Dear Prospective Volunteer:

We are pleased that you are interested in becoming a volunteer at ECU Health 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 ECU Health 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
ECU Health Beaufort Hospital
628 East 12th Street
Washington, NC 27889

Once I have received your application, 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-boarding process. Again, 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 & The Upfront Gift Corner

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

□ ECU Health Medical Center
□ ECU Health Beaufort Hospital
□ ECU Health Bertie Hospital
□ ECU Health Chowan Hospital
□ ECU Health SurgiCenter
□ ECU Health Duplin Hospital
□ ECU Health Edgecombe Hospital
□ The Outer Banks Hospital
□ ECU Health Roanoke-Chowan Hospital

VOLUNTEER SERVICES APPLICATION
FOR VOLUNTEER SERVICE

To The Applicant: We appreciate your interest in ECU 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 ECU Health? IF YES, WHEN? _____	HAVE YOU WORKED HERE BEFORE? NO YES WHEN? _____	EARLIEST DATE AVAILABLE
How did you hear about volunteering at ECU Health? _____ 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 □ VOLUNTEER WORKROOM

□ GIFT SHOP □ EMERGENCY ROOM □ CANCER CENTER □ OUTPATIENT SURGERY/ASU

□ REHAB SERVICES (PT, OT, ETC.) □ NO PREFERENCE □ OTHER

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:_____

ECU HEALTH

Criminal Record Check Form

Criminal record checks will be performed on every applicant at ECU Health 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 County	_____ City County
_____ State Zip	_____ State Zip	_____ State Zip
Dates from_____ to _____	Dates from_____ to _____	Dates 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 ECU Health 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
ECU Health 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 ECU Health, please seek care as needed and contact ECU Health 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** ECU Health 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 ECU Health 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**