VOL-05-FRM
Revised 7/2019

CONWAY MEDICAL CENTER – VOLUNTEER SERVICES AND/OR AUXILIARY
300 SINGLETON RIDGE ROAD
CONWAY, SOUTH CAROLINA 29526
TELEPHONE: 843-234-5486
FAX: 843-234-6811

APPLICATION FOR VOLUNTEER SERVICES AND/OR THE AUXILIARY TRADITIONAL

DATE:____________________________

NAME:____

STREET ADDRESS____

CITY/STATE__________________________________ZIP____________________

HOME PHONE________________ WORK PHONE__________________________

CELL PHONE_________________

E-MAIL ____

BIRTHDAY: MONTH______DAY _____ ARE YOU UNDER THE AGE OF 18? YES______NO________

DRIVERS LICENSE# __________________ STATE_________

EDUCATION LEVEL __________________________ MAJOR COURSE OF STUDY:_________________

HOW DID YOU LEARN ABOUT OUR PROGRAM:
Friend ____ church ____ media ____ other______________________________________

HOBBIES/INTEREST____

HAVE YOU HAD EXPERIENCE OPERATING THE FOLLOWING OFFICE EQUIPMENT?
COMPUTERS__________COPY MACHINES___________CASH REGISTERS__________

PAST WORK EXPERIENCE:____

ARE YOU CURRENTLY ABLE TO PERFORM THE DUTIES REQUIRED OF A VOLUNTEER?
(I.E. Pushing wheelchair, walking, standing etc)_________________________

WHY ARE YOU INTERESTED IN A VOLUNTEER POSITION OR THE AUXILIARY AT CONWAY MEDICAL CENTER

____
____
____

PREVIOUS VOLUNTEER
EXPERIENCE____

COMMUNITY AFFILIATIONS____

AREA OF INTEREST: PATIENT CONTACT ___ NON PATIENT CONTACT ___ CLERICAL ___

ARE YOU CURRENTLY EMPLOYED? YES________ NO_________

I AM ELIGIBLE TO LEGALLY RESIDE IN THE UNITED STATES YES_______ NO_________

DO YOU RESIDE IN THIS AREA (please circle), PERMANENT ______ PART-TIME ______

WHAT ARE YOUR DAYS/HOURS OF AVAILABILITY TO VOLUNTEER

Sun___ Mon___ Tues___ Wed___ Thurs___ Fri___ Sat___

Morning ___ Afternoon ___ Evenings ___ Nights ___

FOR EMERGENCY NOTIFY________________________________PHONE_______________

Relationship ____________________________________

PLEASE LIST NAMES AND ADDRESS OF TWO PERSONAL REFERENCES
(Please no relatives or Church Pastors)

1st.Name:____PHONE_____________

Address:____
Street

____
City State Zip

2nd.Name:____PHONE_____________

Address:____
Street

____
City State Zip

The organization will recruit volunteers without regard to age, disability, race, color, sex, gender, genetic disposition, religion, national origin, sexual orientation or any other non-work related factor.

The Volunteer Services is a department of Conway Medical Center. The CMC Auxiliary is a non-profit charitable 501 c 3 corporation providing fund raising activities to benefit Conway Medical Center.

I hereby understand and agree:

- The acceptance of this application does not create an expressed or implied contract to volunteer.
- I understand that I will be required to complete an onboarding orientation packet prior to beginning my volunteer duties.
- I understand I must have a TB skin test(s) before I can begin volunteering. The hospital will perform the TB skin tests at no charge to the volunteer.
- I understand that if I am issued a volunteer ID badge, I will wear my ID badge while on duty as a volunteer in accordance with hospital policy and it remains the property of CMC and must be returned upon departure.
- I understand and agree that at no time will any information regarding patients/residents of Conway Hospital entities be revealed to anyone other than those authorized to receive it.
- I understand that the giving of the information concerning patient/resident to those not authorized to receive such information is unlawful and shall be sufficient cause for my immediate dismissal.
- I understand that false statements made as part of this enrollment may be considered sufficient cause for dismissal.
- I understand that all CMC owned, rented and leased properties are nicotine free.
- I understand photos/videos taken while participating as a volunteer or at special functions may be used for promotional reasons.
- I understand my contact information may be shared with CMC Foundation and/or CMC Auxiliary.

I hereby authorize Conway Medical Center to receive any criminal history, motor vehicle information, personal credit history, employment history and educational records and similar types of information from any and all governmental agencies, individuals and/or parties or agencies which may generate or maintain such information.

I hereby release said hospital, companies, schools, or persons from all liability for any damage for issuing this information. In addition, if accepted as a volunteer, I hereby agree to abide by the rules and policies of the healthcare organization and agree to accept no monetary compensation for volunteer services provided.

I hereby agree not to hold Conway Medical Center liable for their transmittal or use of their reliance on any of the information even if my volunteer status is terminated or I am denied the volunteer position.

I certify that all answers given by me to the foregoing questions and statements are true and correct.

SIGNATURE____DATE_______

ID Verified by ____DATE___________

VOLUNTEER OFFICE REPRESENTATIVE

CMC
Conway Medical Center
VOLUNTEER SERVICES

VOL-05A-FRM
REV 7/29/2019

Date:______________________

Dear ,

Your name was given to us by ____ who has completed an application to become a volunteer with the Conway Medical Center Volunteer Services. An applicant cannot start to volunteer until this information is completed. We ask that you, as the named reference, complete the form and return it to us within a week in the enclosed envelope.

Sincerely, Carol Biagini, Director, Volunteer Services.

Please describe your relationship with the named person and how long you have known them.

Is this person reliable and dependable, and able to fill obligations?

In your opinion, would this individual be able to take directions well?

Please comment on the person's ability to relate to patients, other volunteers, and hospital staff.

This information is confidential and will be filed with the application. Thank you for taking the time to help this prospective volunteer to achieve their goal. We appreciate it.

Signature of person completing this form: ___________________________________Date:_________________

AFFIDAVIT:

I authorize the hospitals, companies, schools, or persons named above to give any information they may have regarding me. I hereby release said hospitals, companies, schools, or persons from all liability for damage for issuing this information.

_________________________________ _______________
Applicant's signature Date

Applicant must sign this form.

CMC
Conway Medical Center
VOLUNTEER SERVICES

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CMC | VOLUNTEER SERVICES
CONWAY MEDICAL CENTER

VOLUNTEER BACKGROUND RELEASE FORM # VOL-22B-FRM

DISCLOSURE

As part of your onboarding with Volunteer Services, we will request a background check. This may include such reports and information of public records concerning your driving record, criminal records, accidents, drugs/alcohol use, etc., from federal, state and other agencies which maintain such records. A request will be submitted for the following reports: FACIS® Level 3; National Criminal / Sex Offender Search; Department of Motor Vehicles of license issuing state; Social Security Trace; Statewide - Felony and Misdemeanor.

IDENTIFYING INFORMATION BELOW FOR CONSUMER REPORTING AGENCY WILL BE ELECTRONICALLY SUBMITTED

Without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background investigation.

(PLEASE PRINT OR TYPE)

Applicant Name: (First Middle Last)	Current Address: (street address)
Previous Name(s) Used: (i.e.: Maiden)	City: State: Zip:
Social Security Number:	Former Address: (1)
Sex: Race:	City: State: Zip:
Driver's License No.: State of Issue:	Former Address: (2)
Month, Day and Year of Birth*:	City: State: Zip:
Name of High School Location (City, State)	Professional License State Issued
Your Name When Attended Did you graduate? Year	License Number Issue Date Expiration Date

AUTHORIZATION

I AUTHORIZE, WITHOUT RESERVATION, TO FURNISH THE ABOVE-MENTIONED INFORMATION.
You are hereby authorized to disclose all information obtained by the requesting entity for the purpose of making a determination as eligibility to provide Volunteer Services or any other lawful purpose. If a Volunteer, this authorization shall remain on file and shall serve as ongoing authorization for the procurement of reports at any time during the Volunteer period.

By signing below, I certify that I have read and fully understand this release, that prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction, and that I executed this release voluntarily and with the knowledge that the information being released could affect my eligibility to provide Volunteer Services.

Signature: ____ **Date:** ________________________________