Volunteer Application

(Please type or print)

Personal Information

Last Name: ______________________________ First Name: __________________________ Initial: ____________

Address: ____ Apt/Sp: _______________________

City: ____________________________________ State: ___________________ Zip: __________________________

Phone (Home): _______________________________Phone (Work): ______________________________________

Phone (Cell): __________________________________E-mail: ____

Pager: _______________________________________ Gender: Male Female (Please circle)

Date of Birth: _________________________________ Social Security Number: _____________________________

(month/date/year) (for identification purposes only)

Drivers License Number: _______________________ State: ______ Restrictions: __________________________

Automobile Liability Insurance Carrier: ____

Emergency Contact: ____________________________ Phone Number: _____________________________________

Languages you are fluent in, including sign language: ____

Medical Conditions Southern Nevada Health District should be aware of, including allergies: ____________________

____

Employment Information

(**If you are retired**, please complete this section with information relating to your most recent employment.)

Employer Name: ____

Street Address: ____

City: ____ State: ____________ Zip Code: __________

Telephone: (______) _________________________ Ext. ________ Fax: (_____) ____________________

Supervisor: ____

Dates of employment: From: ____________________To: __________________

SOUTHERN NEVADA HEALTH DISTRICT
P.O. BOX 3902, LAS VEGAS, NEVADA 89127
PHONE: (702)759-0881 FAX (702)383-1446

Professional Licensure, Certification, Specialties & Experience

Name on License or Certification (if different): ____

Licensed/Certified As: ________________________________License/Certification #: ________________

Licensing Agency and State: __________________________ Expiration Date: ______________________

List any specialties within your professional licensure(s):

____
____
____
____
____
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Work History

(Please use the space below to present your work history or you may attach your resume.)

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References

Please provide two references of individuals familiar with your qualifications and/or experience.

NAME	ADDRESS	TELEPHONE
1.		( )
2.		( )

Southern Nevada Health District Volunteer Agreement

I, ____, offer to serve as a volunteer within Southern Nevada Health District.

In making this offer, I agree and/or understand that I will:

1. Perform my volunteer services and activities under the direction and guidance of the Southern Nevada Health District.

2. Waive any claims for compensation from the Southern Nevada Health District for any services performed related to my volunteer assignment.

3. Be responsible for any cost or treatment of any illness or medical condition that is not directly related to the performance of my volunteer assignments.

4. Be bound by the Southern Nevada Health District Code of Ethics and Conduct in performing my duties as a volunteer with Southern Nevada Health District.

____ ______________________________

Signature of Volunteer Date

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VOLUNTEER JOB DESCRIPTION

DEFINITION

To support health district department services utilizing English and/or Spanish.

SUPERVISION RECEIVED AND EXERCISED

- Receives general supervision and training from Program Project Coordinators.

EXAMPLES OF ESSENTIAL RESPONSIBILITIES AND DUTIES – ***This class specification lists the major duties and requirements of the job and is not all-inclusive. Incumbent(s) may be expected to perform job-related duties other than those contained in this document***.

- Provide information about services offered by Clark County Health District.
- Administrative duties
- Answer telephones
- Package products for distribution to the public.
- Help customers fill out forms.
- Direct customers to appropriate department to receive services
- Perform related duties and responsibilities as required.

QUALIFICATIONS

Ability to:

- Speak, write and translate standard English to Spanish.
- Follow directions.
- Provide basic program information to the Las Vegas community.
- Communicate in a professional and informative manner with people from a wide variety of cultural and ethnic backgrounds and lifestyles.
- Answer the telephone in the manner indicated by supervisors.
- Prepare clear and concise reports on a weekly basis.
- Use computer efficiently.

Experience and Training Guidelines

Experience:

- None Required
- Must be 18 years of age.

Working Conditions

- Maintain confidential client information.

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VOLUNTEER CODE OF ETHICS

By signing a copy of this code of ethics, I affirm that:

- I will not discriminate against or refuse service to anyone on the basis of race, color, creed, age, sex, religion, disability, or nationality.
- I will evidence a genuine interest in all persons served, and do hereby dedicate myself to their best interests and helping them.
- I will respect the privacy of persons served and hold in confidence all information obtained in the course of service.
- I, upon termination, will maintain client and volunteer confidentiality, and I will hold, as confidential, any information I obtained while volunteering at the Southern Nevada Health District.
- I will not engage in or condone any form of harassment or discrimination.
- I understand that violation of this code may be grounds for dismissal.
- I will not make any public appearances nor speak publicly on behalf of the Southern Nevada Health District without prior approval.
- I will not falsify documents.
- I will not take into my possession any items/monies belonging to the Southern Nevada Health District for my own personal gain.
- I will not solicit monies or donations nor participate in any fundraisers affiliated with the Southern Nevada Health District without prior approval.
- I will not perform my duties while under the influence of drugs and/or alcohol.
- I will perform a minimum of 20 volunteer hours per year.
- I will treat all personnel with fairness and consideration for their dignity and individual worth.

______________________________ ____________________

Volunteer Signature Date

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CONFIDENTIALITY STATEMENT

I have been made aware that confidential patient records and protected health information are maintained on the premises to which I have access. Due to legalities surrounding patient confidentiality, I understand that all written, verbal and electronic communications and documents that I have access to shall remain confidential. None of the above-mentioned confidential records and information shall be removed from the premises except by designated personnel. Under no circumstances shall any confidential patient protected health information be discussed outside the work setting.

________________________________ ________________

Volunteer Signature **Date**

________________________________ ________________

Volunteer Coordinator **Date**

The volunteer signing this form has participated in required HIPAA training.
After signing, this form is to be retained in an administrative file in the Agency.

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VOLUNTEER REGISTRATION FORM

Name:____

Mailing Address:____________________________________

City, State, Zip, Code:________________________________

Telephone:______________________________________

Emergency Contact Name:______________________________

Emergency Contact Phone:______________________________

Please check one:

☐ Guest
☐ Volunteer
☐ Intern____________________________________
☐ Independent Contractor
☐ Manpower Temp

____
(Sponsoring Organization)

Supervisor______________________________________

Length of Assignment: Start:____________ End____________________

Nature Of Work:____________________________________

Work Hours:______________________________________

Work Locations:____________________________________

Nursing Director Approval:_____________________________

Human Resources Approval:_____________________________

Administrative Services Approval:__________________________

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