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ST. FRANCIS HEALTHCARE SYSTEM

VOLUNTEER PROGRAM APPLICATION

We are a Catholic Healthcare System in Hawaii committed to creating healthy communities in the spirit of Christ's healing ministry. Applicant's Initials: _____

LAST NAME_____FIRST NAME_____ MI_____

ADDRESS_____
Street City ZIP

MAILING ADDRESS_____

PHONE: Residence_____Business_____Cell_____

Email Address_____BIRTH DATE____/____/_____S.S.# _____
(MO/DAY/YEAR)

LIST OTHER NAME(S) YOU HAVE BEEN KNOWN BY OR HAVE USED_____

HOW DID YOU HEAR ABOUT OUR ORGANIZATION? _____

WHY DO YOU WANT TO VOLUNTEER WITH US? _____

_____

YOUR CURRENT EMPLOYER or SCHOOL_____

CIRCLE LAST GRADE COMPLETED: HIGH SCHOOL 9 10 11 12 COLLEGE 1 2 3 4 Major _____

USE ADDITIONAL SHEET IF NECESSARY. PREVIOUS VOLUNTEER OR WORK EXPERIENCE (You may list the courses you are currently taking in school):

1._____

2._____

3._____

LIST INTERESTS/HOBBIES, ETC.

_____

PLEASE LIST COMMUNITY AFFILIATIONS (CLUBS, SERVICE ORGANIZATIONS, ETC.)

_____

PERSONAL REFERENCES (Non family members):

1. _____Address_____Phone_____
2. _____Address_____Phone_____
3. _____Address_____Phone_____

EMERGENCY CONTACT – NAME_____

RELATIONSHIP_____HOME PHONE_____ALTERNATE PHONE_____

REASON FOR VOLUNTEERING (for example - Experience needed for School, Community Service, Retired)

_____

AREA OF WORK PREFERRED (Hospice, Clerical, General office etc. _____

If you prefer clerical or general office work, indicate the following: Typing _____ WPM 10 Key_____ Strokes

☐ Excel ☐ Word ☐ PowerPoint Other:_____

LIST ANY OTHER PROFESSIONAL TRAINING, CERTIFICATIONS OR SPECIAL SKILLS, LICENSES, PUBLICATIONS OR OTHER RELATED ITEMS:_____

_____

IF YOUR VOLUNTEER ACTIVITIES INVOLVE DRIVING, YOU WILL BE REQUIRED TO SUBMIT A DRIVERS LICENSE, DRIVING ABSTRACT, PROOF OF INSURANCE, OR OTHER PERTINENT INFORMATION.

DO YOU HAVE AN AUTOMOBILE? Yes☐ No☐

CAN YOU SPEAK A LANGUAGE OTHER THAN ENGLISH? Yes☐ No☐ If yes, what language(s) and how would you rate your fluency? _____

Medical clearance, including negative tb (2-step or chest x-ray), must be verified by St. Francis Healthcare System before a volunteer can report to her/his assigned department.

Please check (√) the time slots below when you will be available to volunteer.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mornings 8 am – 12 pm							
Afternoons 12 pm – 4 pm							
Evenings 4 pm – 8 pm							
Other hours available:							

PLEASE COMPLETE ONLY IF YOU ARE INTERESTED IN VOLUNTEERING FOR HOSPICE:

Has anyone close to you passed away? Yes☐ No☐ If yes, please explain when and what your relationship with the individual was: _____

_____

Please write a statement regarding why you wish to work with the dying patients and their families:

_____

_____

_____

St. Francis Healthcare System of Hawaii
Volunteer Programs Department

Volunteer Acknowledgement of Confidentiality Policy

It is the policy of St. Francis Healthcare System of Hawaii that all volunteers must safeguard information regarding patients/families and employees. No medical information, including the fact that a person has been treated in the hospital, and/or hospice may be released except by the patient/families themselves; including volunteers who are patients. All information is to be kept completely confidential and not discussed with others, including other volunteers. The only exception is in the event that information is needed for medical treatment or to comply with legal processes or legal requirements.

This policy also applies to volunteers who gain information about operations, activities and business affairs of the company. Any such information is to be kept in strictest confidence and is not to be discussed with anyone other than the appropriate entity staff. Questions about specific instances should be directed to your supervisor.

Volunteers are asked to sign this statement to indicate their understanding of this policy. Any volunteer who violates this policy is subject to disciplinary action, up to and including termination, and may also be subject to civil and/or criminal penalties for violations. Violations by others should be reported immediately to your supervisor.

Volunteer Acknowledgement Signature_____ **Date**_____

Print Name _____

Volunteer Agreement

I agree to abide by the policies and regulations of St. Francis Healthcare System of Hawaii and to participate in orientation and training as required. I plan to/have read the Volunteer Programs Handbook that I will receive at the orientation class.

I understand that all volunteer work is undertaken without any expectation of monetary or pecuniary benefit or payment of any manner of compensation by St. Francis Healthcare System of Hawaii.

I further understand and agree that St. Francis Healthcare System of Hawaii may, at any time, and without notice or reason, dismiss me or any individual from voluntary service.

Volunteer Acknowledgement Signature_____ **Date**_____

VOLUNTEER NOTICE & AUTHORIZATION
REGARDING CRIMINAL BACKGROUND CHECK

A criminal background check may be done to verify this information. While disclosing a criminal conviction will not automatically disqualify you from volunteering, omissions and/or falsifications of information provided may result in termination from the volunteer program.

Have you been convicted* of a crime within the last 10 years?

☐ Yes ☐ No

If yes, please (1) explain when and where, and (2) describe the nature and outcome of the case.

_____

_____

_____

_____

_____

***Convicted means an adjudication (decision) by a court that the defendant committed a crime, not including final judgments required to be confidential pursuant to section 571-84 in the Hawaii Revised Statutes.**

<u>Attestation/Declaration Statement</u>: I hereby certify that the volunteer application, resume, criminal conviction, and/or information provided by me is true and complete and without omission to the best of my knowledge. I understand that misrepresentation of any material facts, including experiences, skills, and qualifications, may exclude me from consideration for volunteering or may result in my termination if discovered after I am accepted into the program. I also understand that my volunteering is contingent upon completing an Immunization Review and reference check.

Signature: _____ Date: _____