



# Palos Community Hospital

## Application for Volunteer Services

Mail to: Palos Community Hospital  
 Volunteer Department  
 12251 S. 80<sup>th</sup> Ave.  
 Palos Heights, IL 60463

Phone: (708) 923-4041

*Placement of volunteer positions depends on availability and recommendation of the Volunteer Director. Volunteers do not take the place of salaried staff at Palos Community Hospital. Volunteer service is not intended in any way to lead to paid employment. Please complete all of the enclosed forms in this packet before mailing them back to the Volunteer Department. Thank you for choosing Palos Community Hospital.*

Please print all information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender:  Male  Female

Current or Last Place of Employment \_\_\_\_\_

Please check:  Employed  Retired  Other \_\_\_\_\_  Student \_\_\_\_\_  
(Name of School and Yr. of Graduation)

Education:  High School  Undergrad Degree  Graduate Degree  Trade School

Do you speak a second language?  No  Yes If yes, language(s) \_\_\_\_\_

**EMERGENCY CONTACTS (Must be listed)**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_ Phone Number \_\_\_\_\_

**Times/Days you are available to volunteer:**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If you are a college student applying, please circle the months that you are available to volunteer:  
 \* Also note: College students must attach a copy of their High School Immunizations with this application.*

*Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.*

Office Use:                      Date Received:                      Acknowledgment Letter:                      Orientation Invite Date:

► **PERSONAL REFERENCE (not a relative)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Best Time To Contact \_\_\_\_\_

► **Have you ever been convicted of a criminal offense other than minor traffic violation?**  No  Yes

If yes, please explain: \_\_\_\_\_

► **Do you have any medical limitations on the type of volunteer work you can perform?**  No  Yes

If yes, please explain: \_\_\_\_\_

► **Please indicate the reason you are seeking a volunteer position (check all that apply)**

Personal fulfillment  Professional development  Family/friends involved with hospital (name) \_\_\_\_\_

Extra Time  Possible future career  Requirement for class/degree (# hours required \_\_\_\_\_)

► **How did you learn about volunteer opportunities at Palos Community Hospital?**

Friend  Employer  School  Doctor  Website  Hospital volunteer/Employee (name) \_\_\_\_\_

Clergy  Other \_\_\_\_\_

► **What kind of volunteer opportunities are you interested in and why?** \_\_\_\_\_

► **Is there a particular type of volunteer work in which you are interested in? (Check all that apply)**

Patient Contact  Indirect patient contact  Greeter  Patient Transporter  Home Delivered Meals Driver

Clerical/filing  Lifeline Installer  Gift Shop  Sewing  Patient waiting rooms

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

**FOR VOLUNTEER OFFICE USE ONLY:**

Volunteer Agreement  Volunteer Health History  Health Reference  Orientation Review

ID Issued  Uniform Issued  Background Check  Position Description

Health Testing Requirements 1<sup>st</sup> PPD \_\_\_\_\_ 2<sup>nd</sup> PPD \_\_\_\_\_ Titer \_\_\_\_\_

Orientation Date: \_\_\_\_\_ Assignment: \_\_\_\_\_ Day/Time: \_\_\_\_\_

Training \_\_\_\_\_

# VOLUNTEER REQUIREMENT AGREEMENT

## CONFIDENTIALITY

- I shall hold absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, personnel and fellow volunteers.

## HIPAA

- I am responsible for keeping all information confidential, including, but not limited to a patient's physical condition, financial status, and personal problems.

## VOLUNTEER ROLE

- My role as a volunteer is to assist the hospital in my trained volunteer position. My services are donated to the hospital without contemplation of compensation or future employment.
- Never give medical assistance and/or advice to the patient and his/her family. I fully understand that this is the responsibility of the professional medical staff.
- Placement in an area depends upon both the current needs and the new volunteer's desires and skills.
- New volunteers are required to attend an orientation to learn hospital policies and procedures.

## STANDARDS

- I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others. I will represent the hospital in a professional manner and I will value my volunteer performance.
- I shall, at all times, uphold the Philosophy, Mission and Standards of Palos Community Hospital.

## DRESS CODE

- I understand that I will have a specific dress code that I must follow as a volunteer. I will be required to purchase a volunteer uniform as a part of my uniform from the Volunteer Department.
- I understand that I must wear my ID badge at all times. The ID badge is the property of Palos Community Hospital, and must be returned when service is terminated or if I require a leave of absence.

## HEALTH REQUIREMENTS

- Once accepted as a volunteer, I shall submit to (2) PPD skin tests, which will be administered by PCH Employee Health Services at the Hospital at no charge to the volunteer. The PPD skin test must be read by our Employee Health Service or Triage nurse to be valid. The 2<sup>nd</sup> required PPD test must be completed 14 days after the first test. Failure to comply with testing will result in discontinuation of volunteer service.
- I shall complete a "Volunteer Health History" form in which Employee Health Services will keep on record while I am a volunteer. This information should include verification of vaccination records prior to starting volunteer service.
- It is my responsibility to submit the required "Health Reference" form which must be completed by a physician to confirm the health status and limitations of the volunteer.
- I will report to volunteer service fit for duty, which means I am able to perform job duties in a safe, appropriate and effective manner.
- It is my responsibility to have a written physician's note to return to volunteer service if I have had a communicable disease, surgery or a procedure that could affect the status of my volunteer work.
- Volunteers working with direct patient contact will be required to have a titer test taken to verify immunization status and an annual PPD skin test. This will be discussed at the interview process with the Director of Volunteers to see if you will be eligible for this test. There is no cost to the volunteer for this test if administered by PCH and approved by the Director of Volunteer Services.

## EXPECTATIONS

- It is required that all volunteers consent to a criminal background check.
- I understand that the direction of my volunteer services is dependant on my competency to perform a task, and that placement is satisfactory to the requesting department for service.
- I will be required to complete an annual Safety, Infection Control and Policy review.
- I authorize permission to the Volunteer Services Department to verify references provided on my application.
- I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
- It is my responsibility to inform the volunteer office and the department in which I volunteer as far ahead as possible if I am unable to work.
- Smoking is not permitted anywhere on the hospital campus. Intoxicating beverages or illegal drugs should not be consumed prior to reporting on duty. Violation of any of these may result in immediate dismissal.
- I understand that the Volunteer Service Department reserves the right to terminate my volunteer status as a result of:
  - Failure to comply with Hospital policies, rules and regulation.
  - Absences
  - Unsatisfactory attitude, performance or appearance.
  - Any circumstances which in the judgment of the Department Director, would make my continued service as a volunteer contrary to the best interests of the Hospital.

**By signing this, I have read the following requirements and fully understand what is expected of my volunteer service.**

**Signature of Applicant** \_\_\_\_\_

**Date** \_\_\_\_\_