FAIRVIEW PARK HOSPITAL

Adult Volunteer/Chaplain Application

Volunteers serve Fairview Park Hospital without salary, and work within the hospital under the supervision of specified personnel and the Volunteer Coordinator. To be considered, the following must be completed and submitted to the Volunteer Coordinator.

☐ Application ☐ Drug Test Consent ☐ Physical ☐ Background Form ☐ Immunization Record

Name: _____ Date: _____
Address: _____ Email: _____
Date of Birth: _____ Age: _____ Social Security #: _____
Cell Phone: _____ ☐ S ☐ M ☐ L ☐ XL ☐ 2XL
Driver's License Number: _____ Education/Degree: _____
Name on Badge: _____

Contact in Case of Emergency

Name: _____ Phone: _____
Email: _____ Relationship: _____

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker
If presently employed, name of company: _____ Work Phone: _____
Position: _____ Work hours and days: _____

References

Please choose someone other than a relative who can attest to character/dependability. At least one reference for whom you have worked is preferred. ***If applying for chaplain, please list your personal pastor/mentor as one reference.***

Name: _____ Phone: _____
Email: _____ Relationship: _____
Name: _____ Phone: _____
Email: _____ Relationship: _____
Name: _____ Phone: _____
Email: _____ Relationship: _____

I would like to volunteer in (list top three areas/departments of preference, or write *Chaplain*):

1. _____
2. _____
3. _____

Volunteer Availability: (Please circle the days and times you are available to work.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM PM EVE	AM PM EVE	AM PM EVE	AM PM EVE	AM PM EVE	AM PM EVE	AM PM EVE

Were you referred by a volunteer/chaplain? Who? _____

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Have you ever been convicted of a crime? (I understand that if I have been convicted of a crime, I am not automatically disqualified from consideration for volunteer service; but, that giving false or incomplete information is sufficient cause to disqualify me from volunteer services.) ◯ **No** ◯ **Yes** **If yes, please explain:** _____

Are you presently charged with any violation of the law? ◯ **No** ◯ **Yes** **If yes, give date/place/nature of charges:**

How did you become interested in our program? _____

What do you hope to gain from your volunteer experience? _____

Have you served in a health care setting before? ◯ **No** ◯ **Yes** **If yes, describe the experience:**

Are there any work conditions you must avoid/limitations to health?

The information provided in this application is true in all respects, without any willful omissions. I give my consent for a representative of the Volunteer Office to contact the references listed.

As a volunteer/chaplain, I…

- ☐ Agree to attend the volunteer orientation and train until I am competent to perform the required duties;
- ☐ Agree to comply with all the rules and regulations of the hospital and the Volunteer Department;
- ☐ Understand that I may be dismissed from my duties for willful wrong doing or negligence and/or performing duties outside of my service description;
- ☐ Agree to call my assigned area or volunteer office as soon as possible when I have scheduling changes;
- ☐ Understand that Fairview Park is not obligated to utilize my services as a volunteer nor am I obligated to accept the volunteer assignment offered;
- ☐ Agree to uphold the confidentiality agreement with the hospital.

I acknowledge and have read the statements above and agree to abide by the expectations of the Volunteer Program and Coordinator, as well as those of Fairview Park Hospital.

Signature: _____ Date: _____

Fairview Park Hospital Volunteer Services
200 Industrial Blvd. | P.O. Box 1408
Dublin, Georgia 31021
(478) 274-3640

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Drug & Alcohol Policy

It is the intent of Fairview Park Hospital to provide a working environment as free from the use of non-prescribed drugs and alcohol as reasonably possible. Given the easy access to controlled substances in the health care setting and the potential risk to patients and others if health care employees are attempting to perform their duties while using or having used drugs or alcohol, Fairview Park Hospital has adopted the following policy regarding drugs and alcohol. We ask for your full cooperation as health care professionals in implementing this policy and, just as important, educating other employees and the general public to the risks of substance abuse.

The sale, manufacture, distribution, purchase, use, possession, reporting to work, or working while impaired by intoxicants, non-prescribed narcotics. Hallucinogenic drugs, marijuana or other non-prescribed controlled substances is prohibited while on facility property or during working hours. *The distribution, sale, purchase, use or possession of equipment, products and materials which are used, intended for use, or designed for use with non-prescribed controlled substances also is prohibited while on facility property or during working hours. Reporting to or being at work with a measurable quantity of non-prescribed narcotics, hallucinogenic drugs, marijuana or other non-prescribed controlled substances in blood or urine is also prohibited. Reporting to or being at work with a measurable quantity of prescribed narcotics in blood or urine or use of prescribed narcotics is also prohibited where in the opinion of the facility such use prevents the employee from performing the duties of his or her job or poses a risk to the safety of the employee, other persons, or property.

An applicant or employee may be requested to undergo a blood test, urinalysis, “breathalyzer” test or other diagnostic test under any of the following circumstances:

1. Following the acceptance of a job offer conditioned upon the passing of a drug test;
2. Where there is reason to believe in the opinion of the facility that an employee is impaired by intoxicants, drugs or narcotics while on facility property or during working hours or that an employee has reported to work with a measurable quantity of intoxicants, drugs, or narcotics in blood or urine;
3. Where an employee is involved in an on-the-job accident;
4. After the discovery of any missing controlled substance or other unusual event that the Facility believes may indicate a violation of this policy or a mishandling of controlled substances.

Where there is reason to believe in the opinion of the Facility that an employee is impaired by intoxicants, drugs or narcotics, or is in the possession of any intoxicants, drugs, narcotics or equipment, products and materials used, intended for use or designed for use with non-described controlled substances, the facility may search any facility property and/or an employee’s personal property that has been brought onto facility property (including but not limited to vehicles, handbags, briefcases, etc.) and the employee may be requested to submit to a search by facility representatives of his/her person and/or property.

The facility property covered by this policy includes property of any nature owned, controlled, or used by the facility, including but not limited to parking lots, offices, desks, file cabinets, lockers and vehicles.

An employee’s refusal to submit immediately to a requested search of his/her property or to a blood test, urinalysis, “breathalyzer” test or other diagnostic test or a positive result on such test(s) indicating impairment or prior use of intoxicants, non-prescribed narcotics, hallucinogenic drugs, marijuana or other non-prescribed controlled substances may result in disciplinary action up to and including immediate discharge.

Nothing in this policy alters the fact that all employees of Fairview Park Hospital are employed for an indefinite period and that such employment may be terminated with or without cause or notice at the will of either the employee or the facility.

*Employees in positions that affect patient care are conclusively presumed to be under the influence of alcohol when the blood alcohol level is 50 mg/dl or greater. Other employees are conclusively presumed to be under the influence of alcohol when blood alcohol level is 100 mg/dl or greater.

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Alcohol & Drug Standard Policy & Procedure

APPLICANT'S STATEMENT

Fairview Park Hospital has adopted a DRUG and ALCOHOL POLICY applicable to all of its employees. A copy of this policy has been provided to you.

I certify that I have read and understand Fairview Park Hospital's Drug and Alcohol Policy and I further agree and consent to taking any blood, "breathalyzer" or urinalysis tests requested by the hospital as part of employment physical or otherwise and authorize the release of any test results to Fairview Park Hospital.

If hired by the hospital, I hereby give my consent to any drug or alcohol testing as may be required by the hospital and authorize release of any such test results to the hospital.

Applicant Signature: _____ Date: _____

**Applicants under the age of 18 will be required to have a legal parent/guardian present during the drug/alcohol screening process.*

***All applicants will receive authorization for testing directly from the Volunteer Coordinator or HR personally during the application process, after the completed application has been received. Applicants must provide a photo ID during the testing process.*

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Annual Physical Update

Name:	Department/Unit Name:

Date of Birth: _____ Telephone No.: _____

Home Address: _____ City/Zip: _____

In Case of Emergency, notify: Name: _____ Telephone No: _____

Address: _____ City/Zip: _____

Height: _____(feet/inches) Weight: _____(pounds)

Do you wear: ○ Glasses ○ Contacts ○ Hearing aids Regular eye exams? ○ Yes ○ No

Allergies (including Latex allergy or sensitivity):

Current Medications:

The following information is required to assist in determining each employee's condition of health. Answer questions carefully by placing an X in the YES or NO column. "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employees and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with the law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual or his/her family member's genetic tests, the fact that an individual or his/her family member sought or received genetic services, and genetic information of a fetus carried by an individual or his/her family member or an embryo held by an individual or his/her family member receiving assistive reproduction services."

PERSONAL HEALTH HISTORY

Have you had or do you have any of the following?

	YES	NO		YES	NO
High Blood Pressure	○	○	Fainting Spells	○	○
Heart Trouble	○	○	Gall Bladder Trouble	○	○
Rheumatic Fever	○	○	Epilepsy	○	○
Kidney Trouble	○	○	Dislocation of Joints	○	○
Stomach or Duodenal Ulcer	○	○	Broken Bones	○	○
Diabetes	○	○	Back Pain	○	○
Asthma	○	○	Back Injury	○	○
Hay Fever	○	○	Knee Injury	○	○
Allergies	○	○	Head Injury	○	○
Rupture of Hernia	○	○	Varicose Veins	○	○
Cancer	○	○	Severe Headaches	○	○
Tumor	○	○	Mental or Nervous Disorders	○	○

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	YES	NO		YES	NO
Skin Conditions or Chronic Rash	○	○	Complications from Childhood Diseases	○	○
Anemia	○	○	Sciatica	○	○
Yellow Jaundice	○	○	Eye Trouble	○	○
Persistent Weight Loss without Dieting	○	○	Ear Trouble	○	○
Persistent low grade temperature	○	○	Productive Cough for more than 2 weeks	○	○
Loss of Appetite	○	○	Night Sweats	○	○
Persistent Shortness of Breath	○	○	Coughing up Blood	○	○

	YES	NO	LIST
Are you at present under a doctor's care for any condition?	○	○	
Have you ever had any operations?	○	○	

	YES	NO	Type	How Much per day/week/month?
Do you use tobacco?	○	○		
Do you drink alcohol beverages?	○	○		

The following information is also required for females:

	YES	NO
Trouble with your female organs or breasts?	○	○
Tumor or cysts of your female organs or breasts?	○	○
Do you have any bleeding or discharge between your menstrual periods?	○	○
Cancer of your female organs or breasts?	○	○
Do you lose time from work because of your menstrual periods?	○	○
Date of last menstrual period: _____	○	○
Are you pregnant at this time?	○	○

Your medical representative has my authorization to request from a personal physician, hospital, clinic, etc., information regarding my medical history, physical condition or diagnosis when deemed necessary. To the best of my knowledge, the foregoing statements are correct and complete.

Signature: _____ Date: _____

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SAD/INTERNAL TRANSFER AND NON-EMPLOYEES # 11721
VOLUNTEER INFORMATION

FULL NAME: _____

Any Other Names Used: _____

Email address: _____ (Provide if you prefer to receive information via email)

Social Security No: ____/____/____ Date of Birth: ____/____/____

Current Address: _____ City: _____ State: _____ Zip: _____

Driver's License State: _____ No.: _____

Have you ever been convicted of a crime?* ○ Yes ○ No

Offense: _____ County: _____ State: _____ Date: _____

Offense: _____ County: _____ State: _____ Date: _____

*To disclose additional criminal history, please provide those details on a separate sheet of paper and attach it to this form.

Please provide all locations where you have resided for the past seven (7) years, starting with your current residence.

City	State	Dates	
		From	To
1.			
2.			
3.			

STATE LAW NOTICES

Minnesota applicants or employees only: You have the right to request in writing from PreCheck, Inc., a complete and accurate written disclosure of the nature and scope of the report(s) requested by the Company. Place an X here ☐ for a disclosure to be sent to you.
Oklahoma applicants or employees only: Mark an X here ☐ for a free copy of a consumer report if one is obtained by the Company.
California applicants or employees only: Please mark this field ☐ 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.
California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____
New York applicants or employees only: If an investigative consumer report has been requested by the Company, the name and address of the consumer reporting agency furnishing the report can be found on the following disclosure and authorization document. You have the right to inspect and receive a copy of the investigative consumer report by directly contacting the consumer reporting agency, PreCheck, Inc. In connection with the Company's request for the preparation of a consumer report or investigative consumer report about you, the Company has provided you with a copy of Article 23-A of the New York Correction Law. Please mark this field to acknowledge receipt of a copy of Article 23-A: ☐.
Maine applicants or employees only: If you are applying for a position in the State of Maine, you may request and promptly receive from the consumer reporting agency copies of all investigative consumer reports about you requested by the Company. The name and address of the consumer reporting agency furnishing the report can be found on the following disclosure and authorization document.
Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.
Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested.

I have read and understand the above information and assert that all the information provided by is true and accurate.

Signature: _____ Date: _____

[1]The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

SAD/Internal Transfer and Non-Employees # 11721
Volunteer Disclosure & Authorization

FULL NAME: _____

Any Other Names Used: _____

Email address: _____ (Provide if you prefer to receive information via email)

Social Security No: ____/____/____ Date of Birth: ____/____/____

Driver's License State: _____ DL Number: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

SAD/Internal Transfer and Non-Employees ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. 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. 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. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd, Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your volunteering with the Company to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YUR RIGHTS UNDER THE FIAR 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 the Company at any time after receipt of this authorization and throughout the term of my volunteering, 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 PreCheck, Inc., 3453 Las Palomas Rd, Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, 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.

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ Date: _____