

Dear Prospective Volunteer,

Thank you for your interest in the Volunteer program at Northern Regional Hospital by helping the professional staff provide quality care. Volunteers greet patients and visitors, deliver flowers and mail, assist with patient transportation, serve patients meal trays, and a variety of other tasks.

Not only is a volunteer's commitment important to the individuals they serve, but also to the community as a whole. A well-run hospital is an asset to any community and we are fortunate to have an excellent facility in Surry County from which to obtain quality health care services.

Volunteers can be an invaluable addition to the hospital team when you consider the volunteer opportunity to be a priority in your schedule. All volunteers should approach their work with the goal of providing excellent service to the patients, visitors and staff of our hospital.

While the Hospital appreciates the countless hours of service that have been provided by volunteers to our patients and staff, we also recognize the need to maintain a safe environment for everyone present in the hospital. For this reason, only individuals who are able to walk without an assistive device will have volunteer hours scheduled in the hospital in any capacity. Specifically, those requiring walkers, crutches, canes, or other hand-carried supportive devices for walking will not be qualified to perform volunteer hours in the hospital. Those who are wheelchair-bound and able to maneuver safely and independently, however, will be allowed to work as scheduled.

Please return the completed application to the Volunteer Coordinator. After your application has been reviewed, the Coordinator will be in touch concerning a screening interview. Once you have secured a volunteer position, you must attend an orientation session, as well as pass a criminal background check, drug screen, and TB screening.

Again, thank you for your interest in the Volunteer program at Northern Regional Hospital. For questions, please contact the Department of Volunteer Services by phone at 336-783-8196 or by email at *tbeasley@nhsc.org*. We look forward to welcoming you as one of our newest volunteers.

Jina L. Beasley

Tina L. Beasley Volunteer Coordinator Northern Regional Hospital 830 Rockford Street P.O. Box 1101 Mt. Airy, NC 27030



## **VOLUNTEER BENEFITS**

In recognition of their willingness to donate their time and/or present or past service to the Hospital in an official capacity, this policy outlines the benefits available to all volunteers who serve Northern Regional Hospital of Surry County:

- Privilege to make cash purchases at the Northern Regional Hospital pharmacy
- Free flu vaccine annually and free Hepatitis B Vaccine series
- A 20% discount on merchandise in the Gift Shop (excluding sale merchandise)
- Free meal in the cafeteria on the day you work. Meal cannot exceed \$7, and you must work a minimum of 4 hours
- Uniforms furnished at no cost
- Annual Recognition during Volunteer Week
- Invitation to annual Recognition Banquet in the spring
- Access to Employee Health Clinic, including free blood pressure checks
- Free Gym Membership for volunteer and spouse at Northern Wellness & Fitness



### ADULT VOLUNTEER APPLICATION

Please Print. Entire	Application Mus	t Be Completed.	
Date//			
Name(Last)	(First)	(Mid	dle)
Male or Female Date of Birth			-
Current Home Address			
City	State	Zip C	ode
Telephone (Home)			
Education Completed:  High School	Some College	🗆 College 🛛 Gradu	
If employed, please complete:			
Employer's name:	Your po	sition:	
Employer's address:			
Have you ever been employed by Northe			
Are you currently a student?			
Do you have any relatives employed at No			
If yes, please list their name(s) and relation	on:		
Days Available: 🗆 M 🗆 Tu 🗆 W 🛛	∃Th □F	Time Available: 🛛 A	м 🗆 рм
Uniform Size: $\Box$ S $\Box$ M $\Box$ L $\Box$ XL	□ 2XL □ 3XI	_	



Security: Your response to any of these security questions will not automatically disqualify you from volunteering. However, if you answer "No" and a criminal history is found or you answer "Yes" but did not include all convictions you will be disqualified from consideration.

Have you ever been convicted (pleaded guilty or been found guilty) of a misdemeanor or felony? (List any and all convictions and provide dates of each including, but not limited to, major traffic violations, writing bad checks, and DWI)  $\Box$  Yes  $\Box$  No

If yes, explain:

Presently, are you charged with committing a criminal offense, misdemeanor or felony?

Yes \_\_\_\_\_ No\_\_\_\_\_

If yes, explain:

What are your reasons for wanting to become a volunteer at Northern Regional Hospital?



**References:** List two people other than relatives who would be willing to serve as personal references.

Name		Telephone Number				
Street Address	City	State	Zip Code			
E-mail Address						
Name		Telephone	Number			
Street Address	City	State	Zip Code			
E-mail Address						
<b>Emergency Contact</b> : In the end of the notified.	event of an emergency, please list th	ne person you v	would want			
Name		Rela	tionship			
Home Telephone Number	Business Telephone Number	Cell	Phone Number			



### **Applicant Agreement**

I acknowledge that the answers on this application, and in any interviews that may follow, are true, and that any misrepresentation or false information on my part will be grounds for exclusion from this program. I understand that volunteers are a part of Northern Regional Hospital, and are subject to all rules, regulations and proper authority. My signature also indicates my approval for you to contact my references.

The Volunteer Services Department is not obligated to provide a placement, nor are you obligated to accept the position offered. We do not accept anyone required to perform courtordered community service. All applications are held for 90 days. The first 90 days of the volunteer experience will be probationary.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex.

Applicant Signature

Date



# STATEMENT OF CONFIDENTIALITY

In the process of performing your duties at Northern Regional Hospital, it is possible to become aware of and/or overhear many things regarding our patient's confidential health information. **All** of the information concerning patients or hospital business must be held in the strictest confidence and must not be discussed with others in the hospital who do not have a "need to know" or with any individual outside the hospital, or used by employees for personal reasons.

Volunteers who violate the confidentiality of Northern Regional Hospital information and/or patient information will be subject to <u>IMMEDIATE</u> termination of clinical privileges.

General inquiries concerning patients should be referred to the information desk or the nurse in charge of the unit who will only release information about the general condition of the patient. Calls from the media should be forwarded to the Director of Physician/Community Relations or the Administration Office.

It is your responsibility as an employee or affiliate of Northern Regional Hospital to protect our patients and their families at all times by adhering to this statement.

I, the undersigned have read, heard an explanation, and understand this statement of confidentiality of patient and/or hospital information and agree to hold such information in strictest confidence.

Applicant Signature

Date

Witness Signature

Date



## VOLUNTEER INTEREST QUESTIONNAIRE

Please identify the activities that you would like to participate in:

1.	Information Desk	very much	somewhat	not interested
2.	Surgery Waiting	very much	somewhat	not interested
3.	Emergency Room	very much	somewhat	not interested
4.	OB Department	very much	somewhat	not interested
5.	General Office	very much	somewhat	not interested
	typing	very much	somewhat	not interested
	photocopying	very much	somewhat	not interested
	filing	very much	somewhat	not interested
	stuffing envelopes	very much	somewhat	not interested
	answering phones	very much	somewhat	not interested
6.	Delivering Flowers/Mail	very much	somewhat	not interested
7.	Gift Shop	very much	somewhat	not interested
8.	Patient Transportation	very much	somewhat	not interested
9.	Physician Offices	very much	somewhat	not interested

Please enter any questions or comments you have concerning the program. Also, please list any special skills that you have that may be useful to the patients, visitors, or staff of our hospital (piano, singing, computer skills, flower arranging, etc.)



# MEDICAL HISTORY QUESTIONNAIRE

Name:					
Address:					
Telephone #:			Date of Birth:		
Personal Physician:					
Past and present medica	ll history:				
Have you ever had any o	f the following	<u>;</u> ?	Check Yes or No		
	<u>YES</u> <u>N</u>	<u>0</u>		YES	<u>NO</u>
High Blood Pressure			Neck/back/spine problems		
Allergies			Fainting		
Asthma			Eye Problems		
Arthritis			Glaucoma		
Cancer			Headaches		
Chronic cough			Heart trouble		
Epilepsy			Jaundice		
Diabetes			Hepatitis		
Ear trouble			Skin condition		
Rheumatic fever			Tuberculosis		
Thyroid problems			Mumps		
Measles			Stomach/intestine problems		
Chicken pox			Kidney/bladder problems		
MMR Vaccine			Fit tested for TB mask		



If you answered yes to any of the above, give details:

	ve you ever been injured on the job?	□ No date of the ir	ijury?
A.	Name and address of physician:		
B.	What part of your body was injured?		
C.	Did you receive worker's compensation benefits?	□ Yes	🗆 No
D.	Did you receive any permanent disability?	□ Yes	□ No
E.	Has a physician ever given you physical restrictions?	□ Yes	🗆 No
	If yes, describe:		
	Have you ever had any problems with your back?	□ Yes	🗆 No
	If so, give name of treating physician, approximate da	te, and any I	ifting limitati



3. List any operations and/or serious medical illnesses that you have had, include dates:

4.	Are you receiving any medical treatment at this time?	s 🛛 No
	If yes, give reason:	
5.	List all medications you are taking and the reasons:	
6.	Have you ever been treated for nervous or mental illness? $\Box$ Ye	s 🗆 No
	If yes, explain:	

I, the undersigned, do hereby certify that the answers to the above questions are true, and give permission for the medical examination. I authorize release of medical information to this facility, which may be necessary in determining my ability to meet the requirements of the job for which I am applying. I understand that giving false information about my health is grounds for dismissal from Hospital employment.

Signature

Date



### CRIMINAL RECORDS and BACKGROUND RELEASE AUTHORIZATION and DISCLOSURE

#### COMPANY OR ORGANIZATION:

I,

#### FIRST NAME

#### MIDDLE NAME

LAST NAME (Please Include Jr., Sr., II, III, etc.)

understand that UNIQUE BACKGROUND SOLUTIONS will seek and obtain consumer reports / investigative reports about me as defined in the Fair Credit Reporting Act (FCRA). These investigative reports may include, whichever are applicable, but are not limited to verification of Social Security Number, names and dates of previous/current employment, work experience, professional and personal references, criminal history records (from local, state, federal, international and other law enforcement agencies' records), sexual offender's lists, wants and warrants records, motor vehicle records, military records, educational verification, license verification, credit history, civil cases, OIG/GSA, OFAC/Patriots Act, any sanction lists, and drug testing. I understand and authorize that these records may be used for the eligibility and qualification of my employment/contract/volunteering. I hereby authorize, without any reservation, the full release of these records and information for UNIQUE BACKGROUND SOLUTIONS and/or its designated agents or representatives to conduct the searches and investigations and to provide copies of said investigations to my potential employer/organization. I authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation, or public agency may have. This authorization and consent shall be valid in original, fax, or copy form.

I also authorize the full release of the information described above, without any reservation, throughout any duration of time with this organization. I also certify that all information provided below or on my resume and employment application is correct to the best of my knowledge. Any false statements provided on this form, my resume or employment application will be considered just cause for the termination of employment at any time. Upon request, UNIQUE BACKGROUND SOLUTIONS will supply a copy of my reports and my rights under the FCRA. Requests may be directed to: UNIQUE BACKGROUND SOLUTIONS PO Box 1604, Mt. Airy, NC 27030 or by phone at: (336) 786-7030

CHECK THIS BOX if you are applying for work with a California, Minnesota or Oklahoma-based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. CA Codes 1785.20.5, 1786.16(a)(5)(b)(1), & 1786.22; MN Code 13C Subdivision 2; OK Code 24 O.S. §148. Background screening information may be obtained through UNIQUE BACKGROUND SOLUTIONS. For information on UNIQUE BACKGROUND SOLUTIONS.'s privacy policies, visit their website at http://www.UniqueBackground.com

Responses to the following questions are completely voluntary. You need not respond to have your application considered. However, law enforcement agencies and other entities, for positive identification purposes, require the following information when checking public records. It is confidential and will not be used for any other purposes.

### Please Print Clearly

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FIRST NAME	MIDDLE NAME	LAST NAME	
SOCIAL SECURITY NUMBER	DATE OF BIRTH (Month/Day/Year)	PLEASE CIRCLE ONE	RACE
		MALE OR FEMALE	

#### Alias/Maiden/Previous Name(s) Use the back of this form if more space is needed.

FIRST NAME	MIDDLE NAME	LAST NAME	YEARS USED

### List all addresses, including current address, for the past 7 years. Use the back of this form if more space is needed.

ADDRESS, CITY and STATE	ZIP CODE	COUNTY	DATE FROM	DATE TO

#### Complete if applying for a position that may involve driving a motor vehicle.

DRIVER'S LICENSE NUMBER STATE ISSUED		STATE ISSUED	EXPIRATION DATE