

Joe DiMaggio Volunteer Application

We appreciate your interest in volunteering at Joe DiMaggio Children's Hospital. We are one of the region's leading Pediatric Hospitals.

If you are looking for a rewarding way to help children while showing your support and appreciation of Joe DiMaggio Children's Hospital, we are looking for you!

The volunteers are a dynamic group who, every day, live the Mission and Vision of our Healthcare System. Attached you will find our volunteer application.

Please read it carefully and follow the directions.

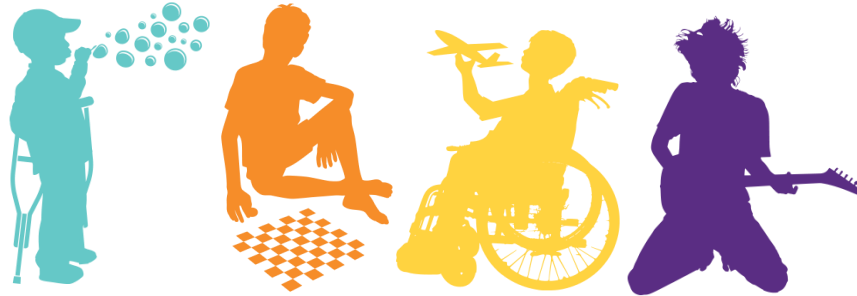
There are items below intended for Teen Volunteers only on page 2 and 3 of the application.

What is Expected of a Joe DiMaggio Children's Hospital Volunteer?

- A desire to meet the needs of our community, patients, families, visitors, physicians, and employees.
- A commitment to a four-hour weekly shift, minimum 6 months, and 100 hours of service.
- Purchase of a Volunteer uniform (\$20.00) cash. All fees are non-refundable.
- A completion of a Tuberculosis Screening (MHS – provides on-site)
- A flu shot is required of all volunteers (MHS – provides on-site)
- Please note that we do not accept court-ordered community service hours.

****Please email your completed application to MFelson@mhs.net****





If you are a potential **Teen Volunteer**, please attach the following documents in your email with your completed application:

- Minimum age to volunteer is 14 years old.
- A completed Volunteer Application with your guardian's signature.
- Character reference on letterhead from a responsible person other than a family member.
- Complete copy of your most recent Academic Transcript (not a report card) showing a **2.50 GPA** or above from your last term.
- Proof of age, i.e., Driver's License or Birth Certificate.
- As a Teen Volunteer, you will be given a letter following your interview pledging a six-month commitment. This letter must be signed by your parent and returned on the day of the new volunteer orientation.

If you do not have all the above or meet the above criteria, please do not email your application.

ALL APPLICANTS will be screened and interviewed after the application has been received via email.



Teenage Volunteers Only

Information for Parents

1. All teenagers must be interviewed and approved by the Director of Volunteer Services.
2. All teenagers must email a complete application.
3. Teen uniforms consist of either white/khaki/black pants JDCH Volunteer Golf Shirt.
4. Jeans are not prohibited.
5. Uniforms must be worn at all times. They are purchased on the first day of your volunteer assignment.
6. Total uniform, ID badge, and registration fee cost is \$20.00 Cash.
7. All volunteers are expected to work a four-hour shift per week and are entitled to a free meal.
8. Service hours will be awarded at the completion of their six-month commitment. Service hours letters must be requested within a month of leaving the Volunteer Services Department.



Parental Consent Form Joe DiMaggio Children's Hospital Volunteer Program * Teens Only *

Date: _____

My daughter/son (_____) has my consent to become a Teenage Volunteer for Memorial. *PLEASE PRINT*

In addition, I do hereby give my consent to have him/her tested for Tuberculosis (PPD) as part of the standard pre-employment/volunteer physical assessment process.

I have read and understand the above requirements.

In addition, I have gone over the cover sheet with my teenager, and he/she meets the requirements requested.

Parent's Signature: _____
PLEASE PRINT

Relationship to applicant: Parent ____ Legal Guardian ____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____





Hands that heal. Hearts that care.

College Students

- Required to complete 4 hours of volunteer service hours per week.
- 100-hour commitment.
- A current copy of your college class schedule.



*** PLEASE NOTE ***

We do NOT offer internship hours for your school-specific programs, shadowing, or observation opportunities.





VOLUNTEER APPLICATION

PLEASE PRINT

Circle one: Adult College Student Teenager

Date: _____

Name: _____
Last First M.I.

Address: _____
Street Address Apartment Number

City State Zip

Email address: _____

Primary phone #: _____ - _____ **Secondary phone #:** _____ - _____

Date of birth: ____ / ____ / ____ **Sex:** FEMALE MALE

Driver's license #: _____

Previous / Current occupation: _____

Personal or work reference: _____
Name Phone #

Signature: _____

**Prospective volunteers will be subjected to a background check.
Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, sex, marital status, or disability.**



Months Available

Please circle ALL that apply

January February March April May June
 July August September October November December

Please check the times you are available to volunteer:

	MON	TUES	WED	THUR	FRI	SAT	SUN
Morning							
Afternoon							
Evening							

Please select the area you feel you would best be able to serve within Joe DiMaggio Children's Hospital:

Family Resource Center	Food Pantry	Newborn ICU	Greeter/Escort
Nurses Stations	Respiratory	Emergency Department	Clerical
Surgical Services	Wellington	Central Supply	Imaging
Inpatient Rehab	Child Life	Food and Nutrition	

NOTE: You must be 18 years or older to volunteer in the Emergency Department, Newborn ICU, and Surgical Services

Other: _____

We do NOT place volunteers in these areas: BILLING & CODING, MEDICAL RECORDS, BEHAVIORAL HEALTH, PSYCHOLOGY, OR MORGUE.

Do you speak or write any foreign languages? YES NO
 If yes, please indicate which language(s): _____

Previous volunteer experience: _____

Past employee of Memorial Healthcare System? YES NO
 If yes: Dates employed and facility _____

Are there any volunteer duties you will be unable to perform safely? YES NO
 If yes, please explain: _____



Information for Background Check Purposes

* For 18 years and older only *

Have you ever been convicted of a felony? Yes _____ No _____
Have you ever pled Nolo Contendre (no contest) to a felony? Yes _____ No _____
Have you ever pled guilty to a felony? Yes _____ No _____
Have you ever been found guilty of a felony? Yes _____ No _____
Have you had an adjudication withheld for a felony? Yes _____ No _____
Have a nol pros for a felony? Yes _____ No _____
Are you presently charged with a felony? Yes _____ No _____

Have you ever had to serve probation in any pre-trial intervention as a result of a criminal charge? Yes _____ No _____

NOTE: A yes response does not necessarily disqualify an applicant from acceptance as a volunteer.

Please list any city/state where you have resided. Include the month and year.
We are required to go back ten years.

Previous address: _____
City State Zip Month/Year

Previous address: _____
City State Zip Month/Year

Previous address: _____
City State Zip Month/Year

Previous address: _____
City State Zip Month/Year

**Due to the high cost of background checks, if you fail to complete the six-month minimum commitment and minimum of 100 service hours, reinstatement will not be considered.
Please ask for clarification if this is not clear to you.**

I acknowledge that I have read and understand the commitment I am making.

Signature: _____

Date: _____



NOTICE TO APPLICANT OR EMPLOYEE OF INTENT TO OBTAIN AN INVESTIGATIVE CONSUMER REPORT

Dear Applicant or Employee:

In connection with your application or employment, Memorial Healthcare System would like to procure certain background information concerning you, which is contained in an investigative consumer report. An investigative consumer report may include information regarding your: creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, and/or criminal background. This information may be gathered from personal interviews with your neighbors, friends, and/or associates, e.g., former employers.

Before we may procure an investigative consumer report, you must authorize such procurement in writing. You have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report. However, if you are an applicant, we will not consider you further for employment if you so decline. If you are an employee, we may consider employment action if you decline.

Below you will find a release allowing us to obtain an investigative consumer report concerning the foregoing questions. Please read the release carefully before signing it and indicating your choice regarding disclosure.

RELEASE TO PROCURE AN INVESTIGATIVE CONSUMER REPORT

I have read the "Notice to Applicant or Employee" provided. I understand that I have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report concerning me.

I understand that the investigative consumer report may contain information concerning my: creditworthiness, credit standing, general reputation, personal characteristics, mode of living, and/or criminal background. I also understand that this information may be gathered from personal interviews with my neighbors, friends, and/or associates, e.g., former employers.

As disclosed above, I understand the nature and scope of the investigation that is going to be made into my background.

Understanding these rights,

_____ I authorize Memorial Healthcare System to procure an investigative Consumer Report concerning me.

_____ I do not authorize Memorial Healthcare System to procure an investigative Consumer Report concerning me.

Name (*print please*): _____

Former names: _____

Signature: _____

Date: _____

