



Jewish Hospital

a century of excellence

100
1903 - 2003

Application Date _____

Adult Teen College

At which facility do you wish to volunteer?

- Jewish Hospital
- Outpatient Care Center

Last Name		First Name		MI	Nickname
Address			Apt. #		Home Phone
City			State		Zip
Birth Date	Month	Day			

Education and Work Experience

	Circle Last Grade Completed				
Employer	High School	9	10	11	12
Work Phone	College	1	2	3	4

Volunteer Work Preference

- Visitors/Families
- Direct Patient Contact
- Indirect Patient Contact
- Clerical Support Services
- Physical Therapy (College students only)
- Occupational Therapy (College students only)

Availability

Please check the boxes for the days and times you are most often available to volunteer.

	M	T	W	T	F
Morning					
Afternoon					

Emergency Contact

Name	Work Phone	Home Phone
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How did you hear about our Volunteer Program? _____

Signature _____ Date _____

FOR STUDENTS ONLY

School Presently Attending				Grade Level
Birth Date	Month	Day	Year	

IT IS VERY IMPORTANT THAT YOUR IMMUNIZATION RECORD IS ATTACHED TO THIS APPLICATION

**FOR STUDENTS UNDER 18 YEARS OF AGE
PARENT'S/LEGAL GUARDIAN'S AUTHORIZATION**

I hereby agree to allow _____ to serve as a
Name of Teen Volunteer Applicant
Teen volunteer at Jewish Hospital for such hours as are mutually agreed to by the Teen Volunteer applicant and those in charge of the program. I fully understand in the course of his/her duties, Teen Volunteer applicant may be permitted to enter patient areas of the Hospital.

In consideration of the opportunities extended to the Teen Volunteer applicant under the Teen Volunteer Program, I hereby release, remit, discharge, and relieve the Jewish Hospital HealthCare Services from any and all claims of whatever nature on behalf of the Teen Volunteer applicant arising out of and as a result of his/her service to Jewish Hospital HealthCare Services.

Date

Parent/Legal Guardian's Signature

FOR OFFICE USE ONLY

Date of Interview _____

Placement _____

Time _____

Orientation Date _____

Orient With _____

EMPLOYEES WHO VOLUNTEER ACKNOWLEDGEMENT FORM

Thank you for your interest in volunteering for the organization! This acknowledgement form has been prepared to ensure that everyone concerned understands our policy regarding the limits and boundaries under which employees may volunteer for Jewish Hospital & St. Mary's HealthCare.

Please read the form carefully and direct any questions you may have to the Director of Volunteer Services. Once signed, return the form to the Volunteer Services Department. A copy of the form will also be retained in your personnel file.

I, _____, request to be registered as a Volunteer for Jewish Hospital & St. Mary's HealthCare.

I am currently employed in the _____ Department and my job title is _____.

By signing below, I confirm that I have read, understand and agree to abide by the following policies and restrictions:

- In order to volunteer, I must formally register with the Volunteer Services Department. The Director of Volunteer Services must receive this form prior to beginning my volunteer training. In order to be valid, another adult must witness this form.
- I understand that I am required to be formally trained by the Volunteer Services Department. Topics covered during Orientation and annual reorientation will be waived to avoid duplication of training.
- I will be performing services strictly as a Volunteer without coercion by my employer and without compensation for my services now or in the future.
- I will not volunteer, at any time or under any circumstances, in the department in which I am employed.
- I am permitted to volunteer in other departments or programs providing there is clearly no conflict of interest and I choose to volunteer at my request.
- As an employee, I will not perform duties as a volunteer in another department that are the same or essentially the same as the duties specified in my employment job description.
- I will volunteer only during non-working hours when I am clocked out and officially off duty.
- If there is any question regarding a particular situation or this policy, I will contact the Director of Volunteer Services or the Director of Human Resources prior to performing any questionable tasks or duties.

Volunteer Applicant: _____ Date: _____

Volunteer Services Witness: _____ Date: _____

**No One Dies Alone
Compassionate Companion
Employee Volunteer Agreement**

Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

Home Telephone: _____ Work Telephone: _____

I am currently a:

- JHSMH Employee
- JHSMH Volunteer

The date of my last TB Test was: _____

I, the undersigned, am currently a JHSMH employee and/or a JHSMH volunteer. I understand I am offering my services as a *Compassionate Companion* in the role of a volunteer for the *No One Dies Alone* program. I understand I will not receive or expect compensation for my time and also understand I am in no way acting in my role as an employee of JHSMH and I will not perform or assist in any usual and customary patient care done by medical personnel. As a volunteer, I will have the ability to accept or decline requests to be a *Compassionate Companion* at my own discretion.

Signature _____ Date _____