Thank you for your interest in volunteering at Memorial Healthcare System. The Memorial Healthcare System is recognized as one of the outstanding Healthcare Systems in the country. The volunteers are a dynamic group who everyday live the Mission and Vision of our Healthcare System. Attached you will find our SPECIFIC volunteer application for working with one of our Patient and Family Advisory Councils.

Please read it carefully and follow directions. There are items below intended for Teen Volunteers only.

WHAT IS EXPECTED OF A Memorial Healthcare System Patient and Family Advisory Council Member

- A desire to meet the needs of our community, patients, families, visitors, physicians, and employees.
- A one year commitment.
- Please be prepared to give us a copy of your driver’s license.
- A mandatory Patient and Family Advisory Council orientation.
- Teen volunteer, Youth Advisory Council instructions and guidelines are on next page.
- A completion of a Tuberculosis Screening (PFAC Mentor/Family Support Network).

PLEASE CALL Michelle Barone, Director of PFCC at 954-265-0191 or 954-265-3000 TO SCHEDULE AN INTERVIEW. PLEASE DO NOT MAIL IN YOUR APPLICATION – BRING IT WITH YOU WHEN YOU ARRIVE FOR YOUR INTERVIEW.
Memorial Healthcare System

PFCC PFAC ADVISOR 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

SOCIAL SECURITY #: _______ - _______ 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.

DEPARTMENT: ____________________________ DAYS: ____________________________ HOURS: ____________________________

OFFICIAL USE ONLY
PLEASE SELECT THE AREA YOU FEEL YOU WOULD BEST BE ABLE TO SERVE WITHIN THE
PFAC COUNCILS OF MEMORIAL HOSPITAL SYSTEM

REGIONAL       JDCH / YOUTH       SOUTH       PEMBROKE       WEST       MIRAMAR

        SPECIAL NEEDS       PRIMARY CARE

Committees
Cancer Center  Maternity  Patient Relations  Pharmacy
Diabetes Center  Women’s Imaging  PFCC Education  Coffee Cart Host
Sickle Cell  Outpatient  Dietary  Discharge
New Born ICU  Family Support  Hospitality

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

PREVIOUS VOLUNTEER EXPERIENCE:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

WHICH FACILITY ARE YOU INTERESTED IN BECOMING A MEMBER OF THE MEMORIAL PFAC
ADVISOR PROGRAM AND WHY?

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

How did you learn about our PFAC program?
Newspaper  _____  Newsletter  _____
From a friend  _____  School  _____
Volunteer Recruitment Event  _____  Web site  _____
Ad in program or bulletin  _____

Page 3 of 6
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, PLEASE INCLUDE MONTH AND YEAR. WE ARE REQUIRED TO GO BACK TEN YEARS

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Due to the high cost of background checks if you fail to complete the six-month minimum commitment and minimum 100 service hours re-instatement may 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:_____________________

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TEENAGE VOLUNTEERS ONLY

INFORMATION FOR PARENTS

1. All teenagers must be interviewed and approved by the President of the Youth Advisory Council (YAC) and the Manager of the YAC.
2. All teenagers must submit a complete application at the time of the scheduled interview.
3. YAC Shirts are available; please ask about them at your first meeting.
4. Ask how the Auxiliary assists its teen volunteers who serve 500 or more hours.
5. Service hours will be awarded at the completion of their six-month commitment. Service hour letters must be requested within a month of leaving the Volunteer Services Department.

PARENTAL CONSENT FORM FOR
JOE DIMAGGIO CHILDRENS HOSPITAL YOUTH ADVISORY COUNCIL

Date: ______________

My daughter/son has my consent to become a Teenage Volunteer for Memorial. In addition, I do hereby give my consent to have him/her tested for Tuberculosis (PPD) as part of 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: ____________________________________________________________

Address __________________________ City __________ State __________ Zip __________

Home Phone: ________________________ Work Phone: ____________________________
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 contain 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 which will allow 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: ________________________________________________________________