PORTER REGIONAL HOSPITAL VOLUNTEER APPLICATION

First Name	M.I	Last Name	Date of Birth	Volunteer Category
			____/____/_____	☐Student (14-17) ☐Adult (18 and up)
Please check all that apply:	☐Mr. ☐Mrs. ☐Ms. ☐Sr. ☐Jr. ☐Dr. ☐Other: _____			

Address 1	Address 2	City	State	ZIP

Preferred Phone #	Secondary Phone #	Email Address

Marital Status	Spouse First Name	Spouse Last Name
☐Single ☐Married ☐Widowed		

Emergency Contact (EC) Name (REQUIRED)	EC Relation	EC Phone #

Education Information

High School	City	State	Grade Completed
College/University	**City**	**State**	**Degree**
College/University	**City**	**State**	**Degree**

Computer Skills
(check all that apply)

☐Microsoft Excel
☐Microsoft Word
☐Microsoft Outlook
☐Microsoft Publisher
☐Others:
_____

Community Organization Involvement or Affiliations
(please fill in)

_____ _____
Organization Position

_____ _____
Organization Position

_____ _____
Organization Position

Have you ever been an employee of Porter Hospital or any of its entities? ☐Yes ☐No

Employee or Retiree of:

Relatives that are currently employed at any of the above listed?: **Relationship:**

Availability: (circle and check all that apply): **S M T W TH F S** ☐Morning ☐Afternoon ☐Evening

Do you have any restrictions that might affect your volunteer placement? ☐No ☐Yes; Please Explain:

Parental/Legal Guardian Consent (needed if volunteer is 17 and under)

I hereby give permission for my daughter/son to volunteer at La Porte and/or Starke hospitals and certify that all information is correct. I give permission for my child to have a 2-step PPD screening for tuberculosis, a flu vaccination, and a five-panel urine drug screen **at which I will be present for.** All will be given at Workforce Health at no charge, providing my child returns to the same location within 48 hours after receiving the TB test to have it read by a certified professional. Failure to do this will render the test invalid. I understand that my child cannot begin her/his service until the results of his/her tests have been confirmed. I also understand that when my child has completed his/her service, the volunteer attire and badge will be returned to the Volunteer Services Department. Failure to return these items could result in payment for them.

_____ _____

(Parent or Guardian Signature) (Date)

Volunteer Commitment

- ❑ I authorize my references to provide information to Porter Regional Hospital Volunteer Services that is relevant to my volunteerism.
- ❑ I agree to abide by the policies and regulations of Porter Regional Hospital.
- ❑ I agree to respect the dignity and rights of each individual and maintain all patient information in STRICT CONFIDENCE. I understand that violations of any of the policies of Porter Regional Hospital may result in my immediate dismissal from the Volunteer Program.
- ❑ I understand that I must pass a New Volunteer Screening with Workforce Health that includes proof of the following: Photo ID; Immunization Record (if available); Corrective Lenses (if applicable); TB test results (if done in the last 12 months); and a five-panel urine drug screen before my volunteering may begin.
- ❑ I understand that if I am over 18, a criminal background check and OIG Sanction check will be conducted before my volunteering may begin.
- ❑ I understand that making the minimum three-month commitment to volunteer means that I will be present and on time as scheduled.
- ❑ I understand, if accepted as a volunteer, I will be subject to a review to ensure my volunteer placement coincides with the policies and procedures of Porter Regional Hospital.
- ❑ I understand that volunteerism is subject to conditions of the Drug Free Workplace Act of 1998.
- ❑ I also understand that when I have completed my service at Porter Regional Hospital, the volunteer attire and badge will be returned to the Volunteer Services Department. Failure to return these items could result in payment for them.

_____ _____ _____

(Applicant Signature) (Date) (SS# if 17 and under for TB tracking)

COMPLETE BELOW IF YOU ARE 18 AND OVER

Porter Regional Hospital – Release of Information

Last Name: _____ First Name: _____ M.I. _____ Maiden _____

Social Security Number: _____ Date of Birth (mm/dd/yyyy): _____

I hereby authorize and give consent to the release of my criminal background history to Porter Regional Hospital, or any affiliates, as is required for the purpose of volunteerism.

I hereby waive, release and surrender any and all rights to claims which I have against the city, county or state mentioned above, or any of its officers or employees as a result of the release of such records.

_____ _____

Signature of Applicant Director of Volunteer Services

*All service records will be kept for a minimum of three years