



Dear Prospective Volunteer:

We are pleased that you are interested in becoming a volunteer at Vidant Beaufort Hospital. In order to expeditiously facilitate the process, I encourage you to complete the entire packet of information and return it with a copy of your most recent immunization record.

You may return it to the front desk at the main lobby of Vidant Beaufort Hospital. The office hours are 8:00 AM - 4:30 PM, Monday - Friday. If your preference is mailing it you can address it to:

Volunteer Services Department
Vidant Beaufort Hospital
628 East 12th Street
Washington, NC 27889

Once your application has been received, you will be contacted via email or telephone to schedule an interview. If your talents and gifts match what we are in need of, we will begin the on-line on-boarding process. Again, we thank you for your interest and remember, "The best way to find yourself is to lose yourself in the service of others." - Mahatma Gandhi.

If you have additional questions feel free to contact me at **(252) 975-4161**.

Sincerely,

Jamie Tice,
Manager, Volunteer Services

Please check the box to the left of the appropriate facility:

- Vidant Medical Center
- Vidant Duplin Hospital
- Vidant Beaufort Hospital
- Vidant Edgecombe Hospital
- Vidant Bertie Hospital
- The Outer Banks Hospital
- Vidant Chowan Hospital
- Vidant Roanoke-Chowan Hospital
- Vidant SurgiCenter



VIDANT HEALTH™

VOLUNTEER SERVICES APPLICATION FOR VOLUNTEER SERVICE

To The Applicant: We appreciate your interest in Vidant Health and we are sincerely interested in your qualifications to serve our patients and families. Questions on this application are asked for the sole purpose of considering you for volunteer service. We do not discriminate on the basis of race, religion, sex, national origin, age, or handicap status. **A 3-MONTH COMMITMENT IS REQUIRED.**

Date: _____

(Circle One) Mr./ Ms. / Miss / Mrs.

Name	(Last)	(First)	(Middle)	(Preferred)	HOME PHONE
Present Address (number and street)					BUSINESS PHONE
City, State, Zip Code				CELL PHONE	
OCCUPATION				SHIRT SIZE (S, M, L, XL, 2XL, 3XL,4XL)	
DATE OF BIRTH		EMAIL ADDRESS			
HAVE YOU WORKED FOR VIDANT? IF YES, WHEN? _____		HAVE YOU WORKED HERE BEFORE? NO YES WHEN? _____		EARLIEST DATE AVAILABLE	
How did you hear about volunteering at Vidant? _____					
Have you previously volunteered here? Yes No If so, when? _____					
Are you currently a student? If so, where? _____					

MISCELLANEOUS REQUIRED INFORMATION (PLEASE ANSWER ALL QUESTIONS CAREFULLY)

In case of emergency, notify _____
(name) (relationship) (phone)

Physician to contact: Dr. _____
(name) (phone)

Describe any work-related limitations, physical or emotional _____

Hobbies, Education, Skills, Interests _____

Have you ever pleaded guilty or been convicted of a crime other than a minor traffic violation:
Yes No If yes, Explain: _____

Are you related to anyone employed by us: Yes No If yes, give name and relationship _____

If you desire to earn volunteer hours for school or another organization with a special program for credit (club, etc., we do not accept community service hours) please list:

(organization) (reference person) (phone)

Why do you want to be a volunteer? _____

PLEASE CHECK ALL AREAS OF INTEREST

PATIENT ACCESS SERVICES/ADMISSIONS RADIOLOGY WORKROOM

GIFT SHOP EMERGENCY ROOM CANCER CENTER OUTPATIENT SURGERY/ASU

OTHER _____ NO PREFERENCE

VOLUNTEER COMMITMENT – Most volunteer positions require the volunteer to commit a minimum of four (4) hours of service once a week. Special service areas require cross-training and a commitment of a total of four (4) months. A three month commitment is required for a school or job reference

TRAINING/HEALTH – A Joint Commission volunteer orientation and health screen is required before placement and cross training. An update of the health screen and TJC competency review is required annually. All current required immunizations will be given unless documented proof is submitted with the application.

Name: _____ Date: _____



VIDANT HEALTH™

Criminal Record Check Form

Criminal record checks will be performed on every applicant at Vidant Health (VH) or its subsidiary corporate entities. If the information you furnish on this form is found to be false, you will be disqualified/dismissed. You will not be considered for future employment/service for 18 months.

Please answer the following questions concerning your past history (Check all that apply):

1. Have you ever been
 - a. Convicted of a misdemeanor? Not necessary to include minor traffic infractions. Yes No
 - b. Convicted of a worthless check(s) (if you have paid off a check at Magistrate's office or Courthouse this is probably a worthless check conviction)? Yes No
 - c. Convicted of any DWI's (Driving While Impaired)? Yes No
 - d. Convicted of violation or violations of any drug laws the Controlled Substances Act of North Carolina or similar laws of any state or nation? Yes No
 - e. Convicted of any crimes of violence such as assault, harassment, communicating threats, rape, kidnapping, manslaughter, murder? Yes No
 - f. Convicted of a felony? Yes No
 - g. Convicted of any crime involving child abuse, child neglect, or indecent liberties with a minor? Yes No
 - h. Convicted of a violation or violations of a Professional Practice Act? Yes No

IF THE ANSWER TO ANY OF THE FOREGOING QUESTIONS IS "YES", PLEASE EXPLAIN EACH CONVICTION ON THE BACK SIDE OF THIS FORM, INCLUDING COUNTY AND STATE OF CONVICTION. IF NEEDED, ADDITIONAL SHEETS ARE AVAILABLE UPON REQUEST IN THE OFFICE FROM WHICH YOU OBTAINED THIS APPLICATION.

2. Please list all names you have ever been known by including birth name, previous marriage(s), legally changed, nicknames and aliases.

(1) _____ (2) _____
 (3) _____ (4) _____

3. Please list street, city and state where you have lived for the last **ten (10) years** including military and school addresses (use additional sheet if more space is needed).

_____	_____	_____
Street	Street	Street
_____	_____	_____
City	County	City
_____	_____	_____
State	Zip	State
Dates	Dates	Dates
from _____ to _____	from _____ to _____	from _____ to _____

I hereby certify that the answers on this application and this insert are true and correct, all that any misrepresentation or false information on my part will disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination.

In connection with this request, I authorize all law enforcement agencies, city, state, county and federal courts to release information they may have about me to the corporate entity of VH to which I am applying or someone acting on their behalf.

_____	_____
Signature of Applicant	Date
_____	_____
Print Full Name	Social Security Number
_____	_____
Date of Birth	Valid Driver's License Number (if you do not have license state reason)
_____	_____
Current Address	State where license was issued
_____	_____
City	State
_____	Zip

Dates: from _____ to _____

Date of Birth is required solely for purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

CONFIDENTIAL RECORD
Vidant Occupational Health
Demographic Information Sheet for Volunteers

Name: _____		
Last	First	Middle
Date of Birth: ____/____/____		Social Security # _____
Address: _____		
Street/Apartment/P.O. Box		
_____	_____	_____
City	State	Zip
Contact Phone #: (_____) _____ - _____		
_____		_____
Personal Physician's Name and Address		Phone #
_____	_____	_____
Name of Emergency Contact	Relationship To You	Phone #
Allergies: (Food, Medication, Latex, Etc.) _____		
Current Medications: _____		

ACKNOWLEDGEMENT OF INSTRUCTION REGARDING ACCIDENTAL INJURY

If you sustain an injury while on duty at Vidant Health, please seek care as needed and contact Vidant Risk Management at 252-413-4473 for further instructions.

ACKNOWLEDGMENT OF INSTRUCTION REGARDING BLOOD EXPOSURES

All blood exposures are to be **immediately** reported to the Manager/Supervisor/Charge Person **and** Vidant Occupational Health Department where the volunteer will be instructed on the process. If Occupational Health is closed, the Manager/Supervisor/Charge Person will contact the Patient Care Coordinator/Nursing Supervisor **immediately**. The Patient Care Coordinator/Nursing Supervisor will instruct the volunteer on the process.

I have read the above information, and have had an opportunity to ask questions which have been answered. I understand that it is my responsibility to contact Vidant Risk Management at any time I have a job-related exposure to any communicable disease.

Signature of Volunteer (or parent/guardian if under 18)

Date Signed