Memorial
Regional Hospital South

VOLUNTEER APPLICATION PACKET

Thank you for your interest in volunteering at Memorial Regional Hospital South. The Memorial Healthcare System is recognized as one of the outstanding Healthcare Systems in the country. The volunteers are a dynamic group who everyday live the Mission and Vision of our Healthcare System.

Attached please find our volunteer application. There are also instructions attached for Teen Volunteers only.

What Is Expected Of A Memorial Regional Hospital South Volunteer

- A desire to meet the needs of our community, patients, families, visitors, physicians, and employees.
- A commitment of a four-hour shift per week and minimum 6 months and 100 hours of service.
- Purchase of a Volunteer uniform ($20.00). All fees are non-refundable.
- A completion of a Flu shot and Tuberculosis screening (two-part process).
- Completion of a background screening. (Adults 18 years old and over)
- Completion of New Volunteer Orientation.
- Please note: We do not accept court ordered community service hours.

Please call Volunteer Services at 954-518-5460 for additional information or to schedule an interview. Bring the completed application with you (along with other required documents) when you come for the interview. Thank you.

3600 Washington Street, Hollywood, FL 33021

Memorial
Regional Hospital South

TEEN VOLUNTEER INSTRUCTIONS

If you are a potential Teen Volunteer please have all the following prior to calling for an interview:

1. A completed Volunteer Application, with your parent/guardian's signature.
2. A character reference letter on letterhead from a responsible person other than a family member is required.
3. A complete copy of your most recent Academic Transcript/Report Card showing a **2.50 GPA** or above. This is a cumulative GPA, not for one semester.
4. Proof of age, (must be at least 14 years of age) i.e., Drivers License or Birth Certificate.

If you do not have all the above or meet the above criteria please do not call and schedule an appointment.

Appointment:_____ Orientation:_____	**TEENAGERS ONLY** Proof of Age:_____ Transcript:_____ Letter of Recommendation:_____	Copy of Drivers License:_____ Background Check:_____
OFFICIAL USE ONLY		

MEMORIAL REGIONAL HOSPITAL SOUTH
VOLUNTEER APPLICATION

PLEASE PRINT

CIRCLE ONE: ADULT STUDENT TEENAGER

DATE:_____

NAME:_____
Last First M.I.

ADDRESS:_____
Street Address Apartment Number

_____
City State Zip

EMAIL ADDRESS:_____

PRIMARY PHONE #:_____-_____ **SECONDARY PHONE #:**_____-_____

DATE OF BIRTH: _____/_____/_____ **SEX:** **FEMALE** **MALE**

SOCIAL SECURITY #: _____-_____-_____ **DRIVER'S LICENSE #:**_____

PLEASE LIST ALL CITIES AND STATES WHERE YOU HAVE LIVE – THIS IS FOR BACKGROUND CHECK PURPOSES ONLY

PREVIOUS ADDRESS:_____
City State Zip

PREVIOUS / CURRENT OCCUPATION:_____

PERSONAL OR WORK REFERENCE:_____
Name Phone #

EMERGENCY CONTACT:_____
Name Relationship Phone #

NAME OF YOUR DOCTOR:_____
Physician's Name Phone #

SIGNATURE:_____

Prospective volunteers will be subjected to a background check. Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, sex, martial status or disability.

MONTHS AVAILABLE:

(PLEASE CIRCLE ALL THAT APPLY)

JAN FEB MAR APRIL MAY JUNE JULY AUG SEPT OCT NOV DEC

PLEASE CHECK THE TIMES YOU ARE AVAILABLE TO VOLUNTEER.

	MON	TUES	WED	THUR	FRI	SAT	SUN
Morning							
Afternoon							
Evening							

PLEASE SELECT THE AREA YOU FEEL YOU WOULD BEST BE ABLE TO SERVE

Admitting/Regist.
Adult Day Care
Clerical
Materials Mgmt.
Outpt. Therapy Services
4th Floor Nursing
5th Floor Nursing
6th Floor Nursing
5th Floor – 2p-6p
Admissions Asst.
6th Floor – 2p-6p
Admissions Asst.
Inpatient Rehab-Gym
Lab
Emergency Dept.
Outpatient Lab
SBCHS Clinics
Surgical Waiting
Organizational Development
Pet Therapy
Deliver Mags.
Transportation
Women's Imaging
Outpatient Services

Other:_____

We do not place volunteers in these areas: RESPIRATORY THERAPY, BILLING & CODING, MEDICAL RECORDS, ULTRASOUND

Do you speak or write any foreign language? YES NO
(If yes, please indicate which language(s):_____

PREVIOUS VOLUNTEER EXPERIENCE:_____

ARE THERE ANY VOLUNTEER DUTIES YOU WILL BE UNABLE TO PERFORM SAFELY?
(YES) (NO) IF YES, PLEASE EXPLAIN

_____

_____

How did you learn about our volunteer program?

Newspaper _____ **Newsletter** _____ **From a friend** _____
Web site _____ **Volunteer Recruitment Event** _____
Ad in program or bulletin _____ **School** _____

Describe what you want to get from your volunteer experience with this organization, by checking all that apply:

Social interaction/fun _____
A sense of giving back _____
Networking opportunities _____
Increase skills _____
An activity different from work life _____
An activity similar to my work life _____
Other _____

TEENAGE VOLUNTEERS ONLY

INFORMATION FOR PARENTS

1. All teenagers must be interviewed and approved by the office of Volunteer Services.
2. All teenagers must submit a complete application at the time of the scheduled interview.
3. It is the responsibility of the teen volunteer to provide his/her own transportation.
4. Uniforms must be worn at all times.
5. Teen uniforms consist either of white/khaki/black pants, MRHS Volunteer Polo Shirt or Jacket. Total cost for uniform is $20.00.
6. All volunteers are expected to work a four-hour shift per week and are entitled to a free meal.
7. Service hours will be awarded at the completion of their six-month commitment. Service hours letters must be requested within a month of leaving the Volunteer Services Department.

PARENTAL CONSENT FORM
MEMORIAL REGIONAL HOSPITAL SOUTH TEENAGE VOLUNTEER PROGRAM

Date:_____

My daughter/son has my consent to become a Teenage Volunteer for Memorial Regional Hospital South. In addition, I do hereby give my consent to test to have a Purified Protein Derivative (PPD), to test for Tuberculosis, and a Flu shot as part of standard pre-employment/volunteer, physical assessment process.

Parent's Name (please print): _____

Parent's Signature:_____

_____

Address **City** **State** **Zip**

Home Phone:_____ Work Phone:_____

INFORMATION FOR BACKGROUND CHECK PURPOSES

for 18 years and older only

Have you ever been convicted of a felony?	Yes_____	No_____
Have you ever pled Nolo Contendre (no contest) to a felony?	Yes_____	No_____
Have you ever pled guilty to a felony?	Yes_____	No_____
Have you ever been found guilty of a felony?	Yes_____	No_____
Have you had an adjudication withheld for a felony?	Yes_____	No_____
Have a nol pros for a felony?	Yes_____	No_____
Are you presently charged with a felony?	Yes_____	No_____

Have you ever had to serve probation in any pre-trial intervention as a result of a criminal charge? Yes_____ No_____

NOTE: A yes response does not necessarily disqualify an applicant from acceptance as a volunteer.

PLEASE LIST ANYCITY/STATE WHERE YOU HAVE RESIDED, PLEASE INCLUDE MONTH AND YEAR.

PREVIOUS ADDRESS:_____
City State Zip Month/Year

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City State Zip Month/Year

PREVIOUS ADDRESS:_____
City State Zip Month/Year

PREVIOUS ADDRESS:_____
City State Zip Month/Year

Due to the high cost of background checks if you fail to complete the six-month minimum commitment and minimum 100 service hours re-instatement will not be considered. Please ask for clarification if this is not clear to you.

I acknowledge that I have read and understand the commitment I am making.

Signature: _____

Date:_____

Memorial Healthcare System

NOTICE TO APPLICANT OR EMPLOYEE OF INTENT TO OBTAIN AN INVESTIGATIVE CONSUMER REPORT

Dear Applicant or Employee:

In connection with your application or employment, Memorial Healthcare System would like to procure certain background information concerning you which is contained in an investigative consumer report. An investigative consumer report may contain information regarding your: creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, and/or criminal background. This information may be gathered from personal interviews with your neighbors, friends, and/or associates, e.g., former employers.

Before we may procure an investigative consumer report, you must authorize such procurement in writing. You have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report. However, if you are an applicant, we will not consider you further for employment if you so decline. If you are an employee, we may consider employment action if you decline.

We intend to ask your former employer(s) the following questions concerning you:

- What were the dates of your former employment?
- What position(s) did you hold?
- Were you ever demoted or otherwise disciplined? If so, what were the circumstances?
- Did you perform your job in a satisfactory manner?
- Under what circumstances did you leave?
- Would you rehire the individual?

On the next page of this form you will find a release which will allow us to obtain an investigative consumer report concerning the foregoing questions. Please read the release carefully before signing it and indicating your choice regarding disclosure.

Memorial Healthcare System

RELEASE TO PROCURE AN INVESTIGATIVE CONSUMER REPORT

I have read the "Notice to Applicant or Employee" on the other side of the form.
I understand that I have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report concerning me.

I understand that the investigative consumer report may contain information concerning my: creditworthiness, credit standing, general reputation, personal characteristics, mode of living, and/or criminal background. I also understand that this information may be gathered from personal interviews with my neighbors, friends, and/or associates, e.g., former employers.

As disclosed on the back of this form, I understand the nature and scope of the investigation that is going to be made into my background.

Understanding these rights,

- O I **authorize** Memorial Healthcare System to procure an Investigative Consumer Report concerning me.
- O I **do not authorize** Memorial Healthcare System to procure an Investigative Consumer Report concerning me.

(Please Print Your Name): _____

SIGNATURE: _____

DATE: _____