



# VOLUNTEER APPLICATION PACKET

## KEEP PAGES 1-2 AS A REFERENCE

Thank you for your interest in the Volunteer Services Program at Community Medical Centers. Attached please find the following documents: Application for Volunteer Services, Acknowledgment, Confidentiality Agreement, Consent for Minor to Participate in Volunteer Activities, and Consent to Treatment of Minor. Please note, if you are selected to proceed in the volunteer process, the general time frame for the entire application process could be approximately 30-90 days.

## MINIMUM REQUIREMENTS FOR VOLUNTEERS:

- Must be age fourteen (14) or older (minors ages 14-17 require parental consent).
- Junior Volunteers between 14-17 years of age must submit two letters (from school or community leaders, not a relative) of recommendation.
- Adult volunteers must be willing to commit to at least one hundred (100) hours of service.
- Junior volunteers must be willing to commit to at least fifty (50) hours of service.
- Completed application packet submitted prior to interview with Volunteer Services Representative.
- All selected Volunteers must attend and successfully complete mandatory New Volunteer Orientation.
- Successfully pass a Tuberculosis (PPD- Mantoux) skin test or chest x-ray and submit results.
- Successfully pass background check (We are required by law AB 655; Cal. Civil code 1786 et.seq. to inform you that we conduct criminal background checks on all adult applicants. This law also requires us to provide written notice that a background check will be conducted and upon conclusion of the background check, a hardcopy of the results will be provided-if requested.)

## PLEASE NOTE:

1. If an interview is granted, completion of the interview process does not guarantee placement in the Volunteer Services Program.
2. There is NO direct "hands-on" care with patients unless assisting a staff member.

## APPLICATION PROCEDURE:

### STEP ONE: Application:

Submit a completed application packet (attached) to the Office of Volunteer Services of your choice.

**Incomplete applications will not be CONSIDERED.**

### STEP TWO: Interview:

For applicants interested in volunteering at:

- Community Regional Medical Center: If your application is selected a staff member of Volunteer Services will contact you to schedule an interview.
- Clovis Community Medical Center: Applicant must call the Volunteer Office to schedule an interview. 559-324-4091

**Please come dressed appropriately in interview attire.**

### STEP THREE: Selection:

If you are selected to continue in the volunteer process after your application and interview:

Selected applicants WILL BE required by policy to successfully complete New Volunteer Orientation, Criminal Background Investigation and TB test.

\*\*Volunteer applicants will complete and have a cleared Tuberculosis (PPD- Mantoux) skin test or chest x-ray. This test may be administered by your own physician at your expense and the results submitted to the Volunteer Services Department or through Community Medical Center's Employee Health Services Department (authorization form required).

### STEP FOUR: Placement:

- After successfully being selected and processed, placement arrangements are made.
- **Please note individuals who fail to follow thru with entire process will not be placed.**
- You will be issued a photo identification badge and you will be trained in the sign-in procedure.
- You will be required to purchase a uniform.



# APPLICATION FOR VOLUNTEER AND STUDENT SERVICES

**OFFICE PERSONNEL USE ONLY:**

Interview date: \_\_\_\_\_  
 PPD submitted: \_\_\_\_\_  
 Volunteer #: \_\_\_\_\_  
 Orientation date: \_\_\_\_\_  
 Start date: \_\_\_\_\_  
 Area assigned: \_\_\_\_\_

**Community Regional Medical Center**  
 Volunteer Department  
 P.O. Box 1232  
 559.459.2863  
 559.459.6799 Fax

**Clovis Community Medical Center**  
 Volunteer Department  
 2755 Herndon Ave.  
 559.324.4091  
 559.324.4098 Fax

<b>PERSONAL INFORMATION</b>				Birth date (month/day/year): _____	
LAST NAME			FIRST NAME & MIDDLE INITIAL		
HAVE YOU EVER WORKED UNDER ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF "YES", PLEASE LIST OTHER NAME(S)		
PRESENT STREET ADDRESS			CITY, STATE		ZIP CODE
HOME PHONE #	WORK OR MESSAGE PHONE #	E-MAIL ADDRESS		SOCIAL SECURITY NUMBER:	
<b>Please check the boxes that apply to you:</b>					
I am a: <input type="checkbox"/> Student Volunteer (college or training) <input type="checkbox"/> Work Experience Volunteer <input type="checkbox"/> Court-Ordered Community Service Volunteer <input type="checkbox"/> Other _____			I am interested in: <input type="checkbox"/> Junior Volunteer (14-17 years of age) <input type="checkbox"/> Adult Volunteer (18+ years of age) <input type="checkbox"/> Other _____		
I was referred by:			I am interested in volunteering because:		
My hobbies and interests are:					
<b>Student Volunteers Only - Current High School/College Information</b>			<b>Emergency Contact:</b>		
School attending:	College Major:		Name:	Relationship:	
Grade or Year:	Is volunteer work a requirement for school credit? Yes____ No____		Address:	City, State, Zip:	
			Telephone:	Cell Phone:	
<b>AREA OF INTEREST</b>					
POSITION OR AREA OF INTEREST:			ALTERNATE POSITION:		
DATE AVAILABLE TO START WORK:			FACILITY PREFERENCE: <input type="checkbox"/> Clovis Community Medical Center <input type="checkbox"/> Community Regional Medical Center <input type="checkbox"/> Other: _____		
SHIFT AVAILABLE TO WORK:					

## SKILLS & CERTIFICATIONS PLEASE LIST/CHECK THE SKILLS YOU POSSESS

COMPUTER SKILLS/PROGRAMS:

IDC-9/CPT-4 CODING       INSURANCE BILLING  
 ADMITTING                       CPR  
 Expiration Date \_\_\_\_\_

DATA ENTRY:

WPM: \_\_\_\_\_

LIST LANGUAGES YOU SPEAK, READ OR WRITE **OTHER THAN ENGLISH**:

LANGUAGE: \_\_\_\_\_ ( ) SPEAK ( ) READ ( ) WRITE

LANGUAGE: \_\_\_\_\_ ( ) SPEAK ( ) READ ( ) WRITE

## EDUCATION

SCHOOL/INSTITUTION	NAME & LOCATION	MAJOR	DEGREE RECEIVED
HIGH SCHOOL			DIPLOMA OR GED: YES _____ NO _____
TECHNICAL SCHOOL TRADE/BUSINESS COLLEGE			
UNIVERSITY OR COLLEGE			
OTHER			

LICENSES/CERTIFICATIONS with EXPIRATION DATES (LIST ALL):

## REFERENCES PLEASE LIST INDIVIDUALS FIT TO EVALUATE YOUR CAPABILITIES – PREFERABLY MANAGERS, PEERS, SUBORDINATES – NO RELATIVES.

NAME: 1.	RELATIONSHIP	COMPANY	TITLE	HOME/WORK PHONE #S
NAME: 2.				

## GENERAL INFORMATION

DO YOU HAVE RELATIVES EMPLOYED/VOLUNTEERING AT COMMUNITY MEDICAL CENTERS, ITS SUBSIDIARIES &/OR AFFILIATES? YES \_\_\_\_\_ NO \_\_\_\_\_

NAME 1.	RELATIONSHIP	FACILITY/DEPARTMENT	HAVE YOU EVER BEEN INVOLUNTARILY SEPARATED FROM A JOB? YES _____ NO _____
NAME 2.	RELATIONSHIP	FACILITY/DEPARTMENT	

IF YES, PLEASE EXPLAIN:

**HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST SEVEN (7) YEARS? (a conviction does not necessarily bar you from volunteering.)** YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN AND STATE CHARGE, COURT, DATE & DISPOSITION OF CASE:

**PLEASE COMPLETE (this question is necessary in case you are placed in a position with regular access to drugs and medication):** HAVE YOU EVER BEEN ARRESTED ON CHARGES OF POSSESSION, SALE, TRANSPORT, CULTIVATION OR SELLING TO A MINOR, ANY CONTROLLED SUBSTANCES, OR FORGING OR ALTERING PRESCRIPTIONS? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN AND STATE CHARGE, COURT, DATE & DISPOSITION OF CASE:

**EMPLOYMENT HISTORY**

DO NOT WRITE "SEE RESUME" COMPLETE APPLICATION IS REQUIRED PLEASE BEGIN WITH PRESENT OR MOST RECENT EMPLOYER, AND ACCOUNT FOR ALL PERIODS OF EMPLOYMENT, INCLUDING PART-TIME, SUMMER, VOLUNTARY AND MILITARY EXPERIENCE. SALARY HISTORY MUST BE INCLUDED. ATTACH ADDITIONAL SHEETS IF NECESSARY. INFORMATION PROVIDED WILL BE VERIFIED.

<b>EMPLOYER</b>		MAY WE CONTACT? YES _____ NO _____		SUPERVISOR NAME/TITLE		REASON FOR LEAVING	
ADDRESS				PHONE:			
DATE STARTED (MO/YR)	DATE LEFT (MO/YR)	DUTIES & RESPONSIBILITIES					
BASE STARTING SALARY	BASE ENDING SALARY	POSITION/TITLE					
PLEASE EXPLAIN ANY LAPSE IN EMPLOYMENT							
<b>EMPLOYER</b>		MAY WE CONTACT? YES _____ NO _____		SUPERVISOR NAME/TITLE		REASON FOR LEAVING	
ADDRESS				PHONE			
DATE STARTED (MO/YR)	DATE LEFT (MO/YR)	DUTIES & RESPONSIBILITIES					
BASE STARTING SALARY	BASE ENDING SALARY	POSITION/TITLE					
PLEASE EXPLAIN ANY LAPSE IN EMPLOYMENT							
<b>EMPLOYER</b>		MAY WE CONTACT? YES _____ NO _____		SUPERVISOR NAME/TITLE		REASON FOR LEAVING	
ADDRESS				PHONE			
DATE STARTED (MO/YR)	DATE LEFT (MO/YR)	DUTIES & RESPONSIBILITIES					
BASE STARTING SALARY	BASE ENDING SALARY	POSITION/TITLE					
PLEASE EXPLAIN ANY LAPSE IN EMPLOYMENT							
<b>EMPLOYER</b>		MAY WE CONTACT? YES _____ NO _____		SUPERVISOR NAME/TITLE		REASON FOR LEAVING	
ADDRESS				PHONE			
DATE STARTED (MO/YR)	DATE LEFT (MO/YR)	DUTIES & RESPONSIBILITIES					
BASE STARTING SALARY	BASE ENDING SALARY	POSITION/TITLE					
PLEASE EXPLAIN ANY LAPSE IN EMPLOYMENT							
<b>EMPLOYER</b>		MAY WE CONTACT? YES _____ NO _____		SUPERVISOR NAME/TITLE		REASON FOR LEAVING	
ADDRESS				PHONE			
DATE STARTED (MO/YR)	DATE LEFT (MO/YR)	DUTIES & RESPONSIBILITIES					
BASE STARTING SALARY	BASE ENDING SALARY	POSITION/TITLE					
PLEASE EXPLAIN ANY LAPSE IN EMPLOYMENT							

# ACKNOWLEDGEMENT

\_\_\_\_\_  
Applicant's Initials

I authorize any person, school, current employer (except as expressly noted), past employer(s), and organizations named in this application form (and accompanying resume or other documentation, if any) to provide the person(s) at Community Medical Centers (CMC) who is making a decision regarding placement in the volunteer program with relevant information and opinion, personal or otherwise. I release all parties from all liability for any damage that may result from furnishing information and opinion, which is truthful, without malice or made in good faith to you.

\_\_\_\_\_  
If minor, parent or guardian's initials

\_\_\_\_\_  
Applicant's Initials

I understand and agree that this application nor my acceptance of a volunteer position constitutes a contract of continued volunteering, and I further understand that I should not and I agree that I will not, rely upon the foregoing as forming a contract of volunteering or as a guarantee or promise of continued volunteering. I understand and agree that my volunteer position with CMC is for no definite period, and volunteering may be terminated at the will of myself (after completion of my 50-hour commitment) or by CMC for any reason at all or for no reason, with or without notice.

\_\_\_\_\_  
If minor, parent or guardian's initials

\_\_\_\_\_  
If minor, parent or guardian's initials

I hereby acknowledge that I have read and understand the above statements. I also certify that I, the undersigned applicant, have personally completed this application. I declare that the facts contained in this application (and any resume or other documents) are true and complete to the best of my knowledge. I understand that any false information or omission will disqualify me from further consideration for volunteering and if discovered at a later date will be justification for my dismissal from volunteering.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

If minor, Parent or Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_



**Volunteer placement with Community Medical Centers is based on the skills, interests and abilities of the applicant as well as the needs of individual facilities. Volunteering is not meant for the sole purpose of job/career training, nor is it meant to lead to paid employment within Community Medical Centers.**

**ALL VOLUNTEERS MUST COMMIT TO A MINIMUM OF 100 HOURS OF SERVICE  
TO BE CONSIDERED FOR A VOLUNTEER POSITION**

**CONFIDENTIALITY AGREEMENT**

Believing that Community Medical Centers has need of my services as a Volunteer, I agree to: Hold as absolutely confidential all information which I may hear directly or indirectly concerning the medical center, patients, physicians, other professional staff, employees or any volunteer and I will not seek out confidential information in regards to the same. My services are donated to Community Medical Centers without contemplation of compensation or future employment, and given with humanitarian or charitable reasons.

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

**CONSENT FOR MINOR (under age 18) TO PARTICIPATE IN VOLUNTEER ACTIVITIES**

This will authorize, a minor, to participate in such volunteer activities at Community Medical Centers as may from time to time be prescribed by the hospital's Volunteer Services.

We release Community Medical Centers from any claim or liability for any injury or illness resulting to said minor while participating in such volunteer activities, not occasioned by any fault or neglect on the part of the Hospital. I understand and accept the requirements as set forth in the attached cover letter, and give my permission and assistance in reinforcing the rules and regulations for my child to serve as a volunteer.

Parent or Guardian (please print name) \_\_\_\_\_

Parent or Guardian (signature) \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION OF PARENTAL CONSENT TO TREATMENT OF MINOR (under age 18)**

(I) / (We), the undersigned parent/legal guardian(s) of \_\_\_\_\_, a minor, do hereby authorize Community Medical Centers as agent(s) for undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. The authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until the volunteer's 18<sup>th</sup> birthday unless sooner revoked in writing delivered to said agent(s).

Parent or Guardian (please print name) \_\_\_\_\_

Parent or Guardian (signature) \_\_\_\_\_ Date \_\_\_\_\_