



Application Packet for Adult Volunteers

Our volunteers provide countless hours of service to our patients, visitors and families. They are integral part of our Crestwood family, staffing the Information Desk, serving as patient advocates, and providing support in various departments throughout the hospital. We are thankful for their willingness to share their time and talents in support of Crestwood and the community. And volunteering has its own rewards: new friendships, new experiences, new challenges, and the satisfaction that comes from knowing that your efforts truly make a positive difference in the quality of life for our community.

Interested in volunteering? We have many wonderful volunteers with room for more! In order to volunteer, you must meet the following criteria: **Volunteer applicants should be 19 years of age or older, willing to commit to volunteer for one 4 hour shift per week and a minimum of 60 hours throughout a six month period.**

Shifts: Volunteer shifts generally run 8 AM - 12 PM (Morning), 12-4 PM (Afternoon), and 4-8 PM (Evening). Some departments can offer more flexibility with those times.

These volunteer efforts include:

- Greeting and Directing Visitors at Our Information Desks
- Escorting families in the surgery waiting areas
- Mail and Flower Delivery to Patients
- Assistance in over 15 departments of the hospital
- Visiting patients and assisting nursing staff

How do I become a Volunteer?

1. Completed the attached application and gather any additional documentation.
2. Contact us to schedule an interview. Prospective volunteers will be interviewed by one of the Volunteer Services staff or Volunteer Executive Board. Bring your completed application and any other requested documents, such as a copy of your immunization records (if available) and a letter of recommendation, to your interview.
3. Once accepted as a volunteer, you will complete the pre-volunteer process including criminal background check, TB skin test, drug screening and provide proof of immunizations (a copy of your records will work) as well as a letter of reference. New volunteers will be required to complete a one hour orientation prior to beginning their volunteer service. Volunteering for college credit requires a student volunteer agreement. Please indicate if you are volunteering for college credit.

An interview to volunteer may be scheduled by phone at 256.429.4076. Please bring your completed paperwork with you.

Thank you for your interest in joining the Volunteer Program at Crestwood Medical Center! We look forward to meeting you.



CRESTWOOD MEDICAL CENTER

Application Packet for Adult Volunteers

Date _____

Last Name _____

First Name (preferred) _____

Street Address _____

City _____ State _____ Zip Code _____

Email Address _____

Telephone _____ Alternate Telephone _____

Date of Birth ____ / ____ / ____ Social Security Number _____

Male Female

Emergency Contact Name _____

Relationship _____ Telephone _____

Interest Questionnaire

Why are you interested in volunteering? _____

Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)?

No Yes

If yes, please describe the service requirements

Service Organization & Contact _____

Phone Number _____

Is there anything that may adversely affect your ability to perform volunteer duties?

No Yes

If yes, please describe in detail _____

Are there any accommodations needed in order for you to safely and competently perform volunteer duties as requested? _____

Do you have any physical, visual or hearing needs we need to consider? No Yes
If yes, please explain _____

Areas of Volunteer Service

Please check all areas that you are interested in volunteering in the hospital:

- | | |
|--|--|
| <input type="checkbox"/> Information Desk | <input type="checkbox"/> Surgery Waiting Area |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Special Procedures |
| <input type="checkbox"/> Day Surgery | <input type="checkbox"/> Registration Escort |
| <input type="checkbox"/> Imaging Center | <input type="checkbox"/> Women's Center |
| <input type="checkbox"/> Orthopedic/Surgical Patient Floor | <input type="checkbox"/> Outpatient Cardiac Area |
| <input type="checkbox"/> Medical Patient Floor | <input type="checkbox"/> Oncology Patient Floor |
| <input type="checkbox"/> Progressive Cardiac Patient Floor | <input type="checkbox"/> OB/GYN Patient Floor |
| <input type="checkbox"/> Therapy Services | <input type="checkbox"/> Intensive Care Unit/Waiting Areas |
| <input type="checkbox"/> Other: _____ | |

When are you available to begin volunteering? _____

Check when you wish to volunteer. Each shift is 4 hours.

- | | | | |
|------------------------------------|-------|----|-------|
| <input type="checkbox"/> Monday | _____ | to | _____ |
| <input type="checkbox"/> Tuesday | _____ | to | _____ |
| <input type="checkbox"/> Wednesday | _____ | to | _____ |
| <input type="checkbox"/> Thursday | _____ | to | _____ |
| <input type="checkbox"/> Friday | _____ | to | _____ |
| <input type="checkbox"/> Saturday | _____ | to | _____ |
| <input type="checkbox"/> Sunday | _____ | to | _____ |

Education and Work Experience

What is your highest level of education? High School, Vocational, College, etc.? _____

Have you ever worked or volunteered at a hospital? No Yes _____

Last Place of Work (if any): _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor's Name: _____

References

Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not provide recommendations.

1. Reference Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

2. Reference Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Other

1. Have you ever been convicted of a felony? No Yes

2. Have you ever been convicted of a misdemeanor? No Yes

If Yes to either question, please describe the conviction(s) in detail, including dates. _____

Certification and Authorization

Carefully read this section prior to providing signature below.

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Date _____ Signature _____

Only the Director of Volunteer Services and Administrative officers are authorized to make offers of volunteering on behalf of Crestwood Medical Center and its related facilities. All offer of volunteer opportunities are conditioned upon successful completion of a background investigation. Application remains active for 90 days only.

Certification and Authorization for Volunteers

Please read the following paragraph carefully before signing.

I certify that the information I have provided is true and correct to the best of my knowledge and belief. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer. If accepted as a volunteer, I must abide by all of the policies, rules and regulations of Crestwood Medical Center.

I authorize Community Health Systems (the "company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employers to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied a volunteer position based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application. (HR: for volunteers and auxiliaries, only a criminal background check is required)

Date

Print legal first, middle and last name

Social Security Number

Date of Birth

Driver's License # and State Issued

Street Address

City

State

Zip

Signature

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<p>For Internal Use: OIG Sanction Check ____ Initials ____ Date Background Check ____ Initials ____ Date</p>
