

Volunteer Application

Name:	First:		Last:			
Address:	Street:					
	City:		State:	Zip Code:		
Phone Number:						
Email Address:						
Volunteer Type:	Junior (16-17 yrs old):			Senior (18+ yrs old	d): □	
Date of Birth:						
Gender	Female	Ma	ale 🗆			
Work Status	Employed □	Unemploy	/ed □	Student 🗆	Other	
Volunteer Emergen	cy Information:					
In case of illness or individuals:	personal emergency du	ring my vo	lunteer assignn	nent, please contact	the following	
*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	o you:				
1	Name:		Phone:			
2	Name:		Phone:			
Have you ever been in trouble with the law, convicted of a misdemeanor or felony?						
Yes □ No □	If Yes, please explain:					

We ask that volunteers commit to work for a minimum of <u>six months and volunteer one</u> <u>four hour shift per week.</u> 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



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 ofand the attached policies. I am aware of the respons		, I ha	ve reac	d this application
and the attached policies. I am aware of the respons	ibility t	hat my c	child w	vill assume as a
volunteer at Davis Hospital and Medical Center and				
Minimum 3.0 GPA required of junior volunteersPl	ease su	bmit a	сору о	f your most
recent report card.				
Signature of Parent/Guardian	-			Date
	3.7	T G	377	0.0
SHIRT: Type-POLO: SMOCK: Size-SM	NI	LG	XL_	Other:
Omission of pertinent information by applicant not of	lisclose	d in this	applic	cation
or discussed during the initial interview will be grou	nds for	dismiss	al.	
If you have any successions according well-untaring you				
If you have any questions regarding volunteering yo The Volunteer Coordinator at #801-807-7003	u may c	contact		
The volumeer coordinator at 4001 007 7005				
Please return application to:				
Volunteer Coordinator				
Davis Hospital and Medical Center 1600 West Antelope Drive				
Layton, UT 84041				
***To be filled out by Voluntee	r Coord	dinator*	**	

Uniform Fee:

Volunteer Pic:

Start Date:

Volunteer #:

Orientation date:

ID badge:

Scheduled Day/Shift:

Interview Date:

Work area:



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 <u>must</u> 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.

Davis Hospital

AND MEDICAL CENTER

Volunteer Information

Please Detach and Keep for your Reference

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. \\iasis.corp\\dhm2\$\RUP DAVIS\woodwaje\Desktop\Application\2017 Volunteer application.doc

Revised: 10/7/2015



Davis Hospital & Medical Center # 9041

APPLICANT'S FUL	L NAME			
Any Other Names U	sed			
Social Security No.	//	Date of Birth ¹		
Email address:		(Provide if you prefer	to receive information v	a email)
Current Address				
City	State	Zip		
		L. Number		
Address on D.L.:				
Name of High School	ol. College, University of	or Institution of Professional	Training where you com	pleted the
highest level (□ GE	ED – provide state)		, , , , , , , , , , , , , , , , , , , ,	
Campus Name		Campus City	Campus State	
	nder which you graduat	ed ar Graduated/GED Complet	ad	_
		enses, certifications, or regi		-
Туре	State/Region or I	ssuing Organization	Country	Number
-		ssuing Organization		
				paper to provide additional entries)
		County		
		e resided for the past seven provide additional entries)		your current residency.
, ,		Date From:		
		Date From:		
		Date From:		
4. City:	State:	Date From:	Date To:	
I have read and und	erstand the above info	rmation and assert that all in	formation provided by r	ne is true and accurate.
Signature:		Date		
Minnesota or Oklahor	ma apolicants or employee	STATE LAW N	NOTICES designated field if you wou	d like to receive a free copy of a consumer
Minnesota or Okiahor report if one is obtained California applicants o credit report at no chan to the current address i California applicants o	ma applicants or employed d by the Company. The re- ir employees only. Please ge if one is obtained by the indicated above.	STATE LAW Notes only: Please mark an X in the sort will be mailed to the current mark the following field if you wo be Company whenever you have sing an X in the designated field.	HOTICES designated field if you would address you indicated on the build like to receive a copy of a right to receive such a copy of a right to receive and are according to the copy of	is form. an investigative consumer report or consum y under California law. The report will be ma
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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 Birth 1	
	Current Address	
	CityStateZip	
	Driver's License State D.L. Number Address on D.L.:	
	DISCLOSURE REGARDING BACKGROUND INVESTIG	ATION
	The prospective organization ("the Company") may obtain information about you from a const connection with your application to volunteer with the Company. Thus, you may be the subject "investigative consumer report" which may include information about your character, general and/or mode of living, and which can involve personal interviews. These reports may contain i criminal history, social security verification, motor vehicle records ("driving records"), verificat history, or other background checks. You have the right, upon written request made within a r to request disclosure of the nature and scope of any investigative consumer report. Please be most common form of investigative consumer report obtained with regard to applicants for empeducation and/or employment history conducted by PreCheck, Inc., 3463 Las Palomas Rd. Al [1-888-773-2432] or another outside organization. The scope of this notice and authorization i Company to obtain from any outside organization all manner of consumer reports and investig throughout the course of your volunteering with the Company to the extent permitted by law.	umer reporting agency made in to fa 'consumer report' and/or an reputation, personal characteristics, information regarding your credit history, tion of your education or employment reasonable time after receipt of this notice, advised that the nature and scope of the ployment is an investigation into your lamogordo, NM 88310; 1(888)PreCheck is all-encompassing, however, allowing the
	ACKNOWLEDGMENT AND AUTHORIZATION I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION ar UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand bot the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company authorization and throughout the term of my volunteering, if applicable. To this end, I hereby a enforcement agency, administrator, state or federal agency, institution, school or university (p bureau, employer, or insurance company to furnish any and all background information reque Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside org Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photograph valid as the original.	th of those documents. I hereby authorize at any time after receipt of this uthorize, without reservation, any law sublic or private), information service ested by PreCheck, Inc., 3453 Las janization acting on behalf of the
	My present employer may be contacted for a job reference. Yes $\;\square\;$ No $\;\square\;$	
	By signing below, I confirm that I have read and understand the above information and that I p	provide my consent.
	Signature: Date	
		ph: 800-999-9881 fax: (800) 207-2778
	Nevada Private Investigator License # 1618	Ver0813
If Under th	he age of 18, please have your <mark>parent or legal guardiar</mark>	ı Sign and Date.
		n Sign and Date.



DRUG AND ALCOHOL TEST RELEASE AND CONSENT

I. EMPLOYEE INFORMATION

Employee name (print full name):						
Date of birth:	Social Security Number:		1	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 guardi	an 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 guardi	an Signature:		Date:			