# VOLUNTEER APPLICATION

**Application for:**  
- Adult Volunteer  
- Teenage Volunteer  
- Intern

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
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**Street Address:** *(please provide a local address)*

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<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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<thead>
<tr>
<th>Home Phone:</th>
<th>Work Phone:</th>
<th>Cell Phone:</th>
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**Email Address:**

**Emergency Contact:**

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>Alternate Phone Number:</th>
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## Previous Volunteer / Work Experience

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<tr>
<th>Organization:</th>
<th>Dates:</th>
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<tr>
<th>Organization:</th>
<th>Dates:</th>
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**Special work experience, training, or talent that you want us to be aware of:**

**Please choose your availability:**

- □ One 4-hour
- □ Several 4-hour shifts per week

<table>
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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<td>AM</td>
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<td>EVE</td>
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<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tr>
<td>AM</td>
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<tr>
<td>EVE</td>
<td>EVE</td>
<td>EVE</td>
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**Areas of Interest** From the list of areas of service online, please indicate which programs would be of interest to you:

**PERSONAL REFERENCES:** Please provide us with two letters of reference. These must be from someone who is not related to you and can attest to your commitment, work ethic and character. The references will need to contain the contact information of the referring person and will need to be brought with you to your interview.
VOLUNTEER PLEDGE OF COMMITMENT

1. CONFIDENTIALITY

I will consider all information confidential which I may hear directly or indirectly concerning a patient, physician or any member of the hospital staff and I will not seek information in regard to a patient.

2. COMMITMENT

I agree to a minimum 100 hours in 6 months commitment to volunteer at Florida Hospital. I will uphold the standards and traditions of the hospital as they are expressed in its Mission Statement, Values and that of the Department I am a team member of.

3. EXPERIENCE

The purpose of the volunteer program is to provide an opportunity to experience a hospital environment and provide needed services and assistance to the hospital staff, patients and visitors. The program is not meant for the purpose of job or career training, nor is it meant to lead to paid employment at Florida Hospital.

SIGNATURE ______________________________________ DATE__________________________

VOLUNTEER CONDITIONS

• I certify that the information on this application is true and complete to the best of my knowledge. I understand that any misrepresentation or omission of facts on this application will be sufficient cause for disqualification of this application.

• I give permission for Florida Hospital to verify any information provided in this application and I authorize my past references or any other persons to answer all questions concerning my ability, character, reputation, and previous employment record. I release all such persons from any liability or damages resulting from having furnished such information.

• I am aware that if I should sustain injury while volunteering that Florida Hospital is not liable. That I must report my injury and have my supervisor or other Florida Hospital employee document my injury.

SIGNATURE ______________________________________ DATE__________________________

Office Use Only

Date of Interview:

Area of service:

Day:

Shift:

Updated 08/2015
PARENTAL CONSENT FORM

To be completed by the parent/legal guardian of individuals under the age of 18:

I give permission for my son/daughter ____________________________, who is at least 16 years old, to participate as a teenage volunteer at Florida Hospital.

I understand that my son/daughter is making a commitment to serve as a volunteer and that I will support his/her participation, which includes reporting for duty as scheduled, except in the event of illness. I understand that he/she will be assigned to an available service suitable to his/her age and capabilities.

I understand that as a requirement to volunteering my child will undergo

- drug screening,
- TB screening test and/ or chest x-ray if appropriate
- Flu vaccination during flu season*
- Florida Hospital will also perform a background check
- My child may also be included in Florida Hospital photos or videos
  Used for marketing or education purposed. (a release form is included in the application packet for this.)

I grant my consent for this.

Signature ______________________________________ Date __________________________

Print Name ________________________________

*Flu shots are free to current volunteers. Obtaining a flu shot is not mandatory. Flu season occurs the beginning of December through the end of March. A volunteer who does not have a flu shot will be required to either take a leave of absence during flu season, wear a mask when in patient areas or be reassigned to volunteer in non-patient areas.

Updated 08/2015
HIPAA is the Health Insurance Portability and Accountability Act (Federal law) that was developed in order to implement a national, uniform system of keeping patients records secure and private, as well as implementing a faster way to process health care claims. Below is a brief description of important aspects of this law that you should be aware of, even if you don’t deal directly with these issues.

**Patient Information**
Only access, use, or disclose, on a legitimate “need to know” basis, patient information for activities related to treatment, payment, and healthcare operations on behalf of the company. ALWAYS maintain the privacy of our patient’s information.

**Minimum Information** – Only access, use, or disclose the minimum information necessary to perform your designated role regardless of the extent of access provided.

**Notice of Privacy Practice**
Staff will provide patients with a Notice of Privacy Practices, which will inform patients of their rights with respect to protected health information, as well as Florida Hospital legal duties.

**Release of Information**
Do not release information for purposes other than treatment, payment, and healthcare operations without written authorization from the patient, except as required by applicable federal, state, or local laws and regulations.

I will abide by the HIPAA Federal law and the Florida Hospital rules and policies regarding confidential information.

Print Name: __________________________

Signature: ___________________________ Date: _______________

In order to be compliant with DNV GL Healthcare, volunteers are required to complete the following questionnaire regarding information that has been received in the Volunteers’ Orientation. Enclosed is a study manual to help you along. **Please circle the correct answers:**

1. **Code Blue stands for:**
   A. Cardiopulmonary Arrest
   B. Bomb threat

2. **Florida Hospital mission is to Extend the healing ministry of Christ:**
   A. True
   B. False

3. **Code Pink stands for:**
   A. Infant/child Kidnapping
   B. A baby girl is born

4. **Code Red stands for:**
   A. Violent Incident
   B. Fire

5. **During a fire we use the acronym RACE stands for:**
   A. Run, Avoid, Call, Evacuate
   B. Remove, Activate, Close, Evacuate

6. **Florida Hospital is accredited by DNV GL Healthcare:**
   A. True
   B. False

7. **Ideas about different treatments and physician recommendations can be discussed with patients:**
   A. True
   B. False

8. **TB tests need to be done:**
   A. Once a year
   B. Every two years

9. **To use a fire extinguisher, the PASS procedure is followed. It means:**
   A. Press, Aim, Shout, Send
   B. Pull, Aim, Squeeze, Sweep

10. **ID badges are to be worn on the upper left part of your uniform:**
    A. True
    B. False

11. **Florida Hospital’s vision is to be a global leader providing highly advanced, faith-based healthcare:**
    A. True
    B. False

12. **The most effective method to prevent the spread of infection is hand washing:**
    A. True
    B. False

13. **Competency assessments are done yearly thru BARE Facts and Competency Evaluations:**
    A. True
    B. False

14. **ISO 9001 is a quality system used as a global standard in order to demonstrate that a company is committed to quality and process improvement:**
    A. True
    B. False

15. **If requested by patients, volunteers are allowed to remove or loosen restraints:**
    A. True
    B. False

16. **Accessing or sharing patient information can result in dismissal from your volunteer position and federal penalties:**
    A. True
    B. False

17. **CREATION Health is Florida Hospital’s philosophy to care for the whole person and to motivate people to adopt healthy lifestyle changes:**
    A. True
    B. False

18. **Volunteers should witness papers when requested by patients:**
    A. True
    B. False

19. **Documents showing patients’ names should be turned upside down:**
    A. True
    B. False

20. **Volunteers are allowed to lift patients:**
    A. True
    B. False

After this questionnaire is completed, please sign, date, and return to your Volunteer Services Department. Thank you!

Name ________________________________________

(Please sign name)

Date: ____________________________

(Please print name)

Campus: ________________

(Please print name)
Florida Hospital Volunteer Services Orientation Declaration

This is to certify that I, ___________________________ have attended the Volunteer Services Orientation and received direction in the following areas of concerning Florida Hospital policies and procedures:

<table>
<thead>
<tr>
<th>Welcome</th>
<th>✓</th>
<th>Our Process Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer Commitment</td>
<td></td>
<td>HIPAA</td>
</tr>
<tr>
<td>History of Florida Hospital</td>
<td></td>
<td>Risk Management</td>
</tr>
<tr>
<td>Campus Priorities</td>
<td></td>
<td>Infection Prevention</td>
</tr>
<tr>
<td>Mission, Vision, Values</td>
<td></td>
<td>Safety &amp; Environment of Care</td>
</tr>
<tr>
<td>CREATION</td>
<td></td>
<td>Looking Right / What NOT To Wear</td>
</tr>
<tr>
<td>The Patient Experience</td>
<td></td>
<td>Discipline Policy</td>
</tr>
<tr>
<td>AIDET</td>
<td></td>
<td>Internal Communications</td>
</tr>
<tr>
<td>Compassion Behaviors</td>
<td></td>
<td>Severe Weather</td>
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<tr>
<td>At Your Service</td>
<td></td>
<td>Solicitation</td>
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<tr>
<td>DNV</td>
<td></td>
<td>Questions</td>
</tr>
</tbody>
</table>

In addition to completing the proper forms, I will abide by the HIPAA (Health Insurance Portability & Accountability Act) Federal Law and the Florida Hospital rules and policies regarding confidential information.

___________________________    _ _________________________  __________
Signature of Above Named Individual  FH Campus Location     Date of Orientation

Updated 08/2015
CONFIDENTIALITY STATEMENT

1. Sign-On:
   - I understand access to the system needs to be protected, and will not reveal the Password to anyone.
   - I understand that an individual ID/Password is an electronic signature and will not intentionally use someone else’s or leave a system unattended where mine is signed-on.

2. Confidential Information.
   - I understand that I may have the right to access confidential information, but will take care only to access what I need for performing my job.
   - I will adhere to ethical standards in protecting confidential information both on and off the job.
   - I will not intentionally give out confidential information to those who don't have a legitimate need-to-know, and I will take reasonable care to make sure that unauthorized people do not see/overhear it, that reports are stored in a safe place, and that unneeded information is properly disposed.
   - I understand that any inappropriate or unauthorized retrieval/review/sharing of private patient or employee information with unauthorized people may result in disciplinary action which could include termination.
   - I will not give confidential information to anyone who is not authorized to have it.
   - I will not discuss confidential information when unauthorized people might overhear it.
   - I will not leave confidential information where unauthorized people might see it.
   - I will access confidential information only during my tour of duty.
   - I will not access confidential information which is not needed to perform my job.
   - I will not take confidential information out of my authorized work area.
   - I will store confidential reports in a locked secure area.
   - I will destroy unneeded confidential information by having it shredded, burned, or returning it to the area that produced it.

I have read and do understand my responsibilities and obligations under this policy, and have signed my acknowledgment to adhere to its terms:

Volunteer Name (Print) ___________________________________________ Op ID _________________
Dept Name ____________________________________________________________________________
Volunteer Signature:_______________________________________ Date__________________________

Updated 08/2015
VOLUNTEER ID BADGE FORM

☐ Volunteer  ☐ Intern  ☐ Pastoral Care

Name:

Campus: please choose one

☐ Apopka  ☐ Altamonte  ☐ Celebration
☐ Children’s  ☐ East  ☐ Kissimmee
☐ Orlando  ☐ Winter Park

For Patient safety purposes, your badge must be returned:

✓ Upon taking a leave of absence
✓ When ending your volunteering or interning with Florida Hospital

Please read and sign the statement below:

I understand and agree that should I take a leave of absence or cease to volunteer, I must immediately return my badge to Florida Hospital

Signature  Date

-------------------------------------------------------------------------------------------------------------------
(Volunteer Office use only)

Employee Number

Badge Number

OPID

☐ Please Give Badge Now  ☐ Please Hold Badge for Volunteer Services

Updated 08/2015
Volunteer Services Department
Training/Competency Checklist

*To be completed with your department representative*

VOLUNTEER NAME: ______________________ DEPARTMENT: _________________

Volunteer: You must return the completed checklist or have department fax to Volunteer Services after 1st training day. Our fax number is: _____________________

<table>
<thead>
<tr>
<th>TASK</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>1. Knows when and where to report for assignment</td>
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<td>2. Knows where and how to clock in and out</td>
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<td>3. Introduced to “Staff Contact” and personnel</td>
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<td>4. Knows whom to contact/call if unable to come in</td>
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<td>5. Has appropriate uniform and ID Badge</td>
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<td>6. Understands service area Guidelines</td>
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<td>7. Understand no smoking rules</td>
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<td>8. New Volunteer is able to locate the following:</td>
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<tr>
<td>- Volunteer Office</td>
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<tr>
<td>- Area of Service</td>
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<tr>
<td>- Public Restroom</td>
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<tr>
<td>- Cafeteria</td>
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<td>- Telephone</td>
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<tr>
<td>- Fire Alarm</td>
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<td>- Fire Extinguisher</td>
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<td>- Fire Exit Map</td>
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<td>- Equipment/Supplies Needed</td>
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<tr>
<td>- Where to find/return keys (if necessary)</td>
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<tr>
<td>9. Safety of Personal Items</td>
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<tr>
<td>10.Demonstrates ability to work independently</td>
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</table>

Volunteer Signature: ______________________  Trainer Signature: ______________________

Checklist Reviewed by: ______________________  Date Completed: ______________________

(Volunteer Department Only)
CONSENT TO OBTAIN CONSUMER REPORTS FOR PURPOSES OF VOLUNTEER SERVICE

In connection with, and for the duration of, my volunteer service with you, I understand that you may obtain consumer reports for placement purposes that relate to my credit, criminal, driving, employment or education history. This information will, in whole or in part, be obtained from Acxiom Information Security Services, Inc., 6111 Oak Tree Blvd, 4th floor, Independence, OH 44131, telephone 800.853.3228. These reports may include information as to my general reputation, character, personal characteristics, mode of living, work habits, job performance and experience along with reasons for termination of past employment from previous employers. I understand that you may be requesting information from various federal, state and other agencies or institutions, which maintain public and non-public records concerning my past activities relating to my driving, credit, civil, education and other experiences.

I authorize, without reservation, any party, institution, or agency contacted by Acxiom or this employer to furnish the above mentioned information:

_________________________________________ Email address: _______________________________

Applicant Name            Date of Birth              Social Security Number

Notice to CALIFORNIA Applicants
Under Section 1786.22 of the California Civil Code, you have the right to request from Acxiom, upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you, which Acxiom has previously furnished within the two-year period preceding your request. You may view the file maintained on you by Acxiom during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services. Upon making a written request, you may receive a summary of your report via telephone.

Notice to NEW YORK Applicants
Under Article 25 Section 380-g of the New York General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

APPLICANT SIGNATURE____________________________________ DATE _________________

Please complete all of the questions on the reverse side of this form. If there is not enough room for complete disclosure of all requested information, please attach an additional sheet of paper with your completed information.
Volunteer Candidate Prescreening Questions:

1. Have you ever been laid off, discharged from an employer or asked to resign by any employer?

2. If you answered “yes” to question #1, please provide information on the employer, date, action and an explanation, otherwise type N/A.

3. Have you ever been denied a professional or occupational license, registration or certificate?

4. Has your license, registration or certificate ever been investigated, revoked, suspended, limited or subject to discipline by any board or governing authority?

5. If you answered “yes” to either or both of questions 3 and 4 please explain in detail, if not please type N/A below:

6. Have you ever pled guilty to any criminal offense(s)(misdemeanor or felony) other than parking tickets? If your offense(s) have been expunged or sealed, please state no.

7. Have you ever been convicted of any criminal offense(s)(misdemeanor or felony) other than parking tickets? If your offense(s) have been expunged or sealed, please state no.

8. Have you ever pled nolo contendere (no contest) to any criminal offense(s)(misdemeanor or felony) other than parking tickets? If your offense(s) have been expunged or sealed, please state no.

9. If you answered “yes” to any or all of questions 6, 7 and/or 8, please provide information on all criminal offense(s), date(s), location(s)(city/state) and disposition, otherwise type N/A.

10. Have you ever served any of the following for any criminal offense? (Check all that apply) □ Pretrial diversion □ Pretrial release
            □ Suspended sentence/prosecution □ Supervised release
            □ Shock/challenge incarceration □ Probation (any type)
            □ Community based punishment □ Community control/supervision/service
            □ Pretrial release □ Deferral/diversion of prosecution
            □ Unconditional discharge □ Restorative justice program
            □ Deferred adjudication □ Deferred adjudication
            □ Postponed judgment □ Conditional discharge
            □ Indeterminate commitment □ Not applicable

11. Any type of alternative, deferred, suspended, postponed or conditional prosecution, adjudication, disposition, sentence, program or release not listed above, please describe: (if not, type N/A)

12. Adventist Health System employees adhere to smoke-free environments; therefore no smoking is permitted in or around our facilities. If selected as a volunteer, are you able to comply with these and any other additional facility-specific smoking policies?

APPLICANT SIGNATURE_________________________________ DATE ____________

PARENTAL SIGNATURE_________________________________ DATE ____________

Updated 08/2015
New Volunteer Orientation Survey

Please fill out survey and give to presenter at the end of orientation

DATE: _____________________________________
NAME: _____________________________________ (optional)

1 = Strongly Disagree  2 = Disagree  3 = Neutral  4 = Agree  5 = Strongly Agree

1. The volunteering process is clear, and I know what to expect next.
   ___1  ___2  ___3  ___4 ___5

2. I know a place/department I would like to volunteer.
   ___1  ___2  ___3 ___4 ___5

3. I feel well prepared to volunteer in a healthcare environment.
   ___1  ___2  ___3  ___4 ___5

4. My presenter was knowledgeable, easy to understand, and an effective communicator.
   ___1  ___2  ___3  ___4 ___5

5. Orientation materials and presentation are effective and clear.
   ___1  ___2  ___3  ___4 ___5

6. The orientation increased my desire to be a part of the Volunteer Team at Florida Hospital.
   ___1  ___2  ___3  ___4 ___5

My primary interest in volunteering is: - Please rank in order of preference, 1 = Greatest interest
   • To improve the safety of care
   • To improve the experience of patients
   • To assist staff in their responsibilities
   • To support an organization I care about

I feel I can best accomplish my goals by volunteering in the following ways: Please make selection(s)
   - With patients in a clinical setting
   - On nursing units assisting staff
   - Information / Guest Services roles
   - Healthcare Administration
   - Clerical support
   - Retail shops
   - Transportation
   - Other

Our goal is to inspire ways that you can contribute to Florida Hospital, and convey that your gift of service is a blessing to others. Do you have additional comments, concerns, or suggestions? How could we make this orientation more beneficial for you?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

We appreciate your input. Thank you!

Updated 08/2015