Providence-Providence Park Hospital
Volunteer Application Process

Thank you for your interest in volunteering with St. John Providence Health (SJPH). The recruitment and placement policy of the Volunteer Services department adheres to SJPH's policy to provide equal, nondiscriminatory employment opportunities. In concurrence with the Fair Labor Standards Act, volunteers do not regularly perform services indispensable to the operation of the hospital.

Checklist to volunteer

- ✓ Complete a volunteer application.
- ✓ Submit the reference form that has been completed by someone who has known you for 6 months or longer. (Family members are not acceptable).
- ✓ Complete the "Contingent Background Check Release Form". Parental signature is also required for applicants under 18 years old. A criminal background check will be conducted.
- ✓ Complete the "Confidentiality Agreement". Parental signature is also required for applicants under 18 years old.
- ✓ A parental consent form is required for applicants ages 16 or 17. Note: Applications for high school students are accepted only during the month of March for the Summer Student Volunteer Program unless they are part of an existing school partnership.
- ✓

Mail or fax completed application to

Providence Park Hospital	**OR**	**Providence Hospital**
Volunteer Services		Volunteer Services
47601 Grand River Ave, Suite A108		16001 W. 9 Mile Rd
Novi, MI 48374		Southfield, MI 48075
Fax: 248-465-4099		Fax: 248-849-8135

Once your application is reviewed, you may be called to interview with a Volunteer Services representative

If selected for placement…

- ✓ Attend a volunteer orientation session.
- ✓ Submit proof of a negative TB test from the current calendar year. This is offered through St. John Providence Occupational Health Services at:

Providence Park Hospital		**Providence Pavilion**
47601 Grand River Ave, Suite B230	**OR**	22255 Greenfield Rd., Suite 422
Novi		Southfield

There is no cost and no appointment needed. TB tests are administered on Mondays, Tuesdays, Wednesdays or Fridays from 7:30a-4p. You must return 48-72 hours later to have it read.

- ✓ Submit proof of an influenza vaccine if volunteering for through the months of December – March.
- ✓ Obtain a volunteer ID badge.
- ✓ Obtain a volunteer uniform: $20 purchase for a jacket or $15 for a polo shirt.
- ✓ Participate in a department specific orientation on your first day of service

Thank you. If you have any questions, please call the Volunteer Services office:
Providence Park, Novi at 248-465-4096 or Providence Hospital, Southfield at 248-849-8806

Volunteer Application

Please answer all questions – Type or Print Clearly.

Personal Information
Please Check: □ Adult □ College □ High School □ 16-17 years old | □ Male □ Female
Prefix: □ Miss □ Mrs. □ Ms. □ Mr.
Name _____ SSN_____ (Last 4 digits)
Address (Please include apartment or unit number)
Number and Street _____
City State Zip Code
Date of Birth E-mail Address
Phone Numbers (Check preferred contact number)
□ Home # □ Cell # □ Work #
Are you a U.S. Citizen or otherwise authorized to volunteer in the U.S.? □ Yes □ No
Have you ever been convicted of a crime, other than a minor traffic violation? □ Yes □ No
If yes, explain _____
_____ (Court-ordered Community Service is not compatible with volunteering at St. John Providence Health System)

Emergency Contact Information – Required
Name Relationship
Home phone Cell phone Work Phone

Referral Information						
How did you hear about Providence Hospital (check appropriate box)						
□ Associate	□ Brochure	□ Church	□ Employer	□ Family	□ Friend	□ Newspaper
□ Physician	□ Retiree	□ School	□ Self-Inquiry	□ TV/Radio	□ Volunteer	□ Walk-In
□ Web/Internet	□ Other (Please state)					

Skills ***Check off all that apply and list languages on line provided***				
□ Accounting/Finance	□ Artist	□ Cashier/Retail	□ Clerical/Office	□ Computer
□ Event Planning	□ Gardening	□ Graphics Design	□ Marketing/Communications	
□ Music	□ Photography	□ Public Speaking	□ Teaching	□ Writing/Reporting
□ Languages -Please list and indicate any language(s) you can speak fluently _____				

Volunteer Objectives   *Briefly describe your reason(s) for volunteering.*

Education   *(Past and current)*
Grade Level Completed_____ Degree(s) _____ Major(s)_____
If currently a student, state name of school
Anticipated year of Graduation
TEENS ONLY: Current or most recent grade GPA

Recent Employment *(List two)*	
1) Employer	Position
Date(s) of employment – From	To
2) Employer	Position
Date(s) of employment – From	To

Volunteer Experience	
1) Organization	
Date(s) of volunteering – From	To
Position	
2) Organization	
Date(s) of volunteering – From	To
Position	

Availability Please check the day(s) and shift(s) you would be available if your application is accepted.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Location Preference Please check the location you are interested in	
□ Providence Hospital Southfield (9 & Greenfield)	□ Providence Park, Novi (Beck & Grand River)
□ Southfield Cancer Center (9 & Greenfield)	□ Assarian Cancer Ctr., Novi (Beck & Grand River)
□ Ascension Medical Center, Howell (I-96 &Latson Rd)	□ Providence Medical Ctr. (Livonia &7 & Newburgh)

Assignment Preference(s)			
□ Clerical	□ Spiritual Care	□ Pet Therapy	□ Greeter
□ Emergency	□ Patient Care	□ Information Desk	□ Other_____
□ Gift Shop/Gift Cart	□Patient Visiting	□Surgical Lounge	

Please read the following carefully and sign and date where indicated below:

I have read all the questions and certify that the information I have given in this application is correct to the best of my knowledge. I understand that any false statements or omissions may be grounds for dismissal. I further understand that my volunteering is contingent upon the satisfactory completion of a Tuberculosis Skin Test, satisfactory reference and criminal background checks. I hereby authorize and request that you make available to any duly authorized representation of Providence Hospital any information relevant to employment history, criminal history, personal character, and background. I hereby waive any right I may have with regard to release of this information to Providence.

Signature of Applicant _____ **Date** _____

ST JOHN PROVIDENCE | Ascension

Volunteer Services
Applicant Reference Form

Prospective Volunteer's Name_____

_____ _____
Name of person giving reference Phone Number

_____ _____ _____ _____
Address City State Zip Code

The above person has applied for volunteer services at St. John Providence Health and has given your name as a reference. Please assist us in determining his/her qualifications by answering the following questions?

1. In what capacity have you known the applicant?

2. How long have you known him/her?

3. Would you recommend this applicant for a volunteer position at St. John Providence Health System? Why/why not?

4. Other comments:

_____ _____
Signature of Person Giving Reference Date

Please return immediately.
Applicant will not be considered for an interview until a reference is returned.
Thank you for your assistance.

Providence Hospital
Volunteer Services
16001 W. 9 Mile Rd.
Southfield, MI 48075
Fax: 248-849-8135

Providence Park Hospital
Volunteer Services
47601 Grand River Ave.
Novi, MI 48374
Fax: 248-465-4099

St. John Providence Health
Confidentiality Agreement

It is the policy of St. John Providence Health (SJPH) to provide our patients with the level of privacy and confidentiality required under the law, whenever we are confided with protected health information concerning any of our patients. Protected health information is information about a person's health or treatment that identifies the person.

In the course of your work or learning experience, you may have access to confidential information (oral, written or computer supported information not otherwise available to the public at large) about patients, their families and/or hospital business. Hospital business information includes computer programs, software and supporting documentation, technological improvement plans, strategic plans, financial information and associate information (including but not limited to co-workers and their families).

Therefore, I agree that:
My right to enter or make use of confidential information is restricted to my need to know the data or information to perform my job responsibilities or assigned duties. I will keep my computer access password(s) confidential. If another method of accessing a computer system is used, such as an ID badge, I will restrict its use to myself. I will not discuss any confidential information in public areas, hallways, elevators, etc.

I will hold all confidential information of which I have knowledge in the truest confidence, as required by law. I agree to utilize confidential information obtained by me only for the benefit of the patient or in performance of my job responsibilities or assigned duties.

Unauthorized disclosure, copying and/or misuse of confidential information is a serious breach of duty and will result in disciplinary action up to and including termination of employment or contract with SJPH, or removal of student or intern from work experience. Further, this agreement mandates compliance extending beyond employment, contract or association with SJPH, as required by law.
If I have questions about my obligation under this agreement or about SJPH policies and procedures related to confidentiality, I understand that I may direct my questions to the facility privacy officer or the SJPH Privacy Officer at (248) 849-5302.

I have read this Confidentiality Agreement and agree to its terms.

_____ _____ _____

Date Signature Name (print)

_____

Signature of Parent

Providence-Providence Park Hospital
Volunteer Services

PARENTAL CONSENT FORM

(High School Students 16 to 18 Years of Age)

My/our daughter/son _____ has my/our consent to service as a Teen Volunteer at Providence-Providence Park Hospital.

I/we release Providence-Providence Park Hospital and its associates from any and all liability for any damages, injury or illness resulting from my/our son's/daughter's participation in such volunteer activities, which occurs through no fault or negligence on the part of the hospital.

I/we understand that, in the event of an emergency, medical treatment may be provided by the Providence-Providence Park Hospital Occupational Health physician or the Emergency Room physician. If I/we cannot be reached by phone and my son/daughter needs non-emergency care, I/we authorize the Providence-Providence Park Hospital Occupational Health physician or the Emergency Room physician to provide the appropriate medical treatment to my son/daughter. This authorization shall be valid while my/our son/daughter is performing volunteer services at Providence-Providence Park Hospital.

I/we give my/our permission to have a T.B. Skin Test performed on my/our son/daughter or I/we will see that results of a T.B. skin Test will be provided to you before the start date of volunteering.

If my/our son/daughter has not received the Hepatitis B vaccine series, I/we will discuss this at the time of my/our son's/daughter's interview and will follow-up with the Occupational Health physician to make a decision in this regard.

THIS MUST BE SIGNED BY PARENT/LEGAL GUARDIAN

Date	
Signature of Parent(s) or Legal Guardian(s)	
Address	
City, State Zip Code	
Home Telephone Number	
Work Telephone Number	

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Ascension ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature _____ Date _____

Parent/Guardian Signature (If under the age of 18) _____ Date _____

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Ascension ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

• In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

• A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

• By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Full Legal Name (Printed) _____ Applicant Signature _____

Date of Birth _____ Social Security Number _____

Current Address _____

City, State, and Zip Code _____ Driver License State/Number _____

Parent/Guardian Signature (If under the age of 18)

_____