

# SELF REGIONAL



HEALTHCARE

## VOLUNTEER SERVICES

1325 SPRING STREET • GREENWOOD, SC 29646 • (864) 725-4177

Dear Applicant:

Thank you for your interest in becoming a volunteer at Self Regional Medical Center. Enclosed are application forms and listed below is general information regarding the Volunteer Services program.

Please complete the forms and be sure to include your signature in the box at the bottom of the physician release form as well as the name of your physician. Return **ALL** forms to Director Volunteer Services, Self Regional Medical Center, 1325 Spring Street, Greenwood, S.C. 29646. The physician release form will be sent to your physician from this office.

When we receive your application, we will call you to discuss your intentions or to set up an appointment to meet with you. We have many areas of service and will work with you to find a position that is satisfactory to you and the department. Your schedule needs and preferences position availability and departmental needs determine assignments.

Volunteer Service is a rewarding opportunity to help others while giving of your self. I look forward to hearing from you, and welcome the opportunity to have you become a part of the Volunteer Services program of Self Regional Medical Center.

Sincerely,

Sandra C. Williams, CDVS  
Director Volunteer Services

Terri Arthur  
Volunteer Coordinator

### **GENERAL INFORMATION REGARDING VOLUNTEER SERVICE IN A HOSPITAL SETTING**

**For the safety of our patients, their families, and our staff we are required to request the following:**

- Volunteers are required to submit to a background check and it must be acceptable to the Director.
- Volunteers are required to have a physician's recommendation/release on file.
- Volunteers are required to have a (free) health check including a TB skin test from Self Regional Medical Center Health Services
- Volunteers are required wear a picture I.D. badge at all times. The badge is provided free of charge.
- Volunteers are required to attend an initial orientation session and annual updates.
- Volunteers are required to wear standard uniform jackets/smocks/vest which may be purchased (\$25.00) from the Volunteer Auxiliary. Your first smock or jacket will be free.
- Ladies wear white shirts under the smock and white, black, or navy blue skirts/pants.  
Men wear sport shirts under the jacket and neutral slacks.  
No jeans are allowed. Any clean comfortable tennis/walking shoes are acceptable.
- Volunteers will receive on the job training with another volunteer or a qualified hospital employee.
- **All volunteers are required to sign and agree to conform to the hospital confidentiality policy.**

# VOLUNTEER SERVICES

## APPLICATION FOR SERVICE

Mr. Mrs.

Name Ms. Miss \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

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

Current Occupation \_\_\_\_\_ Place of Business \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Volunteer Experience \_\_\_\_\_

Why do you want to volunteer? \_\_\_\_\_

Hobbies/Skills/Interests \_\_\_\_\_

Organizations/Civic Groups/Church/Etc \_\_\_\_\_

### Areas of interests & special skills (Please check all that apply)

General Skills: filing \_\_\_ phone receptionist \_\_\_ using copier \_\_\_ record updating \_\_\_ alphabetizing \_\_\_  
computer \_\_\_ sales/cash register \_\_\_ assemble packets \_\_\_ other \_\_\_\_\_

Patient Care Services: patient escort/transport service \_\_\_ visiting with patients \_\_\_ patient/family liaison \_\_\_

General services to patients \_\_\_ Interpreter \_\_\_ (Please specify language) \_\_\_\_\_

### References (Other than relatives) Please include city-state & zip

Name	Address	Phone	Years Known
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1. _____	_____	_____	_____
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2. _____	_____	_____	_____
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Physician \_\_\_\_\_ Date of last physical \_\_\_\_\_

Notify in Emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Have you ever been convicted of a misdemeanor or felon? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_ E-Mail address \_\_\_\_\_

### Please read carefully before signing:

I authorize the investigation of all statements contained in this application. I understand that any misrepresentation or omission of facts is reason for dismissal at any time without previous notice. I authorize the investigation of all matters contained in this application and hereby give Self Regional Healthcare permission to contact schools, previous employers (unless otherwise indicated), and references, and hereby release Self Regional Healthcare from any liability as a result of such contact.

SIGNATURE \_\_\_\_\_ S.S. # \_\_\_\_\_ DATE \_\_\_\_\_

### VOLUNTEER MEDICAL HISTORY FORM

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

ADDRESS \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized during the past three years? \_\_\_\_\_

Has a physician treated you in the last 12 months? \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

List any operations or illnesses \_\_\_\_\_

List any food/drug allergies \_\_\_\_\_

List all Medical Conditions \_\_\_\_\_

Last Tetanus Vaccination \_\_\_\_\_ Have you ever had Chicken Pox? \_\_\_\_\_ Have you ever had Mumps? \_\_\_\_\_

Have you ever had Red or German Measles? \_\_\_\_\_

Have you ever had a positive TB skin test, or been diagnosed with TB? List dates/treatment/chest xray: \_\_\_\_\_

I certify that the answers above are correct to the best of my knowledge. I understand that I may have my blood drawn for immunity to Varicella, Rubella, Rubeola, and Mumps. I consent to the administration of a 2-step TB skin test.

Volunteer's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Social Security No \_\_\_\_\_

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B/P \_\_\_\_\_ Pulse \_\_\_\_\_ WT \_\_\_\_\_ HT \_\_\_\_\_ Visual Acuity (Both Eyes) \_\_\_\_\_

TST #1 Date Administered \_\_\_\_\_ Date Read \_\_\_\_\_ mm

TST #2 Date Administered \_\_\_\_\_ Date Read \_\_\_\_\_ mm

Rubella: Immune Titer Date \_\_\_\_\_ Non-Immune Titer Date \_\_\_\_\_  
Vaccination Date 1. \_\_\_\_\_ **(only one Rubella needed)**

Rubeola: Immune Titer Date \_\_\_\_\_ Non-Immune Titer Date \_\_\_\_\_  
Vaccination Date 1. \_\_\_\_\_ 2. \_\_\_\_\_ **(two Rubeola's needed)**

Mumps: Immune Titer Date \_\_\_\_\_ Non-Immune Titer Date \_\_\_\_\_  
Vaccination Date 1. \_\_\_\_\_ 2. \_\_\_\_\_ **(two Mumps needed)**

Varicella: Immune Titer Date \_\_\_\_\_ Non-Immune Titer Date \_\_\_\_\_  
Vaccination Date 1. \_\_\_\_\_ 2. \_\_\_\_\_

Employee Health Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

**VOLUNTEER SERVICES DEPARTMENT**

**1325 Spring Street  
Greenwood, S.C. 29646**

PHYSICIANS RELEASE FORM

TO: Physician's Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

FROM: Janet Bishop, Director Volunteer Services Phone: 864-227-4177 Date \_\_\_\_\_

REGARDING: Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_ City/State/Zip \_\_\_\_\_

The above named person has applied for volunteer Service at Self Regional Healthcare and has named you as their personal physician.

As this person may be assigned to work directly with patients and their families, I need assurance that they are qualified for this type work. The information you convey to this office will be held in strict confidence and used only for screening purposes of this applicant for work as a volunteer.

Please respond at your earliest convenience and return this form to the VOLUNTEER SERVICES DEPARTMENT OF SELF REGIONAL MEDICAL CENTER. I appreciate your cooperation.

How long have you known the applicant? \_\_\_\_\_

Does applicant have any physical limitations? \_\_\_\_\_

Does applicant have any mental or emotional problems? \_\_\_\_\_

Is this applicant capable of serving as a volunteer? \_\_\_\_\_

List any health problem/limitations that we should know about \_\_\_\_\_

Additional Comments: \_\_\_\_\_

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

I authorize the above named physician to release this requested medical information that is pertinent to my participation as a volunteer of Self Regional Healthcare to the Director of Volunteer Services of SRH.

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

## VOLUNTEER CODE

According to hospital policies and procedures, volunteers must adhere to hospital policies and confidentiality codes just as employees are required to do. Please read carefully the following policies in the volunteer code and the

confidentiality code and sign both to indicate your understanding and acceptance of the content of each.

**VOLUNTEER CODE:**

1. A volunteer is a part of the hospital organization, subject to all hospital rules, regulations, and proper authority.
2. A volunteer is subject to the code of ethics governing the professional staff of the hospital. It is important therefore to:
  - Respect all information concerning the hospital and patients as confidential
  - Follow instructions meticulously
  - Be dignified, pleasant, and quietly efficient
  - Remember that to outsiders you and your actions represent the hospital
  - Never take advantage of your association with the hospital
  - Use the greatest discretion in speaking with patients or visitors. Criticism of the hospital or staff should be taken up with the Director of Volunteer Services so that the situation can be properly investigated.
  - Be dependable and to be on time. If you cannot come, you must try to get a substitute. If unable to do so, notify your chairman or the Director of Volunteer Services.
  - Under all circumstances, you must notify the Director if you plan to be absent from your service. It is not sufficient to notify the hospital employee with whom you work, although this is a courteous thing to remember to do,

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**CONFIDENTIALITY PLEDGE**

I understand that as a Volunteer of Self Regional Medical Center, I may come in contact with information that is considered confidential. Hospital information including patient related information such as patient conditions, problems, diagnosis, or medications and employee information such as employment status, hours of work, or wages is confidential.

I understand and agree that as a term and condition of my continued service as a volunteer, I will hold all Hospital information in confidence. I understand any violation of the confidentiality of medical information will result in the counseling process and may lead to dismissal.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_