



Sutter Davis Hospital

VOLUNTEER APPLICATION

PERSONAL INFORMATION

Name: _____
Last First M.I.

Address: _____
Number/Street City State Zip

Phone: _____ E-Mail: _____

Education: _____
Last/Current School Attended Major Diploma/Degree Awarded

Languages Spoken Other than English: _____

Do you have a spouse or relative employed by Sutter Davis Hospital? Yes No

Have you ever been convicted of a crime other than a traffic infraction? Yes No

Note: Conviction is not an automatic bar to volunteering. Each case will be considered on its own merits.

OFFICE USE ONLY

ORIENTATION _____

INTERVIEW _____

DUES PD _____

BKGD CK _____

TB TEST _____

ID BADGE _____

PROV PER _____

UNIFORM _____

SERVICE _____

EMERGENCY CONTACT INFORMATION

Name Phone Relationship

VOLUNTEER INFORMATION

Previous Volunteer or Business Experience: _____

Hours & Days Available to Volunteer: _____

Skills & Interests: (Circle all that apply)

Computer Buyer

Crafts Typing

Floral Arranging Mailing

Special Events Music

Public Relations Fundraising

Social Events Phone Committee

Art Display Cashier

Other (Describe) _____

Services You are Interested in:: (Circle all that apply)

Information Desk Gift Shop

Surgery Center General Offices/Admin

Patient Services

Radiological Imaging

Emergency Department

TWO PERSONAL REFERENCES FROM PERSONS NOT RELATED TO YOU

1. Name: _____ 2. Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO PROVIDE:

I hereby certify that the information contained in this application form is true and correct. I authorize Sutter Health to contact any references for the purpose of collecting information or obtaining an account of my experience. I agree to hold any or all of them blameless and free of liability for releasing any such information. I understand that as a volunteer, any deletion, misrepresentation or misstatement of the facts as stated or implied is sufficient cause for dismissal. I understand that this application does not bind either me or Sutter Davis Hospital for any specific period regarding my volunteerism.

Signature: _____ Date: _____

Rev: 9/03

An Equal Opportunity Employer observing all Federal and State laws governing fair employment practices.



Sutter Davis Hospital
Auxiliary

VOLUNTEER COMMITMENT AND CONFIDENTIALITY AGREEMENT

- I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.
- My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian and charitable reasons.
- I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies 'for compensation', both on or off of Sutter Davis Hospital property, or act as a runner or capper for an attorney in the solicitation of business. I shall report all known occurrences of solicitation for attorneys to the Hospital Administrative Liaison.
- I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the hospital to engage in these activities.
- I shall submit to examinations, which may include chest x-rays, skin tests, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer service.
- I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
- I shall attempt to resolve any problems related to my volunteer activities with my service manager, and if unsuccessful, attempt to resolve any such problems with the Sutter Davis Hospital Administrative Liaison.
- I shall make my best effort to fulfill my commitment to Sutter Davis Hospital by completing all assignments that I accept. I shall at all times uphold the philosophy and standards of Sutter Davis Hospital.
- I understand that the Auxiliary reserves the right to terminate any volunteer status as a result of (a) failure to comply with Sutter Davis Hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the Auxiliary, would make my continued services as a volunteer contrary to the best interests of Sutter Davis Hospital.
- I understand that Sutter Davis Hospital assumes no responsibility for any contact, visits or services provided by me outside of the responsibilities assigned through the volunteer program of Sutter Davis Hospital.

I have read each of the above conditions and I agree to be bound by them.

Name (please print):

Signature:

Date:

Rev: 12/9/2007 PLF

SUTTER HEALTH SACRAMENTO SIERRA REGION

Volunteers Health Questionnaire

Name: _____ Phone: _____

Birthdate: _____

- | | | |
|--|-----|----|
| 1. Have you ever had a TB test?
(Current written proof required) | Yes | No |
| 2. Did you have a positive reaction? | Yes | No |
| 3. Have you ever had Tuberculosis? | Yes | No |
| 4. Have you had chicken pox? | Yes | No |
| 5. Have you received the Hepatitis B vaccine? | Yes | No |
| 6. Have you had a tetanus vaccine in the last ten years?
What year? _____ | Yes | No |

FOR PROSPECTIVE VOLUNTEERS BORN AFTER 12/31/56

- | | | |
|---|-----|----|
| 1. Have you received the MMR vaccine? | Yes | No |
| 2. Do you have a written record of the
MMR vaccine injection dates. (Written proof required) | Yes | No |

Volunteer's signature

Date

Interviewer's signature

DO NOT WRITE BELOW THIS LINE

Department Assignment: _____

PPD #1 Date Read _____ Results _____

PPD #2 Date Read _____ Results _____

Chest X-ray _____

MMR _____

Chicken Pox _____

Hepatitis B _____ (Proof of Hepatitis B or signed "Declination Form" required)

Employee Health Date

Clearance Signature (to be signed only if volunteer is completely cleared)

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(For Volunteers Under the Age of 18)

Consent for Pre-Employment Physical

I, _____ (Parent or Legal Guardian) give permission to Sutter Employee Health Services to perform a pre-employment physical on my child _____.

I understand that the pre-employment physical requires either a tuberculin skin test or a chest x-ray, which will be performed at the hospital at no cost to the volunteer. I am also aware that my child may need additional immunizations for Measles, Mumps and Rubella (MMR) and Chicken Pox (Varicella) to complete this physical. The hospital cannot provide these additional immunizations. Instead, they should be done by the volunteer's primary physician or other health care provider.

Parent or Legal Guardian Signature

Date