VOLUNTARY SERVICE AND OBSERVATION APPLICATION

FOR OFFICE USE ONLY

APPLICATION IS FOR

- ☐ Adult Volunteer
- ☐ College Student Volunteer
- ☐ Junior Volunteer
  - ☐ School Year *OR* ☐ Summer
- ☐ High School Sponsored Intern
- ☐ Medical Explorers
- ☐ Project Search
- ☐ Medical Staff Shadowing
- ☐ HR Sponsored Shadowing
- ☐ Tour
- ☐ Other ____________

DATE	SOCIAL SECURITY NUMBER		
LAST NAME	FIRST NAME	MIDDLE NAME	NICKNAME
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS	BIRTHDATE

MARITAL STATUS (FOR VOLUNTARY PURPOSES) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

IF MARRIED, SPOUSE'S NAME

PLACE OF EMPLOYMENT	POSITION	WORK PHONE	
PARENT CONTACT INFORMATION IF UNDER 18: PARENT'S NAME	HOME PHONE	WORK PHONE	
EMERGENCY CONTACT: NAME	RELATIONSHIP	HOME OR CELL PHONE	WORK PHONE
PHYSICIAN NAME: (FOR VOLUNTARY PURPOSES)	PHYSICIAN'S PHONE NO.	PHYSICAL LIMITATIONS RELATED TO HEALTH/ALLERGIES	

ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES or NO

Question	YES	NO
Have you ever been found guilty, pled no contest, had a conviction or deferred sentence which was expunged, or do you currently have a pending charge, for any felony or misdemeanor?	☐	☐
Have you ever been sanctioned by, excluded or disbarred from Medicare, Medicaid, or any government healthcare program?	☐	☐
Have you ever received written communication from any board or government agency regarding concerns about your professional practice?	☐	☐
Will you consent to drug screening?	☐	☐
Have you been treated or hospitalized for emotional or psychiatric problems or disorders?	☐	☐
Have you been employed by St. John Health System?	☐	☐

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN

STATEMENT OF CONFIDENTIALITY

Through my association with St. John Health System or its subsidiaries, as an employee, agent, independent contractor, volunteer, student, physician, dependent practitioner, house staff, approved observer or vendor, I understand that patient information in any form (paper, electronic, oral, etc.) is protected by law and that breaches of patient confidentiality can have severe ramifications up to and including termination of my relationship with St. John Health System as well as possible civil and criminal penalties. I will not improperly divulge any information which comes to me through the carrying out of my assigned duties, program assignment or observation. This includes, but is not limited to:

- I will not discuss any patient or any information pertaining to any patient with anyone (even my own family) who is not directly working with said patient.
- I will not discuss any patient information in any place where it can be overheard by anyone who is not authorized to have this information.
- I will not mention any patient's name or admit directly or indirectly that any person named is a patient except to those authorized to have this information
- I will not describe any behavior which I have observed or learned about through my association with St. John Health System or its subsidiaries, except to those authorized to have this information.
- I will not contact any individual or agency outside of this institution to get personal information about an individual patient unless a release of information has been signed by the patient or by someone who has been legally authorized by the patient to release information.
- I will not carry over any personal relationship that I have developed with a patient during the course of my care or observation of the patient, into my off duty hours.
- I will not use confidential St. John business related information in any manner not required by my job or disclose it to anyone not authorized to have or know it.

CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK

- Pursuant to the requirements of the Fair Credit Reporting Act, we are notifying you that we may obtain a Credit Report+ with information about you to assist us in determining whether you are eligible for employment/volunteering. You are hereby notified that you have the right to request a copy, upon proper identification, of the investigative background report contained in St. John Health System files on you at the time of your request.

I have read the above Statement of Confidentiality and agree to abide by the obligations listed. Additionally, I have read the Consent to Perform Criminal History Background Check and grant permission for a background check to be conducted

SIGNATURE ____________ PRINT NAME ____________ DATE ____________

- *If you are 18 or older, your signature indicates your approval for us to check references, conduct a criminal background investigation and contact your physician regarding your emotional and physical health. The organization is not obligated to provide a placement, nor are you obligated to accept the volunteer position offered.*
- *Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex.*
- *The St. John Auxiliary is a membership organization. Active members pay annual dues of $10.00, agree to work no less than fifty hours per year and serve a minimum of six months upon acceptance as a member.*

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- ☐ TB Compliance
- ☐ Immunization Compliance
- ☐ Copy of Driver's License
- ☐ Consent for Minor to Participate
- ☐ Criminal Background Check
- ☐ References

VALUES IN ACTION ACKNOWLEDGMENT

The mission of St. John Health System is to continue the healing ministry of Jesus Christ by providing quality healthcare, in particular being sensitive to the dignity and needs of the sick, the poor, and the powerless. We contribute to the continuing improvement of the overall healthcare status and promote the well being of people in Tulsa and surrounding communities.

Our Core Values are Service, Human Dignity, Presence and Wisdom. I understand that as an employee, volunteer, student, contractor, or agency employee my actions support and fulfill our Mission and Values. I acknowledge I accept the responsibilities of the daily behaviors listed as our Values in Action.

As an employee, volunteer, student, contractor, or agency employee I acknowledge my contribution toward "Medical Excellence, Compassionate Care." My job performance, attendance, and conduct contribute to quality patient care, good business practices and healthy working relationships
with coworkers.

I have read and understand the Values in Action on the opposite side of this page and agree to exhibit the behaviors. I understand that this list is not all inclusive of desired behaviors; organization and department specific policies, procedures, and guidelines must also be followed.

SIGNATURE ____________________ DATE __________

EMAIL AND INTERNET AGREEMENT

I am familiar with the Internet and e-mail security policies and I agree to abide by them. I am aware that my unauthorized or inappropriate use of the Internet may result in disciplinary action against me up to and including fines and/or termination. I further acknowledge my responsibility to keep my password confidential and in the event of a suspected compromise or a security problem I will immediately notify the Information Technology Security Administrator. In addition, when sending files or attachments via e-mail, I will observe all SJMC security and confidentiality policies

I understand that the privilege of using the Internet and e-mail may or may not be granted to me in the future and that if granted is to be used for business reasons only.

I have read the e-mail and Internet agreement and whether I am currently authorized to use e-mail and Internet or may only receive such authorization at some time in the future, I agree to abide by the obligations listed above.

SIGNATURE ____________________ DATE __________

VOLUNTARY SERVICES

AUXILIARY VOLUNTEER APPLICATION

FOR OFFICE USE ONLY		
START DATE	PROGRAM	
PLACEMENT	DAY	TIME

Fill out questions below only if you are applying to volunteer

HOW DID YOU BECOME INTERESTED IN OUR VOLUNTEER PROGRAM

☐ Friend ☐ Relative ☐ Newspaper ☐ Television/Radio ☐ Church ☐ Internet ☐ Other ____________

IF OVER 18	EDUCATION LEVEL ATTAINED	MAJOR	CURRENT STUDENT ☐ Yes ☐ No
IF UNDER 18	HIGH SCHOOL ATTENDING	YEAR	GPA

WORK EXPERIENCE/PAST EMPLOYERS

HAVE YOU VOLUNTEERED FOR THIS ORGANIZATION BEFORE ☐ Yes ☐ No	DATE	UNDER WHAT NAME

VOLUNTEER EXPERIENCE

INDICATE HOBBIES/SKILLS/SPECIAL INTERESTS/LANGUAGE SKILLS

CURRENT LICENSES OR CERTIFICATIONS

SCRUB TOP SIZE (JUNIOR VOLUNTEERS)

SCHEDULING PREFERENCES (DAYS/HOURS AVAILABLE)

☐ AM ☐ PM

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

SUMMER SCHEDULING PREFERENCE (JUNIOR VOLUNTEERS)

☐ Monday/Wednesday ☐ Tuesday/Thursday ☐ No Preference

PERSONAL OR PROFESSIONAL REFERENCES (Please exclude relatives.)

Applications cannot be processed without completed reference information

1	NAME			PHONE NO
	ADDRESS	CITY	STATE	ZIP
2	NAME			PHONE NO
	ADDRESS	CITY	STATE	ZIP

INTERESTS/SKILLS

PLEASE CHECK SKILLS YOU WOULD BE WILLING TO SHARE AS A VOLUNTEER HERE

☐ Repairing	☐ Fundraising	☐ Marketing	☐ Nursing/Medical
☐ Accounting/Bookkeeping	☐ Teaching	☐ Web Design	☐ Listening
☐ Retail Sales/Cashiering	☐ Writing	☐ Computer Experience	☐ Arts/Crafts
☐ Merchandising	☐ Videography	☐ Filing	☐ Book Cart
☐ Hospitality	☐ Photography	☐ Clerical	☐ Special Projects

ADDITIONAL SKILLS/COMMENTS

VOLUNTEER AGREEMENT

If accepted into the volunteer program, I agree to:

1. Hold as absolutely confidential all information that I may obtain directly or indirectly concerning clients and staff and not seek to obtain confidential information from a client.
2. Become familiar with the organization's policies and procedures and uphold its philosophy and standards.
3. Donate my services to the organization without contemplation of compensation or future employment.
4. Be punctual and conscientious, conduct myself with dignity, courtesy, and consideration of others, and endeavor to make my work professional in quality.
5. Furnish and maintain an appropriate uniform and maintain a well-groomed appearance during my volunteer time.
6. Attend orientation and inservice training as scheduled.
7. Carry out assignments and seek the assistance of the job supervisor when necessary.
8. Take any problems, criticism or suggestions to my service area supervisor or to the Volunteer Coordinator or Director of Volunteer Services.
9. Work a specified number of hours on a schedule acceptable to the organization and me.
10. Adhere to the department's sign-in and recording-of-hours procedures.
11. Notify the volunteer office if unable to work as scheduled and find a substitute according to the volunteer substitution policy.
12. Honor a minimum six-month commitment to volunteer service with the first three months being a probationary period. At the end of three months, I may meet with the Volunteer Coordinator to reevaluate my volunteer position.
13. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with organizational policies, rules, and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work, or appearance, or (d) any other circumstances which, in the judgment of the department director, would make my continued service as a volunteer contrary to the best interests of the organization.

I hereby certify that all the above statements are complete, true and correct. I understand that any misrepresentation, falsification and/or omission of the facts as stated or implied on this application or any volunteer form or document and/or during the interview process, may disqualify me from further consideration for volunteer work and may be considered justification for dismissal if discovered at a later date. I hereby authorize St. John Health System to investigate the truthfulness of any and all statements made on this application, on any volunteer form/document or during interviews.

VOLUNTEER'S SIGNATURE ______________________ DATE ____________

FOR OFFICE USE: To be signed at time of acceptance as a volunteer.

DEPARTMENTAL REPRESENTATIVE ______________________ DATE ____________

CONSENT FOR MINOR TO PARTICIPATE

This will authorize my/our child/ward, a minor, to participate in such volunteer activities or observations at St. John Medical Center, Tulsa, Oklahoma, as from time to time may be prescribed by the hospital's director of volunteer services or the designated representative. I (We) understand that the services of my (our) child or ward are donated to the hospital without compensation or contemplation of future employment, and are given for humanitarian, religious, or charitable reasons.

I (We) release St. John Health System and its employees, volunteers and agents from any claim of liability for any damages, injuries or illnesses resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities. In the event said minor needs emergency medical treatment, I (we) authorize the St. John Emergency Department physicians as my (our) agent to consent, on my (our) behalf, for said minor to receive any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of St. John Medical Center, whether such diagnosis or treatment is rendered at the office of said physicians or at said hospital.

I (we) agree to assume the expense or pay the bill for any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is provided to my (our) child or ward in the event he/she needs emergency medical treatment.

I (We) authorize my (our) son or daughter to receive a TB test, at hospital expense, unless I (we) have proof of a negative reaction within the last year. I (we) further agree to provide a current copy of my (our) son's or daughter's immunization history to the hospital's Department of Volunteer Services.

PARENT/GUARDIAN SIGNATURE

PARENT/GUARDIAN SIGNATURE

DATE