BAPTIST Medical Center South

14550 Old St. Augustine Road
Jacksonville, Florida 32258
Phone: 904.271.6081
Fax: 904.271.6649
baptistjax.com

Volunteer Application

Last Name: _____ First Name: _____ M.I.: _____

SS#: _____ Telephone Number: _____ Date of Birth: _____

Spouse's Name: _____

Address: _____City/ZIP: _____

Email Address:_____

Present occupation: _____ Previous occupation (if retired): _____

How did you become interested in our volunteer program? _____

Have you done volunteer work previously? ___ Yes ___ No If yes, please describe. _____

_____

Foreign languages spoken and understood _____

Areas of Interest:

__ Front Desk/Ambassador
__ Gift Shop
__ Patient Care Areas
__ Surgical Services
__ Materials Management/Receiving
__ Emergency Services
__ Courtesy Shuttle
__ Outpatient Registration Desk
__ Patient Rounds

Times Available:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning 8-12							
Afternoon 12-4							
Evenings 4-8						N/A	N/A

References: Please clearly PRINT two (2) non-relative references:

1. Name _____

   Would you prefer we contact via email or postal service? (circle one)

   Street address _____

   City _____ State _____ Zip _____

   Email address _____

2. Name _____

   Would you prefer we contact via email or postal service? (circle one)

   Street address _____

   City _____ State _____ Zip _____

   Email address _____

Emergency Contact:

Name: _____

Relationship: _____ Telephone Number: _____

Primary Care Physician: _____ Telephone Number: _____

I hereby apply for active membership in the Volunteer Program and confirm that I am at least 18 years of age. When assigned, I agree to abide by the rules and regulations governing the organization and the medical center. Specifically, I agree to contribute **a minimum of one year of service to the hospital** and **a minimum of one, four hour shift weekly**.

_____ _____

Signature of Applicant Date

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

BAPTIST
Medical Center South

Background Investigation

To be considered for volunteering with Baptist Medical Center South 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,** include <u>all</u> last names that you have ever had.

List <u>all states</u> where you have resided outside of Florida within the past seven (7) years.
State(s): _____ County (ies): _____

Last Name_____

First Name_____

Middle Name_____

Other Name(s)_____

Social Security #_____

Date of Birth/Year_____

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Sex: Male ___ Female ___ Race: White ___ Black ___ Asian ___ Hispanic ___ Other ___

Driver License # _____ State _____

_____ _____
Signature of Applicant Date

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Immunization History

(Please print)

Name _____ Telephone _____

Address _____ Work Telephone _____

City _____ State _____ Zip _____

Your general health is: Excellent ___ Good ___ Fair ___

Please check if you have had any of the following:

	NO	YES (approx. date)	IMMUNIZATION (approx. date)
Measles			
Chicken Pox			
Mumps			
Tetanus			
Hepatitis (specify type)			
Tuberculosis (TB) or if POSITIVE TB Test provide date and results of last chest x-ray			
Other			

Are there any accommodations or limitations that you would like the Baptist South Volunteer Office to be aware of when assigning you to your area of volunteer service, including medical conditions that restrict your ability to hear, see, stoop, lift or push?
NO _____ YES (please specify): _____

Comments: _____

By signing below I verify that my responses are complete and correct.

_____ _____
Signature of Applicant Date