Volunteer Services
CMC

CONWAY MEDICAL CENTER – VOLUNTEER SERVICES AND/OR AUXILIARY
300 SINGLETON RIDGE ROAD, P.O. Box 829
CONWAY, SOUTH CAROLINA 29528 - 0829
TELEPHONE: 843-234-5486
FAX: 843-234-6811

APPLICATION FOR VOLUNTEER SERVICES AND/OR THE AUXILIARY

DATE:_____

NAME:_____

STREET ADDRESS_____

CITY/STATE_____ZIP_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____

E-MAIL _____

BIRTHDAY: MONTH_____DAY _____ ARE YOU UNDER THE AGE OF 18? YES☐ NO☐

EDUCATION LEVEL _____ MAJOR COURSE OF

STUDY:_____ DO YOU SPEAK ANY FOREIGN LANGUAGE?

YES_____NO_____ ☐ ☐
IF YES, WHAT LANGUAGE _____

DO YOU KNOW SIGN LANGUAGE? YES____☐____NO_____☐_____

HOW DID YOU LEARN ABOUT OUR PROGRAM (please check)
Friend☐church☐ media☐ other_____

HOBBIES/INTEREST_____

HAVE YOU HAD EXPERIENCE OPERATING THE FOLLOWING OFFICE EQUIPMENT?
COMPUTERS___☐___COPY MACHINES___☐___CASH REGISTERS___☐___

PAST WORK EXPERIENCE:_____

ARE YOU CURRENTLY ABLE TO PERFORM THE DUTIES REQUIRED OF A VOLUNTEER?
(I.E. Pushing wheelchair, walking standing etc)_____

WHY ARE YOU INTERESTED IN A VOLUNTEER POSITION OR THE AUXILIARY AT CONWAY MEDICAL CENTER

_____

_____

_____

PREVIOUS VOLUNTEER
EXPERIENCE_____

COMMUNITY AFFILIATIONS_____

AREA OF INTEREST: (please check) PATIENT CONTACT ☐ NON PATIENT CONTACT ☐ CLERICAL ☐

	YES	NO
DID YOU EVER SERVE IN THE MILITARY?	☐	☐
IF YES, DID YOU RECEIVE ANYTHING LESS THAN AN HONORABLE DISCHARGE?	☐	☐
HAVE YOU EVER HELD A POSITION OF TRUST?	☐	☐
HAVE YOU EVER BEEN CONVICTED OF A CRIME? (OTHER THAN A TRAFFIC TICKET)	☐	☐
DO YOU CURRENTLY USE ILLEGAL DRUGS?	☐	☐

ARE YOU A CITIZEN OF THE UNITED STATES? YES☐ NO☐

ARE YOU CURRENTLY EMPLOYED? YES☐ NO☐

DO YOU RESIDE IN THIS AREA (please check), PERMANENT☐ PART-TIME☐

WHAT ARE YOUR DAYS/HOURS OF AVAILABILITY TO VOLUNTEER

Sun☐ Mon☐ Tues☐ Wed☐ Thurs☐ Fri☐ Sat☐

Morning☐ Afternoon☐ Evenings☐ Nights☐

FOR EMERGENCY NOTIFY_____PHONE_____

Relationship _____

PLEASE LIST NAMES AND ADDRESS OF TWO PERSONAL REFERENCES
(Please no relatives or Church Pastors)

1st.Name:_____PHONE_____
Address:_____
Street

_____
City State Zip

2nd.Name:_____PHONE_____
Address:_____
Street

_____
City State Zip

Conway Medical Center Volunteer Services and the Auxiliary do not discriminate on the basis of age, sex, religion, race or national origin. The Volunteer Services and the Auxiliary are non-profit charitable organizations providing volunteer services and fund raising activities for Conway Medical Center. Existence of a criminal record does not mean an automatic bar to obtaining volunteer status. All information provided on these forms is true to the best of my knowledge.

SIGNATURE_____DATE_____

ID Verified by _____DATE_____
VOLUNTEER OFFICE REPRESENTATIVE

I hereby authorize Conway Medical Center to receive any criminal history, motor vehicle information, personal credit history, employment history and educational records and similar types of information from any and all governmental agencies, individuals and/or parties or agencies which may generate or maintain such information.

I hereby agree not to hold Conway Medical Center liable for their transmittal or use of their reliance on any of the information even if my volunteer status is terminated or I am denied the volunteer position.

SIGNATURE_____SS#_____DATE_____

PERTINENT INFORMATION

1. A volunteer is requested to serve a minimum of 4 hours per week. A free meal is provided either before or after such shift in the Conway Medical Center Dining Room. You are requested to stay at your assignment for the entirety of you shift.
2. The Volunteer uniform consists of the burgundy blazer for men or an official burgundy polo shirt and the peach smock/vest for women or an official pink polo shirt. White short or long sleeve tops are to be worn under the jackets and/or vest and beige, navy blue or white pants are the official colors for the long pants. The cost is the responsibility of the volunteer. Closed toe shoes. Jewelry, Pins and badges are to be reflective of a professional image and role within the Medical Center.
3. In the event that you will be unable to keep your regularly scheduled volunteer shift, you are requested to attempt to find a substitute. The Volunteer Office will provide you with such phone numbers. If you are ill and unable to search for a replacement, please notify the Volunteer Office, and we will locate a replacement for you.

VOLUNTEER CODE

Below are listed some of the most important rules of the Conway Medical Center Volunteer Services. After studying them and in agreement – please sign below:

1. *A Volunteer is part of the hospital organization, subject to all hospital rules, regulations and proper authority.*

2. *A Volunteer is subject to the code of ethics governing the professional staff of the hospital. It is important and essential therefore:*
    a. *To respect all information concerning the hospital and patients as confidential*

    b. *To follow instructions meticulously*

    c. *To be dignified, pleasant and quietly efficient*

    d. *To never take advantage of association with the hospital*

    e. *To use the greatest discretion in speaking with patients or visitors. Criticism of the hospital or staff should be taken up with the Director of the Volunteer Services so that the situation can be investigated.*

    f. *To be dependable – to be on time – staff and other Volunteers are waiting for you. If you cannot come, try to get a substitute. If unable to do so, please notify the Director of Volunteers and your assignment area supervisor.*

Date *Signature*

Volunteer Services
CMC

Date:_____

Dear ,

Your name was given to us by _____ who has completed an application to become a volunteer with the Conway Medical Center Volunteer Services. An applicant cannot start to volunteer until this information is completed. We ask that you, as the named reference, complete the form and return it to us within a week in the enclosed envelope.

Sincerely, Director, Volunteer Services.

Please describe your relationship with the named person and how long you have known them.

Is this person reliable and dependable, and able to fill obligations?

In your opinion, would this individual be able to take directions well?

Please comment on the person's ability to relate to patients, other volunteers, and hospital staff.

This information is confidential and will be filed with the application. Thank you for taking the time to help this prospective volunteer to achieve their goal. We appreciate it.

Signature of person completing this form: _____Date:_____

AFFIDAVIT:

I authorize the hospitals, companies, schools, or persons named above to give any information they may have regarding me. I hereby release said hospitals, companies, schools, or persons from all liability for damage for issuing this information.

_____ _____

Applicant's signature Date

Applicant must sign this form.

Volunteer Services
CMC
Conway Medical Center

Date:_____

Dear ,

Your name was given to us by _____ who has completed an application to become a volunteer with the Conway Medical Center Volunteer Services. An applicant cannot start to volunteer until this information is completed. We ask that you, as the named reference, complete the form and return it to us within a week in the enclosed envelope.

Sincerely, Director, Volunteer Services.

Please describe your relationship with the named person and how long you have known them.

Is this person reliable and dependable, and able to fill obligations?

In your opinion, would this individual be able to take directions well?

Please comment on the person's ability to relate to patients, other volunteers, and hospital staff.

This information is confidential and will be filed with the application. Thank you for taking the time to help this prospective volunteer to achieve their goal. We appreciate it.

Signature of person completing this form: _____Date:_____

AFFIDAVIT:

I authorize the hospitals, companies, schools, or persons named above to give any information they may have regarding me. I hereby release said hospitals, companies, schools, or persons from all liability for damage for issuing this information.

_____ _____

Applicant's signature Date

Applicant must sign this form.