zip Code

VOLUNTEER AVAILABILITY: (Please indicate the days and times you are available to volunteer) _____

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 (except at The Jewish Hospital)
 Administrative/clerical
 Reception/waiting room

Have you ever been convicted or pleaded guilty to a felony or misdemeanor resulting in imprisonment or a fine? Yes _____ No _____

(Note: Falsification to this answer will lead to withdrawal of the offer or termination for volunteering.)

IF YES, PLEASE GIVE DETAILS ON THE BACK OF THIS FORM.

I have resided in the state of Ohio for the last five years. Yes _____ No _____

If your answer is NO, please give prior address _____

(Note: Falsification to this answer will lead to withdrawal of the offer or termination for volunteering.)



HAVE YOU EVER WORKED/VOLUNTEERED FOR ONE OF OUR HOSPITALS?

___ No ___ Yes If yes, where and when _____

PERSONAL REFERENCES

Please list two references. Do not use your personal physician or relatives:

Name _____

Address _____

Phone _____

Relationship _____

Name _____

Address _____

Phone _____

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 was discovered.



Acknowledgement/Statement of Commitment

As a volunteer for Mercy Health Partners:

I will be punctual and conscientious in fulfillment of my responsibilities and if for any reason I cannot serve at the assigned time, I will notify the volunteer office and the department in which I am volunteering.

I will consider as **CONFIDENTIAL** all information concerning patients, which I hear directly or indirectly. I will not seek information regarding patients and families.

I will take any problems, criticisms or suggestions to the Director of Volunteer Services.

I will uphold the standards and policies of Mercy Health Partners.

I will return my Mercy Health Partners Identification Badge when I am no longer volunteering.

I certify that the facts and information provided by me on this application are true and complete and I agree that if selected to volunteer, incorrect, incomplete or falsified information will be grounds for discontinuing my relationship with Mercy Health Partners regardless when discovered.

I understand that volunteers are required to have an initial 2-step TB screening prior to status as an active volunteer. Site specific county requirements for annual TB testing/screening is at the discretion of the Director of Volunteer Services.

I understand that the hospital will provide my TB testing, however should my TB screening show a positive reaction; I will seek my physician at my own expense to have further testing to confirm I do not have active TB.

I understand that annual reviews, education and competencies will need to be completed at the discretion of the Director of Volunteer Services.

I authorize Mercy Health Partners to investigate all statements made herein or in my interviews and to obtain conviction records, make volunteer reference checks and obtain any other information relevant to my volunteering. I release Mercy Hospital and all parties from any and all liability for any damages that may result from obtaining or furnishing such information.

I agree to observe all present and subsequently issued hospital policies and procedures. I understand that such policies and procedures do not constitute a contract of volunteering between me and Mercy Health Partners and that Mercy Health Partners may revise its policies and procedures at any time.

I understand that Mercy Health Partners maintains a drug free workplace as required by the Drug-Free Workplace Act of 1988. I understand that the unlawful manufacture, distribution, sale, possession or use of a controlled substance or illegal drugs by Mercy Health Partners volunteers is prohibited on Mercy Health Partners time, both in and on Mercy Health Partners owned or controlled property.

I understand that as of January 2007 **Mercy Health Partners is a tobacco/smoke free campus and tobacco odor is not permitted. I must be completely free of tobacco odor.**

I understand the Volunteer Department is not obligated to provide a placement, nor am I obligated to accept the position offered.

I agree to volunteer for a minimum of 50 hours of service.

I will permit images or photos of me in my role as a volunteer to be used in public relations brochures or videos.

I give permission for Mercy Health Partners to perform a criminal background check on me in accordance with standards set by Human Resources and The Joint Commission.

I WILL ABIDE BY ALL HOSPITAL POLICIES AND PROCEDURES, OHIO BOARD OF HEALTH REGULATIONS, FEDERAL LAWS REGARDING CONFIDENTIALITY (HIPAA) AND TJC STANDARDS REGARDING VOLUNTEERS.

SIGNATURE

_____/_____/_____
DATE