St.Vincent's HEALTH SYSTEM
stvhs.com

VOLUNTEER APPLICATION

PLEASE SELECT THE LOCATION AND/OR SPECIAL PROGRAM WHERE YOU WISH TO VOLUNTEER:			
BIRMINGHAM	☐	BLOUNT	☐
CHILTON	☐	EAST	☐
ONE-NINETEEN	☐	ST. CLAIR	☐
EUCHARISTIC MINISTER	☐		
CUDDLER PROGRAM	☐		
SPIRITUAL CARE VOLUNTEER	☐		

The purpose of this organization shall be to promote and advance the welfare of St. Vincent's Health System through service to our patients and their families, associates and medical staff.

PERSONAL INFORMATION

Last Name:	First Name:	Middle Name:
Other name(s) known as (i.e. maiden, nickname):		Spouse's Name:
Street Address:		Phone Numbers (Include AREA CODE)
City:		Home: ( )
State:	Zip:	Cell: ( )
Social Security Number:	- -	Work: ( )
Email:		

ASSIGNMENT PREFERENCES

Day(s) of the week	Hours	Area of Interest

EDUCATION

School	Name	City	State
High School			
College or University			
College or University			
Other			

WORK EXPERIENCE

Employer's Name	Employer's Address/Zip Code	Duties	Dates

VOLUNTEER EXPERIENCE

Organization's Name	Type Projects	Duties	Dates

REFERENCES (other than family)

Name	Relationship	Daytime Telephone Number

Revised November 2017

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MISCELLANEOUS	
List membership in any professional societies, etc.	
Have you ever worked for St. Vincent's before? Yes ☐ No ☐ If Yes, provide dates, department and title.	

Dates	Department and Title

Provide names/departments/relationships of relatives and/or friends employed or volunteering at St. Vincent's Health System	
How did you learn of our volunteer program?	
Why are you interested in volunteer work?	
Why did you choose St. Vincent's Health System?	

Have you ever been convicted **of a crime (felony or misdemeanor including DUI) other than a routine traffic citation?** Yes ☐ No ☐	Type of Offense	Date of Conviction	Where Convicted (City and State)

ST. VINCENT'S VOLUNTEER SERVICES STATEMENT OF POLICY

It is the policy of St. Vincent's Health System Volunteer Services to provide membership to persons 18 years or older and certain teens 14 to 17 without regard to race, color, gender, age, religion, handicap, or national origin. These members shall conduct themselves in a professional manner at all times and shall demonstrate through example the Core Values of St. Vincent's and Ascension: **Service of the Poor, Reverence, Integrity, Wisdom, Creativity and Dedication.**

CERTIFICATION BY APPLICANT

I certify that the information given on this application is true and correct. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds for St. Vincent's Health System Volunteer Services to deny application or terminate my volunteer services status without notice. I further understand that St. Vincent's Health System Volunteer Services may perform an investigation to determine my suitability for services and I authorize St. Vincent's Health System Volunteer Services to secure the information necessary to make a decision. I further understand that St. Vincent's Hospital will adhere to the provisions of the Fair Credit Reporting Act and other applicable state and federal statutes concerning the securing of information, handling, utilization and release of information obtained in the investigation. **I acknowledge by my signature that I have read and understand these statements.**

_____ _____

Signature **Date**

Office Use _____

SPIRITUAL CARE VOLUNTEER APPLICATION

Spiritual Care is a vital aspect of care at Ascension-St Vincent's Health System: Healthcare That Is Safe, Healthcare That Works, and Healthcare That Leaves No One Behind, for Life. Chaplains and Spiritual Care Volunteers are part of the healing team for patients: whoever they are, whatever they believe or don't believe, wherever they are on life's journey.

Spiritual Care Volunteers extend the ministry of hospital chaplains, visiting new patients and providing a welcoming, listening, non-judgmental, and non-coercive presence. Spiritual Care Volunteers respect the privacy of all patients at all times.

As a part of the application process, all Spiritual Care Volunteer applicants must submit one reference for from a professional leader of the volunteer's local faith community or from one of the Chaplains at Ascension-St Vincent's Health System.

You may attach answers to the following questions to your application if the space provided is insufficient for your response:

If you are interested in serving as a Spiritual Care Volunteer, what gifts, talents, and interests do you bring to the role?

What benefit do you expect to receive from serving as a Spiritual Care Volunteer?

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)

_____

Original Date:	10/01/2012

STVHS VOLUNTEER HEALTH QUESTIONNAIRE

To be completed by volunteer. Bring completed questionnaire to Associate Health Office.

Name *(Last, First, M.I.)*: ☐ M ☐ F	DOB:
Address:	Day Time #
Physician's Name:	Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Pertussis		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any past serious medical conditions

Have you previously had a positive TB test? ☐ No ☐ Yes If yes, what year _____ and describe treatment received.

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

**********IF VOLUNTEER IS UNDER 18 YEARS OF AGE**********

You have my permission for my son/daughter _____ to receive immunizations, testing as required by STVHS.

Parent Signature _____

This form to be kept on file at Associate Health Office while you are an active volunteer at STVHS.

Associate Health St. Vincent's Birmingham
Phone:205 939-7160

Associate Health St. Vincent's St. Clair
Phone: 205-814-2213

Associate Health St. Vincent's East
Phone: 205-838-3991

Associate Health St. Vincent's Blount
Phone: 205-274-3162