

**SMITH NORTHVIEW HOSPITAL
VOLUNTEER SERVICES
STUDENT VOLUNTEER PROGRAM APPLICATION**

Check appropriate program: ___ College ___ High School ___ High School Summer

Name: _____

Date: _____

Address: _____

Phone: _____

Cell phone: _____

SSN: _____

DOB: _____

Email: _____

AGE: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Phone: _____

Relationship: _____

PARENT INFORMATION:

Mother: _____

Wk Phone: _____

Father: _____

Wk Phone: _____

SCHOOL INFORMATION:

Name: _____

Phone: _____

Grade: _____

Degree/Major: _____

PREVIOUS VOLUNTEER OR CIVIC EXPERIENCE:

Organization: _____

Phone: _____

Address: _____

Position: _____

Why do you want to volunteer at Smith Northview Hospital?

HOBBIES, SPECIAL SKILLS OR INTERESTS:

Do you have an interest in a Health Care related career? _____

If yes, explain: _____

Do you have a friend or family member associated with Smith Northview Hospital? _____

If yes, please explain: _____

COMMITMENT:

We ask that all new volunteers make a commitment to be with us for at least six months and volunteer one four hour shift per week. Are you able to make a commitment to volunteer one four hour shift per week?

If no, please explain: _____

REFERENCES: (employers, coworkers, friends, clergy, auxiliary members - no family members)

1 - Name: _____ Phone: _____

Address: _____

2 - Name: _____ Phone: _____

Address: _____

SKILLS/PREFERENCES:	WORK PREFERENCE:	AVAILABILITY:
Helping Visitors Helping Patients Special Projects/Fundraising Clerical/computer Errands/Delivery Answering Phones Other: _____	Visitors/Families Patients Adults Other Volunteers Individually Office No Patient Contact	Please circle the days you are most often available to volunteer: S M T W T F S Please circle the times you are most often available to volunteer: Morning Afternoon Evening

Are you required to volunteer: _____ If yes, by whom? _____

How did you hear about our Volunteer Program? _____

In making application to the Smith Northview Hospital Volunteer Program, I hereby certify that I will abide by the by-laws and policies of this organization. I also certify that the information contained in this application is true and correct. I give my permission for this information to be verified by Smith Northview Hospital. I also understand I would be working in an atmosphere which deals with the welfare of others. Mature behavior would be expected of me at all times. I will be expected to be here when scheduled and on time. When absences are unavoidable, I MUST notify my department of service immediately. Excessive absences may result in me being asked to surrender my time slot to another volunteer on the waiting list. I agree to comply with all the requirements and regulations if selected as a Student Volunteer.

Signature _____

Date _____

_____ Date available to start

Thank you for your interest in us!

**SMITH NORTHVIEW HOSPITAL
VOLUNTEER SERVICES
STUDENT VOLUNTEER PROGRAM**

PARENTS AGREEMENT
(Required for all students Age 14 - 18)

I hereby permit my son/daughter, _____,
(print child's name)

to participate in the Student Volunteer Program at Smith Northview Hospital. I realize the responsibilities of the organization and will cooperate with my son/daughter to comply with the rules and regulations of the organization. I will assume responsibility for his/her transportation.

In the event of a medical emergency, I permit the physicians in the Emergency Department of Smith Northview Hospital to treat my son/daughter.

If my son/daughter is chosen, I give permission for the P.P.D. This test will determine if the student has been exposed to Tuberculosis. The test will be given prior to his/her volunteering at the hospital.

Parent's Signature

Date

PLEASE LIST ANY ALLERGIES OR CHRONIC ILLNESSES:

GCIC Consent Form

In signing below, I hereby authorize the agency in possession of this document to release any and all Georgia criminal record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

Full Name (print: Last, First, and Middle Name)

Alias names used and time periods used (print: Last, First, and Middle Name)

Address

Sex Race

Date of Birth

Social Security Number

Signature

Date

One of the following must be checked:

_____ This authorization is valid for ~~90 days~~ ~~180 days~~ (circle one) from the date of signature.

_____ I, _____ give consent to perform periodic criminal history background checks for the duration of my employment with this company.

Consumer Disclosure Authorization for Background Investigation

In connection with my application for employment with Smith Northview Hospital, I fully understand that Smith Northview Hospital and/or IGI Employee Screening (IGI), as their agent, may request/perform a consumer report/background investigation on me.

The consumer report/background investigation may contain the following types of information: verification of prior employment(s) and dates of employment, academic achievement, professional licensure, and credit reports. I further understand the report may contain information about any prior criminal history, civil litigation, social security number verification, driving records, Uniform Commercial Code (UCC) filings, any liens or judgments, and bankruptcy as a result of a public record(s) search from any federal, state, or any other agency which might contain such records.

Information regarding conviction will not necessarily bar an applicant for employment, but will be reviewed in light of all the surrounding circumstances, including age at the time of the offense, seriousness and nature of the violation, rehabilitation, relationship of the offense to employment and federal statutory requirements.

I authorize and request all persons, schools, business, corporations, credit bureaus, courts, law enforcement agencies, armed forces, employment commissions, and all government agencies to release said information without restriction or qualification. I authorize a Photostat (or facsimile "Fax") of this release to be considered as effective as the original. All results will be proprietary and kept confidential, and will not be provided to any parties other than Smith Northview Hospital or its legal representative. I am aware that I have the right to request the nature and scope of the results, as reported, from Smith Northview Hospital. I voluntarily waive all recourse and release the requested parties from liability for complying with this request/release.

All background information obtained shall be utilized to assist in verification of the employment application. Retrieval and usage of this information complies with all Equal Opportunity Commission, Americans With Disabilities Act, and the Fair Credit Reporting Act (Laws, Rules, and Regulations). Smith Northview Hospital is an Equal Opportunity Employer, and does not discriminate as to race, color, gender, national or religious origin, age, disabilities or any other characteristic protected by law. I understand that the request for Date of Birth is for permissible purpose and not for purposes prescribed by the laws prohibiting age discrimination. The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are least 40 years of age. It is unlawful for an employer to refuse to hire; discharge; or otherwise discriminate with respect to compensation, terms, conditions, or privileges of employment because of an individual's age.

I hereby declare that the answers to the questions on my application and related paperwork which I have been asked to complete, and any attachments to same, are true and correct and that any misstatements of fact(s) or omissions may form the basis for rejection of my application or for my dismissal after employment. I authorize IGI to provide the results of said information to Smith Northview Hospital or its representatives. If hired, this authorization shall remain on file and shall serve as ongoing authorization for Smith Northview Hospital and/or IGI to procure consumer reports/background investigations at any time during my employment period. I further release Smith Northview Hospital and IGI, its officers, employees, and agents, from any and all liability from the results and preparation of any reports concerning my background or myself. I understand and acknowledge that except as provided in the Fair Credit Reporting Act, I may not bring any action or proceeding against IGI, Smith Northview Hospital, or any user or furnisher of information, for defamation, invasion of privacy, or negligence with respect to the reporting of information disclosed pursuant to the Fair Credit Reporting Act, except as to false information furnished with malice or willful intent to injure me. **The facts set forth by me in this application are true and correct to the best of my knowledge and belief.**

PRINT NAME

SOCIAL SECURITY NUMBER

SIGNATURE

DATE

DATE OF BIRTH