BAPTIST HEALTH
Depend On Us For Life.sm

BAPTIST MEDICAL CENTER
800 Prudential Drive • Jacksonville FL 32207
Telephone (904) 202-2059

Visit Us on the Web: e-baptisthealth.com/volunteers

VOLUNTEER APPLICATION

_____ _____
Last Name First Name Middle Initial Spouse's Name

_____
Home Address (Apt. #) City Zip Code

_____ _____
Business Address Occupation

Telephone # (H) _____ (W) _____ Birthday _____

EDUCATION: _____ High School _____ College _____ Post Graduate

Degree(s): _____

WORK STATUS: _____ Employed _____ Retired _____ Unemployed

Previous work experience _____

_____

Reason for volunteering _____

_____

Have you performed volunteer work previously? _____ Where? _____

Do you know anyone in the Baptist Medical Center Auxiliary? _____ Yes _____ No

If yes, please list volunteer's name(s): _____

Where did you hear about our volunteer program? _____

_____

IN AN EMERGENCY PLEASE NOTIFY:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Physician: _____ Phone: _____

WHEN ARE YOU AVAILABLE TO VOLUNTEER? (Day of week and time of day?)

_____

_____

SERVICE AREA OPPORTUNITIES: (please check all areas of interest)

____ *Admitting
____ *Ambulatory Surgery
____ Baby Photo
____ Cancer Institute
____ Caring/visitation
____ Clerical
____ *Day Stay Unit
____ *Emergency Room
____ Employee Health
____ Eye Institute
____ Flower Delivery
____ *Ge Lab
____ Gift Shops
____ Healing Library
____ Information Desks
____ Intensive Care Unit
____ Mammography Services
____ Patient Mail
____ Patient Services
____ Physical Therapy
____ Rolling Store
____ Surgical Waiting Room
____ Other, Please Specify
_____

***Must be able to push a wheelchair**

What do you hope to gain from your volunteer experience? _____

_____

_____

_____

_____

CONFIDENTIALITY

As a member of the Baptist Medical Center Auxiliary, you may have access to confidential information about patients and their needs or to information concerning other employees, volunteers, or business operations. This knowledge imposes a heavy responsibility on you. You have an obligation not to reveal such information under any circumstance outside your assigned duties.

Only physicians, or persons authorized by a physician, may divulge laboratory, medical and surgical findings to the proper persons. Carelessness leading to release of information about patients is ethically wrong and could involved the offending employee, volunteer, and Baptist Medical Center in legal difficulties.

Requesting autographs and gathering in waiting rooms or lobbies to see a patient or family member who may be well known is unprofessional and unacceptable at Baptist Medical Center.

The misuse or violation of security regarding information generated by or stored in information systems will be dealt with promptly, and appropriate corrective action taken.

The unauthorized release by me of confidential information may be cause for my immediate dismissal from the BMC Auxiliary ad could result I my being held legally responsible for damage incurred by patients and their families.

I have read and agree to abide by the above statement regarding the release of confidential information.

_____ _____

Applicant's Signature Date

ABOUT BAPTIST MEDICAL CENTER AUXILIARY

Baptist Medical Center Auxiliary continues to fulfill its mission to the greater Jacksonville community with the same dedication to excellence that has been a hallmark since 1956. Our Auxilians are special people with large hearts and warm smiles who give of themselves to others. We welcome you to join our Auxiliary so you, too, can share the good vibrations that result from being a hospital volunteer at Baptist Medical Center.

We guarantee you will be proud to be a member of our Auxiliary. Our members represent all ages and come from all walks of life. They enjoy making a difference in the lives of others while providing needed volunteer services. Join us and assist Baptist Medical Center in providing quality health care to this community.

OFFICE USE ONLY:

Date Application Received: _____ Interview Date: _____

Welcome Call: _____ Orientation Date: _____

PERSONAL REFERENCES:

Please list name, address, and zip code of references. Do not use relatives.

1) Reference's Name	Address	City, State Zip
2) Reference's Name	Address	City, State Zip
3) Reference's Name	Address	City, State Zip

INTERVIEW AND ORIENTATION:

All prospective members will meet with the membership committee, must attend a volunteer orientation and train until competent to perform the required duties. We want you to feel comfortable in your assigned service.

MEMBERSHIP APPLICATION:

The information provided in this application is true in all respects, without any willful omissions. I understand that if this application is false in any way I will be dismissed without notice regardless of when the false information is discovered.

As an Active member of the Baptist Medical Center Auxiliary, I agree:

- to attend the volunteer orientation and training.
- to comply with all the rules and regulations of the hospital and Baptist Medical Center Auxiliary.
- to call my service chairman as soon as possible when I have scheduling changes.
- to contribute a minimum of 100 hours per year.

I hereby apply for membership in Baptist Medical Center Auxiliary.

Applicant's Signature: _____ Date: _____

Your signature indicates your approval for us to check your references and to process a background check. The Auxiliary is not obligated to provide a placement, nor are you obligated to accept the position offered.

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Background Investigation

To be considered for volunteering with Baptist Medical Center or affiliates, applicants are subject to a background investigation with the Florida Department of Law Enforcement and other state, out-of-state, and local agencies.

Applicants are evaluated on the merits of their qualifications for positions available, regardless of the individual's race, sex, color, national origin, age, disability, religion, marital status, or status as a veteran.

Have you ever been convicted of, or pled guilty, no contest or nolo contendere to a crime? This includes DUI or DWI, a criminal conviction, debarment, sanction, or exclusion related to Medicare, Medicaid, or any other federal or state-funded health care program(s), or ineligibility for participation in a federally- or state-funded health care program? Yes_____ No _____

If yes, give details (date, place, offense(s), disposition, etc.): _____
_____

Have you ever been charged with a crime and either been placed on a court-ordered probation, had adjudication withheld, entered a pre-trial intervention program, or have any criminal charges now pending? Yes_____ No _____
If yes, give details: _____
_____

PLEASE PRINT ALL INFORMATION AND SIGN AT THE BOTTOM

The following information is required to perform the background investigation:
- First and middle names should be as it appears on your birth certificate.
- In the other name field below, please include all last names only that you have ever had.
- List all states & counties in which you have resided, outside of Florida, within the past seven (7) years:

States: _____ Counties: _____

Last Name_____
First Name_____
Middle Name_____
Other Name(s)_____
Social Security # _____
Date of Birth _____
Sex: Male_____ Female _____
Race: White _____ Black_____
Asian_____ Hispanic_____
Other _____
Driver's Lic # _____
State_____

_____ _____
Signature of Applicant Date

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Recruiter's Initials _____

Position _____