CHI St. Luke's Health

Brazosport

Junior Volunteer Application

Name: (Last, First, Middle)		
Address:		
City:	State:	Zip Code:
Home/Cell #:	Work #:	
Email:	Date of Birth:	
Driver's License State & #:	Social Security #:	

Please list any other names used.

Please provide all locations where you have resided for the past seven (7) years. Include city, state, and dates.

Availability

During which hours are you available for volunteer assignments?

_____ Weekday Mornings
_____ Weekday Afternoons
_____ Weekday Evenings
_____ Weekend Mornings
_____ Weekend Afternoons

Jr. Volunteer Assignments

Junior Volunteers will be placed in various areas of the hospital as needed each year.

Special Skills or Qualifications

Please summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

Are you fluent in other languages? ___Yes ___No If yes, which language(s)? _____
_____

General Information

Have you ever been on probation, received deferred adjudication or been convicted of a misdemeanor or felony?
_____Yes _____No

Have you been released from confinement following a conviction for any criminal offense?
_____Yes _____No

Are you presently charged with any violation of the law? _____Yes _____No

If yes to any of the preceding 3 questions, please explain details and dates:

_____

_____

_____

Do you have a special talent we might use, such as drawing, making posters, scrapbooking, craft work, typing, ability to use the computer, photography, decorating ideas?

_____

_____

_____

_____

_____

_____

Please give a short biography (anything you might think is of interest).

_____

_____

_____

_____

_____

_____

Emergency Contact

Name: _____
Address: _____
City/State/Zip: _____
Home Number: _____
Work Number: _____
Relationship to you: _____
Family Physician & Phone: _____

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer with CHI St. Luke's Health Brazosport, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed) _____

Signature: _____

Date: _____

Parental Consent for Junior Volunteer

I hereby give permission for my child _____ to volunteer at CHI St. Luke's Health Brazosport . I understand that he/she will be under the supervision of the hospital staff or adult volunteers and will be expected to follow all hospital rules and regulations, which also include, but is not limited to, a TB skin test, background check and drug screening. As a junior volunteer, my child, is subject to numerous Federal, State, and Local laws. As the parent/guardian, I accept full responsibility and liability for the actions of my child. I understand that he/she is expected to give at least 6 hours of service each month and should give advance notice of absences. I give permission for my child to be treated in the Emergency Room of CHI St. Luke's Health Brazosport in the case of accident, injury or sudden illness while volunteering at the hospital.

Signature of Parent: _____ Date: _____

Thank you for completing this application form and for your interest in volunteering here at CHI St. Luke's Health Brazosport. We hope you enjoy your volunteer experience.

If mailing this application, please mail it to:

CHI St. Luke's Health Brazosport Volunteers
Attention: Membership Chair
100 Medical Drive
Lake Jackson, TX 77566

For office use only:
Dues/Assignment/Area Training Dates/Orientation Date

Dues are one dollar ($1.00) annually for Junior Volunteers and are due with completed application.

Dues Paid: _____ Date: _____

Assignment: _____

Area Training Dates:

1. _____
2. _____
3. _____

Hospital Orientation Date: _____

Area Chairperson Trainer: _____

Background Investigation

CHI St. Luke's Health Brazosport may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with CHI St. Luke's Health Brazosport. 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 the 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/volunteering is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310, 1(888)773-2432 or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing CHI St. Luke's Health Brazosport to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughto0ut the course of your volunteering with CHI St. Luke's Health Brazosport to the extent permitted by law.

Acknowledgment & Authorization

I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by CHI St. Luke's Health Brazosport 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)773-2432, another outside organization acting on behalf of CHI St. Luke's Health Brazosport, and/or CHI St. Luke's Health Brazosport itself. I agree that a facsimile (fax), electronic or photographic copy of the Authorization shall be as valid as the original.

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

Signature of Applicant/Volunteer: _____ Date:_____

Signature of Parent/Guardian: _____ Date:_____

CHI St. Luke's Health Brazosport Volunteers
Consent Form for Drug Screen

Name: _____ Social Security #: _____

I hereby consent to authorize CHI St. Luke's Health Brazosport to collect a specimen of my hair, blood and/or urine and submit it for volunteering, random, work injury or reasonable suspicion drug testing to screen for substance abuse. I further consent to allow the laboratory testing service to make the results of such screening available to the prospective or current employer, CHI St. Luke's Health Brazosport. I realize that if I do not pass the standards established, I will be disqualified as an applicant or be subject to corrective action which may include separation from the volunteer organization.

In consideration for such services being rendered on my behalf, I hereby release the laboratory testing service, its officers, agents and employees from any and all claims which I might otherwise have due to such results being so available. I hereby consent not to file any action at law or in equity against CHI St. Luke's Health Brazosport, the laboratory testing service, their respective officers, agents or employees in connection with the results of such screen being made so available. I hereby agree to indemnify and save harmless CHI St. Luke's Health Brazosport, the laboratory testing service, their respective officers, agents or employees from all damages, expenses, reasonable attorney's fees and costs of court which they or any of them may suffer or incur, jointly or severally, due to the result of such screen being made so available.

I understand that I may be required to provide medical verification and additional information regarding prescribed medications should they affect the test results.

I authorize release of post-accident results to the Hospital's Worker's Compensation carrier, if applicable.

Signature of Applicant/Volunteer: _____ Date:_____

Signature of Parent/Guardian: _____ Date:_____

Witness: _____