

S O U T H C E N T R A L
REGIONAL MEDICAL CENTER

VOLUNTEER APPLICANT INFORMATION

All applicants must be 16 years of age

Thank you for applying for South Central Regional Medical Center's Volunteer Program. Our healing hands need helping hands, and we are grateful for the time and talents each volunteer brings to our organization each day. We lookforward to you becoming a part of our team.

After completing your application, contact Bonnie Smith, Coordinator of Volunteer Services at South Central at 426-4704, to schedule a personal interview. If Bonnie is not in when you call, please feel free to leave a message, and she will return your call. Interviews are conducted at the medical center Monday through Friday at a time that is convenient with you and with the volunteer coordinator.

If your application is approved, you must complete a three hour orientation session before you participate in our program. This session will include an overview of the volunteer, program, information about medical center policies and procedures, and patient confidentiality. You will also watch a videotape on the importance of safety in the medical center setting and tour facility.

Immunization records for measles, mumps, and rubella (MMR) are required if you were born after January 1, 1957. Each volunteer must complete a medical history form. You will be screened for Varicella (Chicken Pox), at which time a blood test may be performed to determine immunity status. **YOU MUST HAVE COMPLETED YOUR 2nd MMR AND HAVE PROOF OF IMMUNIZATION BEFORE BECOMING A VOLUNTEER IF YOU WERE BORN AFTER JANUARY 1, 1957.**

Additionally, volunteers must take the two step TB skin test which will be updated annually or provide appropriate documentation that you have met SCRMC's requirements for TB skin testing. This will be given by SCRMC's Employee Health Department.

Volunteers will have the option to receive the Hepatitis B vaccine immunization series, if needed (If working in areas for risk of exposure to blood and body fluids). Volunteers will be asked to sign a decision statement as to whether or not he/she will receive the Hepatitis B vaccine.

TEEN VOLUNTEERS, age 16 or older, will not have job duties requiring the Hepatitis B vaccine. However, if a teen wishes to receive this immunization, they should contact their personal physician or the Health Department.

As these tests and immunizations (Hepatitis B and TB Skin) are provided to you by the hospital, and are costly procedures, you are asked to make a minimum commitment of 30 hours to volunteer services in order to become a member of our volunteer program. Also, these 30 hours will serve as your probationary period.

APPLICATION FOR VOLUNTEER SERVICES
South Central Regional Medical Center
P. O. Box 607 - Laurel, MS 39441

"We consider applicants for all volunteer positions without regard to race, color, religion, sex, national origin, age, marital or veteran

Position Applying For.		Today's Date:	
Last Name:	First Name:	Middle Initial:	
Address:			
City:	State:	Zip:	
Social Security Number.	Telephone #1:	Telephone #2:	

You must be 16 years old to apply for a position as a SCRMC volunteer.

Have you ever applied here before? YES NO If yes, date(s)/ position(s) _____

Have you ever worked here before? YES NO If yes, date(s) _____

Have you ever volunteered here before? YES NO If yes, date(s) _____

Have you ever worked under another name? YES NO Name: _____

Have you ever been convicted of a crime? YES NO Nature of conviction: _____

*Conviction is not an automatic bar to volunteer services. All circumstances will be considered.

Please list relatives working at or associated with SCRMC: _____

Please list friends working at SCRMC: _____

Month/Day of Birth: _____

If accepted, will you be engaged in any other work, business, or school? YES NO If yes, list hours/ days _____

Please circle days available to Volunteer: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please give best time available for you from 7:00 A.M. to 8:00 P.M. _____

WE DO NOT UTILIZE THE SERVICES OF VOLUNTEERS ON WEEKENDS

EDUCATION

	Name and Location	Years Completed	Major	Graduated/ Degree	Date(s)
High School		1 2 3 4		YES NO	
College		1 2 3 4		YES NO	
		1 2 3 4		YES NO	
Graduate School		1 2 3 4		YES NO	
OTHER					

LICENSOR/ CERTIFICATIONS/SPECIAL TRAINING

Please list any special training you have received, or any specialty areas for which you are currently certified/ licensed. Please include any state or national medical or health care related license (i.e. RN, LPN, LSW, etc.)

License/ Certification	Number	Expiration Date

PROFESSIONAL MEMBERSHIPS

You may exclude those which, the name of which would reveal sex, race, religion, national origin, age, ancestry, handicap or other protected status.

May we contact your current employer? Yes No

EMPLOYMENT and/or VOLUNTEER HISTORY

Account for all employment, including present job and periods of unemployment. Please include any military experience or job-related volunteer work. Start with current or most recent employment.

Dates	Company/Address/ Telephone	Position/ Job Duties	Supervisor's Name		

Are you physically and mentally able to perform the job for which you have applied? Yes No If not, could you perform these functions if a reasonable accommodation were made? Yes No (*This hospital has a policy of non-discrimination with respect to volunteer services for individuals with disabilities. Information as to any handicap or disability obtained as a result of the foregoing inquiries will be kept confidential except as permitted or required by applicable law or regulation. Medical condition information is obtained for the purpose of allowing voluntary action to overcome the effects of conditions which might result in limited volunteer services of qualified handicapped individuals. Providing the information is voluntary, and failure to do so will not result in adverse treatment.)

REFERENCES

Please list the names, professions and telephone numbers of three references who are not relatives. (Preferably previous supervisors or instructors.)

Name	Profession	Telephone

IN CASE OF EMERGENCY NOTIFY:

Referral Source: Name/ Address	Newspaper/ Radio Advertisement Relationship	Other Volunteer Telephone(s)
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_____ SCRMC Employee

Other _____

**SOUTH CENTRAL REGIONAL MEDICAL CENTER
VOLUNTEER SERVICES**

Please Read Carefully

I certify that the answers given by me to the foregoing questions and statements are true and complete to the best of my knowledge and that I have withheld nothing that would, if disclosed, affect this application unfavorably. I authorize the companies, schools or persons named above to give any information regarding my employment, character and qualifications together with any information they may have regarding me, whether or not it is in their records. I hereby release said companies, schools or persons from all liability for any damage for issuing this information. I understand that any falsification, misleading, incorrect, or omitted information will render this application void, and if accepted, would be cause for termination.

I agree to submit myself upon request by the hospital for a LIMITED physical examination by Employee Health and to future physical or other examinations the hospital may require as a condition of continued volunteer service.

I further authorize the medical center to conduct a background check, including previous criminal convictions and previous employment/volunteer service. I understand that failure to list previous criminal convictions or employment/volunteer service above will void this application, and if accepted, would be cause for termination.

If accepted, I agree as a condition of continued service to acquaint myself with, and to abide by all rules, regulations, and policies as established or amended by the hospital. However, I understand that my service can be terminated with or without notice at any time at the option of the hospital or myself. I authorize the hospital to release to future prospective employers any information regarding my volunteer service with the hospital. I hereby release the hospital from all liability for any damage for issuing this information.

III am accepted, I further understand and agree that when my service is terminated by retirement or otherwise, I must return all of Employer's property in my custody, including office keys, manuals, uniforms and identification card.

Signature of Applicant _____ **Date** _____