CMC CONWAY MEDICAL CENTER | VOLUNTEER SERVICES

EMBRACE HOSPICE

CMC/Embrace Hospice Volunteer Application

DIRECTIONS:
Respond to all questions. If a particular question does not apply to you, or the position for which you are applying, write N/A in the appropriate blank. PLEASE PRINT CLEARLY. Incomplete applications will not be considered.

EQUAL OPPORTUNITY EMPLOYER:
CMC/Embrace Hospice will not discriminate against any employee or applicant for employment/volunteering because of race, color, religion, sex, age, national origin, ancestry, citizenship status, disability, handicap or any other legally protected category. Any information received about the applicant will not be used for unauthorized purposes.

PERSONAL			
Name Last First Middle Initial		Social Security No.	Date of Application
Address	City	State	Zip Code
Any ALIAS used:		Primary Phone:	Secondary Phone:
In case of emergency notify:	Name	Phone	

TYPE OF VOLUNTEERING PREFERRED	
Position Applied for: **Volunteer**	Volunteer Position(s) Preferred (Select all that apply): ☐ Any ☐ Home Visits ☐ Hospice House ☐ Administrative ☐ Spiritual Care ☐ Veteran Services ☐ Other (Please Specify): _____
Approximate number of hours you wish to contribute per week _____	
Days Preferred: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sat ☐ Sun	Times Available: ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends

LICENSE OR CERTIFICATION (If Applicable)					
Type	State	Date Received	Last Renewal	Certificate Number	

MILITARY HISTORY (If Applicable)			
Branch	Time Period	Rank	Awards Received
Overall Experience:			

Are you interested in participating in our Veteran to Veteran Program? ☐ Yes ☐ No ☐ Maybe

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CMC/Embrace Hospice is required by law to ask the following questions and may be required by law to report the answers to government agencies responsible for supervising health care, nursing home, home care or hospice activity:

1. Have you ever been convicted and/or been found guilty by a court or competent jurisdiction or a State agency of abusing, neglecting, or mistreating residents or of misappropriating resident property in the State or in any other State? If so, please describe the offense, the place and date of conviction, and the underlying circumstances or other information to help us evaluate your current fitness for employment.

   ☐ NO ☐ YES Explain _____

   _____

2. Have you ever been convicted of a felony? If so, please describe the offense, the place and date of conviction, and the underlying circumstances or other information to help us evaluate your current fitness for employment.

   ☐ NO ☐ YES Explain _____

   _____

3. Have you ever been convicted of (1) cruelty to persons, (2) assault of a person 60 years or older? If so, please describe the offense, the place and date of conviction, and the underlying circumstances or other information to help us evaluate your current fitness for employment.

   ☐ NO ☐ YES Explain _____

   _____

4. Have you ever been sanctioned by a healthcare licensing agency in the State of South Carolina or any other State of the United States? If so, please describe the offense, the place and date of conviction, and the underlying circumstances or other information to help us evaluate your current fitness for employment.

   ☐ NO ☐ YES Explain _____

   _____

"I hereby certify that I have not been convicted and or found guilty of patient abuse, neglect or mistreatment in the State of South Carolina or any other State in the United States. I understand that any offer of volunteering extended to me by CMC/Embrace Hospice is conditional upon the verification of this information with the State Patient Abuse registry and the OIG and that a listing of my name in such registry may act as an automatic withdrawal of any offer of volunteer placement."

"I further understand that if I am applying for a verified or licensed position, any offer of volunteering by CMC/Embrace Hospice is conditional upon verification of my license or certification with the appropriate agency."

_____ _____

Signature of Applicant Date

_____

Name as Written Above

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In Case of an Emergency

Name:_____

Address:_____

_____

Telephone:_____

Email:_____

By providing the above emergency contact information, I authorize the use of the above information in emergency situations involving myself or patients when I need to be contacted.

Reference #1

Name:_____

Address:_____

_____

Telephone:_____

Email:_____

Reference #2

Name:_____

Address:_____

_____

Telephone:_____

Email:_____

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Driver's License Information

Name on License: _____

Driver's License #:_____State:_____ Expiration date:_____

Copy of Drivers license copy on file: Yes No

Automobile Insurance Information

Vehicle Make/Model: _____

Insurance Company Name:_____

Policy #:_____

Copy of Insurance AND registration on file: Yes No

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VOLUNTEER BACKGROUND RELEASE FORM # VOL-22B2-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:** _____

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EMBRACE HOSPICE

Date:_____

Dear

Your name was given to us by _____ who has completed an application to become a volunteer with the Conway Medical Center Embrace Hospice 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.

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