Flagler Hospital Inc.
400 Health Park Blvd.
St. Augustine, Fl. 32086
(904) 819-4411

Dear Future Volunteer:

Thank you for your interest in the Flagler Hospital Volunteer Program. We are continuously looking for motivated and enthusiastic volunteers to work throughout the health system.

The Flagler Hospital Auxiliary helps make the hospital special by providing friendly, dedicated service to patients and staff. Active in almost every area of the hospital, volunteers offer a wide variety of skills, and services, from wheeling patients to and from X-ray and sorting mail, to planning and holding fundraising events.

In order to qualify for the program, volunteers must:

- Commit to three consecutive months from the date of orientation
- Complete a Volunteer Application and Skills Questionnaire
- Complete Authorization Background Check
- Attend a three-hour orientation, held monthly at Flagler Hospital
- Work a minimum of four hours, once a week
- Complete a two-step Tuberculosis (TB) Test after orientation in our Employee Health Office
- Purchase Uniform Shirt
- Pay Annual Dues

Volunteers are recognized quarterly for their hours of service. Many have volunteered over 1,000 hours of their time, and several have volunteered over 10,000 hours! As a member of the Flagler Hospital Auxiliary, you'll be invited to luncheons, seminars, and educational program that keep you abreast of changes in healthcare.

Please note, in order to become a volunteer, you must be 21 years old. **Interviews are held on the first Tuesday of every month. We will be calling you about one week prior to that date to set a time for your interview.** For more information, please call (904) 819-4411.

We look forward to welcoming you into the Flagler Hospital family of volunteers.

Sincerely,

Clara Lugo
Director of Volunteer Services
Flagler Hospital Inc.

Date: ____________________

▪▪▪ 400 Healthpark Blvd • St Augustine, Florida • 32086 • Phone: (904) 819-4411

VOLUNTEER APPLICATION

Available for Volunteering: ☐ Year-Round ☐ Seasonal: (Dates) ______________________ to ______________________

PLEASE PRINT:

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other: ________________ Birth Date (M,D,Y): ____/____/______ U.S. Citizen ☐ Yes ☐ No Sex: ☐ Male ☐ Female

Name: Last: ________________________________ First: ________________________________ MI ______

Preferred Name for ID Badge (if different from above): ________________________________

Street Address: ________________________________ Apt#: ____________

City: ________________________________ State: ________________ Zip: ____________

Home Phone: (_____)______________ Cell Phone: (_____)______________ Work Phone: (_____)______________

Email: ________________________________

IN CASE OF EMERGENCY, NOTIFY:

Name: ________________________________ Relationship: ________________

Street Address (if different form above): ________________________________

City: ________________________________ State: ________________ Zip: ____________

Home Phone: (_____)______________ Cell Phone: (_____)______________ Work Phone: (_____)______________

Physician's Name: ________________________________ Business Phone: (_____)______________

REFERENCES (Local Preferred, No Relatives):

Name: ________________________ Phone: (_____)____________ E-Mail: ________________________

Street Address: ________________________________

City: ________________________________ State: ________________ Zip: ____________

Name: ________________________ Phone: (_____)____________ E-Mail: ________________________

Street Address: ________________________________

City: ________________________________ State: ________________ Zip: ____________

BACKGROUND INFORMATION:

Have you ever been convicted of, had adjudication withheld, or plead guilty or nolo contendre (no contest) to a criminal offense (misdemeanor or felony)? (We do criminal checks. Falsification or failure to disclose this or any other information on this application is grounds for termination. A conviction does not necessarily disqualify you from volunteer service) .... ☐ Yes ☐ No

If YES, please explain: ________________________________

Have you ever been refused bond? .... ☐ Yes ☐ No

If YES, please explain: ________________________________

Have you previously been an employee/volunteer for Flagler Hospital.............. ☐ Yes ☐ No

If YES, provide dates of employment/volunteer service, location and name of supervisor: ________________________________

____

WORK EXPERIENCE, SKILLS and ACTIVITIES:

Currently Employed: ☐ Yes ☐ No ☐ Retired Work Schedule: ______________________________

Occupation/Former Occupation - Work Experience: ______________________________

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SKILL QUESTIONNAIRE:

Check all that apply to you. We will discuss your skills and preferences to assist us in finding a rewarding volunteer position:

✔ FINANCIAL
- ☐ Accounting
- ☐ Banking
- ☐ Bookeeping
- ☐ Other ________________:

✔ RETAIL/BUSINESS
- ☐ Cashier
- ☐ Customer Relations
- ☐ Display
- ☐ Manager
- ☐ Marketing
- ☐ Sales
- ☐ Other; ________________

✔ HEALTH CARE
- ☐ LPN
- ☐ Medical Assistant
- ☐ Medical Records
- ☐ Nurse Aide
- ☐ Physician
- ☐ Radiology
- ☐ RN
- ☐ EMT, Paramedic
- ☐ Other: ________________

✔ PROFESSIONAL
- ☐ CEO/President
- ☐ Directory
- ☐ Manager
- ☐ Supervisor
- ☐ Other: ________________

✔ COMMUNICATION
- ☐ Customer Service
- ☐ Foreign Language

Specify: ________________
- ☐ ____
- ☐ Photography
- ☐ Public Speaking
- ☐ Training
- ☐ Writing/Publishing

✔ PAST LEADERSHIP
- ☐ Board of Directors
- ☐ Chairman
- ☐ Commitee Member
- ☐ President
- ☐ Secretary
- ☐ Treasurer
- ☐ Vice President
- ☐ Other: ________________

✔ COMPUTERS
- ☐ Microsoft Office
- ☐ Excel
- ☐ Word
- ☐ Powerpoint
- ☐ Access
- ☐ Networking
- ☐ Web Design
- ☐ Other: ________________

✔ OFFICE/CLERICAL
- ☐ Computer, Typing
- ☐ Fax, filing, Mail, Phone
- ☐ Receptionist
- ☐ Shorthand
- ☐ Other: ________________

✔ PATIENT CARE
- ☐ Feeding Patient
- ☐ Massage/Back Rub
- ☐ Patient Transport
- ☐ Visiting/Listening
- ☐ Other: ________________

✔ OTHER SKILLS
- ☐ Arts & Crafts
- ☐ Calligraphy
- ☐ Counseling
- ☐ Driver
- ☐ Educator
- ☐ Electrical
- ☐ Engineering
- ☐ Fund Raising
- ☐ Gardening
- ☐ Human Resources
- ☐ Musican Instruments
- ☐ Other : ________________

HOBBIES

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☐ **Other:** ______________________________

HEALTH STATEMENT:

The following pertains to physical problems which could interfere with your ability to perform certain jobs. Do you have, or have you ever had any of the following conditions, ailments or diseases. Please check (✔) all that may apply:

☐ Arthritis ☐ Diabetes ☐ Fainting ☐ Hepatitis ☐ Neck Problems

☐ Asthma ☐ Dizziness ☐ Hearing Defects ☐ High Blood Pressure ☐ Tuberculosis

☐ Back Problems ☐ Epilepsy ☐ Heart Problems ☐ Other: ______________________________

WORK PREFERENCES:

☐ Patient Contact ☐ Non Patient Contact ☐ Information/Clerical ☐ I would also like to Assist with Special Events (fund-raisers, health fairs, recruiting, etc.).

Work Times: ☐ Morning (8:00 AM - 12:00 PM) ☐ Afternoon (12:00 - 4:00 PM) ☐ Evening (4:00 - 8:00 PM)

Work Days: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat. ☐ Sun. ☐ Any Day (Flexible)

I would be interested in a Auxiliary Board Leadership Position: .... ☐ Yes ☐ No

PLEASE READ AND SIGN:

IF ACCEPTED INTO THE FLAGLER HOSPITAL AUXILIARY PROGRAM, I AGREE TO:

- Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff.
- Become familiar with Flagler Hospital policies and procedures and uphold the Code of Excellence.
- Honor my commitment to a specific job assignment.
- Donate my services without contemplation of compensation or future employment.
- Be professional, conscientious and conduct myself with dignity, courtesy and consideration of others.
- Purchase the appropriate volunteer uniform and maintain a well groomed appearance.
- Attend orientation and inservice training as scheduled.
- Carry out assignments in a professional manner and seek Auxiliary assistance when necessary.
- Discuss any problems, criticism or suggestions with my chair person.
- Work a specified number of hours on a schedule acceptable to Flagler Hospital.
- Adhere to the Flagler Hospital Auxiliary volunteer's sign-in procedure.
- Be punctual and notify my chair person if unable to work as scheduled and find a substitute according to the volunteer substitution policy.
- Honor the minimum commitment of volunteer service (three months) with the first 16 to 20 hours being a probationary period.
- I understand that the Flagler Hospital Auxiliary reserves the right to terminate my volunteer status as a result of (a) failure to comply with the hospital's policies; (b) absences without prior notification; (c) unsatisfactory work, attitude, appearance or (d) any other circumstances which, in the judgement of the Director of Volunteer Services, would make continued services as a volunteer contrary to the best interest of Flagler Hospital and its patients.
- I, the undersigned, consent to any pre-volunteer testing/screening required by Flagler Hospital.
- I hereby certify that there are no misrepresentations concerning my personal and professional history. I am aware that misstatements of material facts may cause me to be disqualified from holding a volunteer position with the Flagler Hospital Auxiliary. I have read the above conditions and agree to honor them.

Signature of Volunteer: ______________________________ Date: _____________

FOR OFFICE USE ONLY:

APPLICANT NAME: ____ Phone: (_______)___________________

1. SERVICE AREA: ____

Dept: _________________ Notified: ________ Chair/Supervisor: ___________________ Phone/Ext: ____________

Days: ☐ Mon ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat. ☐ Sun. Hours: _________ /_________

2. SERVICE AREA: ____

Dept: _________________ Notified: ________ Chair/Supervisor: ___________________ Phone/Ext: ____________

Days: ☐ Mon ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat. ☐ Sun. Hours: _________ /_________

3. SERVICE AREA: ____

Dept: _________________ Notified: ________ Chair/Supervisor: ___________________ Phone/Ext: ____________

Days: ☐ Mon ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat. ☐ Sun. Hours: _________ /_________

4. SERVICE AREA: ____

Dept: _________________ Notified: ________ Chair/Supervisor: ___________________ Phone/Ext: ____________

Days: ☐ Mon ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat. ☐ Sun. Hours: _________ /_________

INTERVIEWER COMMENTS: ____

☐ PLACED ☐ UNABLE TO PLACE ____

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DATE:

Interview Dates (s): .. ______________________

Attended Orientation: ______________________

Uniform Purchase: ... ______________________

Dues Paid: .... ______________________

TB Test Complete: ... ______________________

Confidentiality Signed: ______________________

Guidelines Rcvd: ...... ______________________

Resigned: .... ______________________

NOTICE/AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT

I understand that Flagler Hospital may now, or at any time while volunteering, verify information within the application, resume or contract for volunteering. The verification and/or checks may include: driving record, National Sex Offender Registry, and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any state. A photocopy or telephonic facsimile (Fax) of this Disclosure and Consent authorization for Release of Information shall be valid as the original. The results of this verification process will be used to determine volunteer eligibility.

I, authorize Hirease, Inc. and any of its, agents, employees, company personnel to conduct such search on behalf of Flagler Hospital, and I further authorize Hirease, Inc. and any of its agents, employees, and/or other company personnel to disclose orally and/or in writing the results of the search to authorized representatives of Flagler Hospital. All results will be kept CONFIDENTIAL, and the information obtained will not be provided to any partiers other than to designated Flagler Hospital personnel.

I have carefully read and understand this disclosure and consent form and by my signature consent to the release of any motor vehicles records, national sex offender records and/or criminal records. I further understand this consent will apply during the course of volunteering, should I obtain such position, and that such consent will remain in effect until revoked in a written document signed by me. In the event that I wish to refuse or revoke my consent at any time, I understand that I may do so. I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of volunteering is true and complete to the best of my knowledge. I understand that if asked to be a volunteer, any false statements will be considered as a cause for possible dismissal.

I further understand that providing my social security number is voluntary; however, by failing to provide my social security number Hirease, Inc may have the inability to properly verify the information contained in national sex offender record and/or criminal record. Said inability to verify the information may result in an inaccurate, incomplete or improper national sex offender record and/or criminal record which may prevent me from volunteering with Flagler Hospital.

I do hereby agree to forever release, hold harmless and discharge Flagler Hospital, our agent, Hirease, Inc. and their agents, employees, assigns and other company personnel to the full extent permitted by law from any claims, whether known or unknown, any damages, any losses, liabilities, costs and expenses, or any other charge or complaint arising from the retrieving and reporting of information.

Signature: ____ Date: ________________

IDENTIFYING INFORMATION FOR CONSUMER REPORTING AGENCY
(PLEASE PRINT OR TYPE)

Applicant Name: (First Middle Last)	Current Address: (street address)
Other Name(s) Used: (like Maiden)	City: State: Zip:
Social Security Number:	Former Address: (1)
Sex: Race:	City: State: Zip:
Driver's License No.: State of Issue:	Former Address: (2)
Month, Day and Year of Birth*:	City: State: Zip:
Educational Institution Location (City, State)	Professional License State Issued
Name Attended Under Degree Awarded Dates of Attendance/Graduation	License Number Issue Date Expiration Date

FOR CA, MN, OK: PLEASE PROVIDE ME WITH A COPY OF MY BACKGROUND INVESTIGATION REPORT. YES NO

IF YOU RESIDE IN CT, PLEASE LIST YOUR CONTACT INFORMATION FOR REPORT NOTIFICATION:
EMAIL:____

Have you ever been sanctioned, disciplined, debarred, and/or excluded by a duly authorized regulatory agency or are there any current restrictions or limits on your license (s) or certification (s)? Yes No If yes, please attach a complete explanation.

Have you ever been convicted of any criminal violation of the law other than a minor traffic violation or are you now under pending investigation or charges Yes No If yes, please attach a complete explanation.

Without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background investigation.