



VOLUNTEER APPLICATION

Today's Date _____

EMAIL COMPLETED APPLICATION TO volunteer@nahospital.org Please print clearly.

PERSONAL INFORMATION

Name: _____

Address: _____
Street City State Zip

E-mail: _____

How often do you check your email? At least once a week Once a month Rarely/Never

REFERRAL How did you hear about volunteering at Norwegian American Hospital (e.g. **Volunteer Match, Employee of Norwegian American Hospital** **first and last name**) _____

Phone: _____ home cell work

Phone: _____ home cell work

Social Security #: _____ Date of Birth: _____
Required for online background check Month | Day | Year

EDUCATION

-Are you currently in school? Yes No If yes, where? _____

-If college, graduate, or postgraduate student, what are you studying? _____

-If you are volunteering as part of a school, are taking part in an internship or externship, please list the name of the school or program here: _____

-Are you volunteering to fulfill community service hours? Yes No

Name of Organization/ **hours needed**: _____

Note: Court-ordered community service hours are *not* allowed here.

Languages:

English	Speak <input type="checkbox"/>	Read <input type="checkbox"/>	Write <input type="checkbox"/>	Fluent Yes <input type="checkbox"/>	No <input type="checkbox"/>
Spanish	Speak <input type="checkbox"/>	Read <input type="checkbox"/>	Write <input type="checkbox"/>	Fluent Yes <input type="checkbox"/>	No <input type="checkbox"/>
Another: _____	Speak <input type="checkbox"/>	Read <input type="checkbox"/>	Write <input type="checkbox"/>	Fluent Yes <input type="checkbox"/>	No <input type="checkbox"/>

Specific Computer Skills (e.g. Word, Excel, Access, Meditech, etc.): _____

Employer (if applicable): _____

Website: _____

Do you have any previous volunteer experience? _____

RESUME OR CURRICULUM VITAE Please attach your resume or C.V. to this application

AVAILABILITY What **times** are you available to volunteer?

List times that you are available and we can discuss how often you would like to volunteer (e.g. once per week on Wednesdays or Fridays)

Mon: _____ Tues: _____ Wed: _____ Thurs: _____
Fri: _____ Sat: _____ Sun: _____ (e.g. afternoons)

How often can you Volunteer (e.g. once per week)? _____

Note: The Hospital requires a six month commitment. If you cannot volunteer for six months, please let the Coordinator, Volunteer Services know. If you are part of a school or organization, **how many service hours do you require?** _____

VOLUNTEER AREAS OF INTEREST Please refer to the “Welcome Letter” attachment for an explanation of the many volunteer opportunities and **list up to 3** areas that you are interested in Volunteering.

Areas I’m interested in Volunteering: _____

REFERENCES Provide the full name, address and phone of 2 personal and 1 professional references. Relatives may not be used as a reference.

Name: _____

E-mail: _____

Phone: _____ Relationship: _____

Name: _____

E-mail: _____

Phone: _____ Relationship: _____

Name: _____

E-mail: _____

Phone: _____ Relationship: _____

AGREEMENT & SIGNATURE (Under 18 years old – Parent/Guardian Signatures also required)

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Volunteer/Applicant

Signature Date

Parent/Guardian (if applicant is less than 18 years of age)

Date

EMERGENCY CONTACT

In case of emergency, who should we contact? Name _____ Phone _____

Relationship to you: (ex, spouse, mother, etc.) _____

UNIFORM and ID Badge

I understand that I must adhere to the uniform for my Volunteer Department, including wearing my ID badge whenever I volunteer at Norwegian American Hospital.

When my Volunteer Services end, **I will return my ID badge**, and Norwegian American **Vest (if provided)** to the Volunteer Coordinator or Human Resources Department.

Volunteer/Applicant

Signature Date

Parent/Guardian (if applicant is less than 18 years of age)

Date

VOLUNTEER APPLICANT CONSENT TO CONDUCT BACKGROUND CHECK

I understand and agree that as a condition of being selected as a volunteer at Norwegian American Hospital, Norwegian American will conduct a criminal background check. My signature below constitutes my authorization for Norwegian American Hospital or its agents to check my background. I waive and release Norwegian American Hospital and its agents from any and all claims I may otherwise have with respect to any such criminal background check.

Volunteer/Applicant

Signature Date

Parent/Guardian (if applicant is less than 18 years of age)

Date

VOLUNTEER APPLICANT CONSENT TO PPD SCREENING, DRUG SCREENING, AND PHYSICAL

NOTE: Please bring a valid ID to the health screening.

The undersigned consents and authorizes Norwegian American Hospital, the Medical Review Officer (MRO), his/her assistants and employees to obtain urine samples from me for the determination of **screening for drugs**. I understand that all volunteers at Norwegian American Hospital are required to satisfactorily complete a urine test prior to volunteering and to complete a test for tuberculosis (PPD). I further understand that the results of these tests may be released to the Volunteer Services Department upon receiving the results from the MRO. Applicants testing positive may be disqualified as a volunteer at Norwegian American Hospital for a period of six months. I understand that it is the policy of Norwegian American Hospital that volunteers may be asked to submit a urine drug screening at any time during their service here. I also understand that if I am involved in an accident during volunteer hours, I will submit to an additional urine drug and possible alcohol test. If this test is determined to be positive by the MRO, I understand that I will be immediately discharged as a volunteer. I further understand that if my drug or alcohol screening is positive and I am a minor, my parent(s)/guardian will be notified of the results. In addition, I understand that an initial two-step and annual **PPD** screening for tuberculosis will be conducted. This test involves an injection of a testing solution just under the skin of the inner forearm. I understand that the results must be read 48-72 hours later by an employee of Norwegian American Hospital Corporate Health. I also agree to further testing if the results are positive. The health screening also consists of a **physical**: checking eyes, ears, throat, blood pressure, etc.

I understand and acknowledge that the person performing this procedure has fully explained to me the nature of and purpose of this procedure, the probable risks involved and the possibilities of complications. There are no alternatives to the drug urine screen except to not participate in the Volunteer program. I acknowledge that neither the person performing the procedure nor Norwegian American has made any guarantee or assurance as to the results that may be obtained and I agree to hold Norwegian American Hospital, the MRO, his/her assistants and employees harmless from any and all claims for damages for any injury from this procedure.

I have read and fully understand this consent and the explanations referred to in this consent were made.

Volunteer/Applicant

Signature Date

Parent/Guardian (if applicant is less than 18 years of age)

Date

MMR CONSENT

I understand and agree that as a condition of being selected as a volunteer of Norwegian American Hospital that I must show my immunity to measles (rubeola), mumps, and rubella (MMR). This can be documented either by providing my medical record of immunization or by submitting to a blood test to detect immunity. I also understand that this information will be treated as a confidential medial record to be disclosed only as permitted or required by law.

Volunteer/Applicant

Signature Date

Parent/Guardian (if applicant is less than 18 years of age)

Date