Memorial Health

VOLUNTEER INFORMATION SHEET

First Name:_____MI_____Last Name _____

S.S. # _____- _____- _____ D.O.B. _____/_____/_____(mm/dd/yyyy)

Male_____ Female_____ Ethnicity/Race _____

Phone Number_____Email Address_____

Address_____

City _____ State _____ Zip _____

Emergency Contact Information

First Name:_____Last Name: _____

Contact Number: Daytime_____Cell Phone: _____

Email Address_____Relationship _____

VSA-OFFICE USE ONLY

Has applicant ever been convicted of a crime other than a minor traffic violation?
Yes_____No____If yes, please see attachment.

Submitted to HR on: _____

Delivery Method: Inter-Office or Electronic Message

Memorial Health

Volunteer Application

We appreciate your interest in volunteering with our organization and assure you that we are interested in your qualifications. A clear understanding of your background and work history will assist us in placing you in the position that best meets your qualifications to offer you the best volunteering experience.
All applications are under a review for 30-days consideration.

Placement will be limited to available volunteer positions.

Name_____

Address_____

City/State/Zip_____

Home #_____Work # _____

Cell #_____E-Mail _____

Have you ever worked at Memorial Health? _____

If yes, please give dates of employment and department area:

_____

Do you have any relatives who currently work at Memorial Health or who are members of its medical staff? _____

Are you currently employed?_____If so, where? _____

Name of current supervisor or manager: _____

Education background: please check highest level completed

High School_____College_____1_____2_____3_____4 _____

Master's_____Doctorate _____

Memorial Health

Volunteer Locations

Volunteers play an important role in patient care. You will interact with patients and their families, as well as with medical personnel and other staff. Our goal is to place you in a position that allows your talents to shine. There are several areas possible for volunteering.

Patient Care Services:

☐ Children's Hospital of Savannah

☐ Neonatal

☐ Child Life Services

☐ Greatest Need

☐ Anderson Cancer Institute

☐ Laboratory

☐ Radiology

☐ Emergency Room

☐ Rehabilitation

☐ Floor/Unit Desk support

Administrative/Clerical Support:

☐ Heart & Vascular Waiting Room

☐ Employee Health

☐ Information Desk(s)

☐ Pet Therapy

Day(s) of the week preferred: Please indicate times preferred by circling the day and time of day you prefer. List the hours you are available.

Availability: ☐ **Mon** ☐ **Tues** ☐ **Wed** ☐ **Thurs** ☐ **Fri** ☐ **Sat** ☐ **Sun**

Morning_____Afternoon_____Evening _____

Weekends: Saturday ☐ **Sunday** ☐

Morning_____Afternoon_____Evening _____

Volunteer Experience

Name of Organization _____

Address_____

City/State/Zip_____

Position Held_____Supervisor_____

Dates of Service (From)_____(To) _____

Volunteer Experience

Name of Organization _____

Address_____

City/State/Zip_____

Position Held_____Supervisor_____

Dates of Service (From)_____(To) _____

PLEASE LIST TWO REFERENCES and

TWO LETTERS OF RECOMMENDATION:

Name_____Phone_____

Address_____

City/State/Zip_____

Relationship_____

Name_____Phone_____

Address_____

City/State/Zip_____

Relationship_____

Memorial Health

Please tell us why you chose Memorial Health to be a volunteer:

_____

_____

_____

_____

_____

_____

_____

Have you ever been convicted of a crime other than a minor traffic violation?

Yes_____ No_____

If yes, please explain:

Disclaimer and Agreement (***Please read carefully before signing***)

I affirm that the information provided in this application is correct and complete to the best of my knowledge. I understand that volunteer applicants will undergo a criminal background check. I consent to take the pre-volunteer physical health screening and any such future screening(s) as may be required by Memorial Health University Medical Center. I agree to follow hospital policies and procedures for volunteers as outlines in the Volunteer Handbook. I understand that Workers Compensation does not cover volunteers and that I am responsible for maintaining my health insurance. I voluntarily offer my services with a clear understanding there will be no monetary compensation, and that volunteering does not lead to employment.

I understand and agree that submitting this application form does not automatically register me as a Memorial Health University Medical Center volunteer and that there may be specific qualifications I must meet including the acceptance of established volunteer policies and procedures before I may begin volunteering.

I agree to volunteer no less than four hours at a time for a minimum commitment of at least 80 hours over one-year time period. Note that staff will verify all hours once the volunteer has completed all required responsibilities.

Signature_____Date_____

Please note an interview does not guarantee acceptance into the program

Memorial Health University Medical Center
MMCS.Volunteers@HCAhealthcare.com
Volunteer Services
P.O. Box 23089 Savannah, GA 31403
(912) 350-0673 Fax (912) 350-4599

Memorial Health Savannah - Volunteers and High School Students # 14374

VOLUNTEER AUTHORIZATION

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports," including criminal background checks, by the Company at any time after receipt of this authorization and throughout the hiring process and the term of my employment, contract or privileges, if applicable. I authorize the Company throughout the term of my employment or contract, to share any consumer report received with a related entity. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

My present employer may be contacted for a job reference. Yes☐ No☐

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature:_____**Date** _____

First Name:_____**Middle Name:**_____

Last Name:_____

DOB_____**Last four digits of SSN** _____

Parent/Guardian Signature:_____

Date _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

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