

## Volunteer Application Process

Thank you for your interest in volunteering with Ascension Macomb-Oakland Hospital. The recruitment and placement policy of the Volunteer Services department adheres to Ascension Health 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 17 of age. 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:**

Ascension Macomb-Oakland Hospital, Warren Campus  
Attention: Volunteer Services  
11800 East 12 Mile Road  
Warren, Michigan 48093  
Fax: 586-573-5334

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

### *If selected for placement...*

- ✓ Make an appointment for required Health Assessment:  
This is offered through Ascension Macomb-Oakland Hospital Associate Health at:  
Ascension Macomb-Oakland Hospital, **Warren Campus**  
11900 East 12 Mile Road, Warren MI  
Medical Office Building, Suite 207  
Phone: 586-573-5480
- ✓ Attend a volunteer orientation session.
- ✓ Submit proof of COVID vaccination, an influenza vaccine if volunteering for the months of November – March.
- ✓ Obtain a volunteer ID badge.
- ✓ Obtain a volunteer uniform.
- ✓ 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 at 586-573-5112

## Volunteer Application

Please answer all questions – Type or Print Clearly.

### ***Personal Information***

Please Check:  Adult  College  High School  17 years old |  Male  Female

Prefix:  Miss  Mrs.  Ms.  Mr.

Name \_\_\_\_\_ SSN \_\_\_\_\_  
(Last 4 digits)

Home Address (Please include apartment or unit number): \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Numbers (Check preferred contact number)  Home # \_\_\_\_\_

Work # \_\_\_\_\_  Cell # \_\_\_\_\_

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 #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

### ***Referral Information***

How did you hear about Ascension St. John Hospital? (check appropriate box)

Associate  Brochure  Church  Employer  Physician  Family  Friend  Newspaper

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    Music    Cashier/Retail    Clerical/Office    Computer

Event Planning    Gardening    Graphics Design    Photography    Marketing/Communications

Public Speaking    Teaching    Writing/Reporting    Other \_\_\_\_\_

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 Volunteering

St John Hospital (Moross Campus)    Ascension Oakland Campus    Ascension St John Hospital (Macomb Campus)

St John Hospital Van Elslander Cancer Center    Ascension River District Hospital ( East China)

**Assignment Preference(s)**

Clerical    Spiritual Care    Pet Therapy    Greeter/Wayfinder    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 the health assessment testing, and satisfactory reference and criminal background checks. I hereby authorize and request that you make available to any duly authorized representation of Ascension Macomb-Oakland 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 Ascension Macomb-Oakland Hospital.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_



## 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 Ascension St. John Hospital 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.**

Ascension Macomb-Oakland Hospital, Warren Campus  
Attention: Volunteer Services  
11800 East 12 Mile Road  
Warren, Michigan 48093



**VOLUNTEER CONFIDENTIALITY AGREEMENT AND ACKNOWLEDGMENT OF WAIVER OF LIABILITY**

***Confidentiality Agreement***

I hereby acknowledge, by my signature below, that I understand that:

- (1) the protected health information and other confidential records and data (collectively, “Confidential Information”) which I may see or hear or otherwise gain knowledge of in the course of my volunteer activities (“Volunteer Activities”) with Ascension Michigan or one of its affiliates (“Ascension”) is to be kept confidential, private, and secure;
- (2) maintaining confidentiality, privacy, and security of Confidential Information is a condition of my participation in the Volunteer Activities;
- (3) such Confidential Information shall not be used or disclosed to anyone at any time, now or in the future, unless specifically authorized by Ascension; and
- (4) my unauthorized use or disclosure of Confidential Information is possible grounds for: immediate removal from the premises; revocation of all future opportunities to participate in volunteer or similar activities; legal action; and/or a duty to mitigate damages.

***Acknowledgement of Waiver of Liability***

I further acknowledge, by my signature below, that I:

- (1) waive any and all claims, including any negligence claims which I might have against Ascension or its trustees, officers, agents, representatives (the “Ascension Representatives”), in any way arising from or relating to my Volunteer Activities, except for claims arising out of the gross negligence, recklessness, or willful misconduct of Ascension or the Ascension Representatives;
- (2) agree that I will not sue Ascension or the Ascension Representatives, and I will release Ascension and the Ascension Representatives from any claims I may have against each except for in instances of gross negligence, recklessness, or willful misconduct on the part of Ascension or the Ascension Representatives;
- (3) agree that I will indemnify and hold Ascension or the Ascension Representatives harmless against any and all claims or liabilities, including any negligence claims, for damages that I cause to patients and/or Ascension and the Ascension Representatives in any way arising from or relating to the Volunteer Activities; and
- (4) agree to release Ascension and the Ascension Representatives from any liability for the loss of or damage to my personal property while on Ascension property.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

PARENT/GUARDIAN (If individual is a minor): I hereby agree to the above terms on behalf of the above-named individual.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name Program



# PARENTAL CONSENT FORM

(High School Students 17 Years of Age)

My/our daughter/son has my/our consent to service as a Teen Volunteer at Ascension Macomb-Oakland Hospital.

I/we release Ascension Macomb-Oakland 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 Ascension Macomb-Oakland 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 Ascension Macomb-Oakland 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 Ascension Macomb-Oakland Hospital.

I/we give my/our permission to have required health assessment including immunization titers and urine drug testing performed on my/our son/daughter.

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 Associate 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](http://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.

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Full Legal Name (Printed)

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Applicant Signature

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Date of Birth

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Social Security Number

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Current Address

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City, State, and Zip Code

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Driver's License State/Number

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

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