

Davis Hospital

AND MEDICAL CENTER

Volunteer Application

Name:	First:	Last:		
Address:	Street:			
	City:	State:	Zip Code:	
Phone Number:				
Email Address:				
Volunteer Type:	Junior (16-17 yrs old): <input type="checkbox"/>		Senior (18+ yrs old): <input type="checkbox"/>	
Date of Birth:				
Gender	Female <input type="checkbox"/>		Male <input type="checkbox"/>	
Work Status	Employed <input type="checkbox"/>	Unemployed <input type="checkbox"/>	Student <input type="checkbox"/>	Other <input type="checkbox"/>
Volunteer Emergency Information:				
In case of illness or personal emergency during my volunteer assignment, please contact the following individuals:				
*Name:				
Relationship:				
Phone number:				
*Name:				
Relationship:				
Phone number:				
Physician Emergency Information:				
In case of Medical Emergency during my volunteer assignment, please contact the following physician:				
Name:				
Phone number:				
Office Location:				
Please Provide two references not related to you:				
1	Name:			Phone:
2	Name:			Phone:
Have you ever been in trouble with the law, convicted of a misdemeanor or felony?				
Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, please explain:		

We ask that volunteers commit to work for a minimum of **six months and volunteer one four hour shift per week.** Circle one or more shifts for which you are available.

Monday	9:00 AM to 1:00 PM	12:00 PM to 4:00 PM	3:30 PM to 7:30 PM
Tuesday	9:00 AM to 1:00 PM	12:00 PM to 4:00 PM	3:30 PM to 7:30 PM
Wednesday	9:00 AM to 1:00 PM	12:00 PM to 4:00 PM	3:30 PM to 7:30 PM
Thursday	9:00 AM to 1:00 PM	12:00 PM to 4:00 PM	3:30 PM to 7:30 PM
Friday	9:00 AM to 1:00 PM	12:00 PM to 4:00 PM	3:30 PM to 7:30 PM
Saturday	10:00 AM to 2:00 PM	2:00 PM to 6:00 PM	No Evening Shifts After 6:00 PM
Sunday	10:00 AM to 2:00 PM	2:00 PM to 6:00 PM	No Evening Shifts After 6:00 PM

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Please Read Carefully

Volunteers must be able to read, write, communicate effectively and have good personal hygiene. Davis Hospital volunteers must be able to lift 20 pounds and have the capacity and capability to push a normal size person in a wheelchair. Some reaching and bending is required. Volunteers will have minimal exposure to hazardous materials. We require our volunteers to work independently, conduct themselves in a positive and professional manner, be self-starters and be without physical restriction.

Junior Applicants (16-17 Years Old)

As a parent or legal guardian of _____, I have read this application and the attached policies. I am aware of the responsibility that my child will assume as a volunteer at Davis Hospital and Medical Center and I will support him/her in this effort. Minimum 3.0 GPA required of junior volunteers. **-Please submit a copy of your most recent report card.**

Signature of Parent/Guardian

Date

SHIRT: *Type*-POLO:____ *SMOCK:*____ *Size*-SM____ M____ LG____ XL____ **Other:**_____

Omission of pertinent information by applicant not disclosed in this application or discussed during the initial interview will be grounds for dismissal.

If you have any questions regarding volunteering you may contact
The Volunteer Coordinator at #801-807-7003

Please return application to:

Volunteer Coordinator
Davis Hospital and Medical Center
1600 West Antelope Drive
Layton, UT 84041

*****To be filled out by Volunteer Coordinator*****

Interview Date:	Work area:	Scheduled Day/Shift:	ID badge:	Uniform Fee:	Volunteer Pic:	Volunteer #:	Start Date:	Orientation date:
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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Volunteer Information

Please Detach and Keep for your Reference

Lab/Background Test Requirements

All volunteers must take a TB test (tuberculin skin test), a pre-employment drug screening test, and an MMR titer. A background check will be performed for those 18 years and older. An annual flu shot is required for all Volunteers. These tests are mandatory of all volunteers and are conducted at Davis Hospital's lab at no expense to the volunteer.

Volunteer Uniform Fees

\$20.00 is due at the time of hiring for a uniform shirt for each new volunteer. The uniform for men and women is a navy blue polo shirt or smock. Black, tan or white pants are allowed. No crops, shorts, jeans or open-toed shoes.

Training

You must complete orientation training and pass a written test. The Volunteer Coordinator and/or member of the Auxiliary Board conduct the orientation. A fellow volunteer or department employee will provide a tour of the hospital and on-the-job training or "shadowing".

Substitutes

It is the volunteer's responsibility to find a substitute. We suggest that arrangements be made 24 hours in advance of the scheduled shift. You will have available to you a substitute list of available personnel to choose from. You must contact the Volunteer Coordinator with any changes with the schedule and record it on the calendar.

Sign-In Procedures

Please sign on to the computer stationed in the volunteer office upon entering the hospital. The computer is used to track and document volunteer hours and allows for reports to be printed. The computer is used as a time clock so it is important to clock into the computer at the beginning of your shift and clock out at the end of your shift. Volunteers should sign in manually using the "Sign-In" book when the computer is not working.

Supervision

It is the responsibility of the department you are working in to train you in your specific area. Do not hesitate to ask for help or advice. All Volunteers are under the supervision of the Volunteer Coordinator. In the event of the Volunteer Coordinator absence, the Nursing Supervisor will be in charge of the Junior and Senior volunteers.

Codes

Everyone serving or representing the hospital is responsible to learn and observe the emergency codes. These codes will be explained to you at the volunteer orientation training. Code cards are available and should be kept attached to your badge at all times. Volunteers should understand each code and the volunteer's responsibility and/or response to each hospital emergency code.

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Friends

Friends, family and children are not considered part of the volunteer staff. Please do not encourage them to visit socially while you are on duty.

Telephones/Computers

The telephones and Computers are for hospital business only. Please do not use the phone for personal calls other than for an emergency or to obtain a ride home. Cell phones are not permitted in front of guests while on duty as a volunteer.

Meals

Volunteers are allowed one \$7.00 meal per shift worked. The meal is provided courtesy of Davis Hospital for your service as a volunteer. Please do not abuse this privilege. Meals should be staggered so that the information desk remains staffed during volunteer hours. Meal times are as follows:

Shift	Meal Time
9:00 AM to 1:00 PM	12:30 PM
12:00 PM to 4:00 PM	12:00 PM
3:30 PM to 7:30 PM	5:30 PM
10:00 AM to 2:00 PM (Weekends)	12:00 PM
2:00 PM to 6:00 PM (Weekends)	5:30 PM

Work Areas

Work areas are to be kept clean and neat at all times. Refrain from littering with papers or garbage of any kind. Purses and book bags are to be stowed inside the cabinet. Drinks and snacks are to be kept to a minimum. Please eat in the cafeteria whenever possible.

Leave of Absence

A volunteer may take a 6 month leave of absence after completing 100 hours or 6 months of continuous service. The appropriate form must be completed and guidelines followed. Due to the coverage of volunteers needed on each shift, it may not be possible for the volunteer to return to the schedule they worked prior to their leave of absence.

Discipline

Any complaint from an employee, volunteer or visitor about the behavior of a volunteer will be reviewed. After investigation, if the incident is not dismissed, the volunteer will receive verbal notification, and a letter of reprimand or dismissal (depending on the severity of the incident).

Confidential Information (HIPAA)

All information with respect to patients must be held in strict confidence and never be discussed with those outside the hospital or employees not directly concerned with patient care. The hospital administration and authorized personnel are the only individuals allowed to release this information. Please keep in mind that information you hear, see or read must stay in the hospital.

Updated Information

Please read the bulletin board each time you sign in/out for updated information. The “*Everything Book*” kept in the cabinet in the office is a great resource for answers.

Please inform the Volunteer Coordinator with any changes with address and phone numbers.

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Revised: 10/7/2015

Davis Hospital AND MEDICAL CENTER

Davis Hospital & Medical Center # 9041 APPLICANT INFORMATION

APPLICANT'S FULL NAME _____
Any Other Names Used _____
Social Security No. _____ / _____ / _____ Date of Birth¹ _____
Email address: _____ (Provide if you prefer to receive information via email)
Current Address _____
City _____ State _____ Zip _____
Driver's License State _____ D.L. Number _____
Address on D.L.: _____

Name of High School, College, University or Institution of Professional Training where you completed the highest level (GED – provide state) _____
Campus Name _____ Campus City _____ Campus State _____
Name on GED or under which you graduated _____
Year(s) Attended _____ Year Graduated/GED Completed _____

Please provide any current professional licenses, certifications, or registries you may hold:
Name as it appears on license/Certification/Registry _____
Type _____ State/Region or Issuing Organization _____ Country _____ Number _____
Type _____ State/Region or Issuing Organization _____ Country _____ Number _____

*Have you ever been convicted of a crime? Yes No (Please attach a separate sheet of paper to provide additional entries)
Offense _____ County _____ State _____ When _____
Offense _____ County _____ State _____ When _____

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.
(Please attach a separate sheet of paper to provide additional entries)

1. City: _____ State: _____ Date From: _____ Date To: _____
2. City: _____ State: _____ Date From: _____ Date To: _____
3. City: _____ State: _____ Date From: _____ Date To: _____
4. City: _____ State: _____ Date From: _____ Date To: _____

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature: _____ Date _____

STATE LAW NOTICES

Minnesota or Oklahoma applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form.
California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above.

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law.

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

¹ The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

Nevada Private Investigator License # 1618

If Under the age of 18, please have your **parent or legal guardian** Sign and Date.

Signature _____ Date: _____

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Davis Hospital & Medical Center # 9041
VOLUNTEER DISCLOSURE & AUTHORIZATION

APPLICANT'S FULL NAME _____
Any Other Names Used _____
Social Security No. ____ / ____ / ____ Date of Birth¹ _____
Current Address _____
City _____ State _____ Zip _____
Driver's License State _____ D.L. Number _____
Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The prospective organization ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your volunteering with the Company to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my volunteering, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

My present employer may be contacted for a job reference. Yes No

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ Date _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

Ver0813

If Under the age of 18, please have your **parent or legal guardian** Sign and Date.

Signature _____ Date: _____

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DRUG AND ALCOHOL TEST RELEASE AND CONSENT

I. EMPLOYEE INFORMATION

Employee name (print full name):		
Date of birth:	Social Security Number:	Date:
Street Address:		Phone:
City:	State:	Zip:

II. CONSENT

I, _____ (print name) understand that as a condition of employment with IASIS Healthcare, LLC that I will be required to undergo a drug and alcohol test for post-accident or reasonable suspicion in accordance with the policy. Further, I understand that refusal to give consent to be drug and alcohol tested in order to comply with IASIS Healthcare, LLC policy will subject me to termination of employment.

Employee Signature:	Date:
Witness Signature: Parent or guardian Signature:	Date:

III. RELEASE OF RESULTS

I, _____ (name of employee) do hereby give my consent to release the results of my drug and alcohol test(s) conducted throughout the course of my employment with IASIS Healthcare, LLC and its affiliates to my Employer.

Employee Signature:	Date:
Witness Signature: Parent or guardian Signature:	Date: