

Memorial

Applicant Name _____

Applicant Email _____

_____ Interview - Application / all paperwork complete

_____ Application & Health Paperwork emailed to recruitment.team@mhg.com

_____ Employee Health Paperwork emailed

Security: _____ Fingerprints taken

_____ Fingerprints cleared

_____ Left form in security for badge to be made

_____ Name badge made

Computer

Access: _____ Emailed Access Request Form (Main Page)

_____ Received username & password

_____ Employee Health Appt. – TB and FLU given

_____ Infection control video

_____ Add to mailing list, email list and birthday list

_____ Jacket or Shirt distributed _____ size

_____ Job Assigned _____

_____ Hours willing to work _____ Days willing to work

Memorial

Dear Sir or Madame:

Thank you for your interest in the Memorial Hospital Volunteer Auxiliary.

This program is a vital part of Memorial Health System and we value our volunteers. Many challenging and rewarding volunteer opportunities await you at Memorial. The volunteers provide numerous services that impact not only our patients, staff, and visitors but, our community.

Enclosed you will find a volunteer application. Please complete the application, including the volunteer interest form. This will help us to place you in an area that is perfect for you.

Once you have completed the form, please contact me through email at dvarhol@mhg.com, or by phone at (228) 865-3375 to schedule a time that is convenient for you to come in. Your visit is very important to me so please make every effort to schedule an appointment so I will be able to meet with you personally.

If you have any questions or if I can assist you, please don't hesitate to contact me. I look forward to meeting you.

Thank you again for your interest in the Memorial Hospital Auxiliary.

Dawn Varhol
Volunteer Coordinator
(228) 865-3375

Volunteer Application

Memorial Health System is an Equal Opportunity Employer.

Memorial Health System is a non-smoking facility. Smoking is prohibited within the hospital and on the hospital campus.

Personal Data

First _____ Middle _____ Last _____

Date of Birth _____ Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? () No () Yes-If yes, please

list _____

Have you ever been convicted of a crime? () No () Yes

Note: Convictions include guilty pleas and pleas of nolo contendere. A conviction will not necessarily bar you from volunteer status. Each conviction will be judge on its own merits as to time, circumstances and seriousness.

If yes, please explain _____

Emergency Information

Emergency contact:

Name: _____

Relationship to you: _____

Home Number: _____

Cell Number: _____



Volunteer Experience

Please list any previous volunteer experience _____

Questionnaire

1. Why are you interested in volunteering?

2. Is there anything that may adversely affect your ability to perform volunteer duties () No () Yes-
If yes, please explain

3. Would you be interested in serving on the Auxiliary Board of Directors? () No () Yes

4. Please select all areas that you are interested in working in the hospital:

- | | |
|--|--|
| <input type="radio"/> Gift Shop | <input type="radio"/> Vendor Sales |
| <input type="radio"/> Cancer Resource Center | <input type="radio"/> Cardiac Cath Lab Waiting Room |
| <input type="radio"/> Escorts | <input type="radio"/> Infusion Clinic (CHF) Waiting Room |
| <input type="radio"/> Flower Delivery | <input type="radio"/> Emergency Department |
| <input type="radio"/> Surgery Waiting Room | <input type="radio"/> Pet Therapy (requires certification) |
| <input type="radio"/> Same Day Admit | <input type="radio"/> ICU Waiting Room |

5. How did you hear about the Memorial Auxiliary?

6. When can you start volunteering? _____

Other

Please share any information you think would help us get to know you. This can be work history, hobbies, etc.

References

Please list two personal references other than family.

Reference 1

Name _____ Relationship _____ Contact # _____

Reference 2

Name _____ Relationship _____ Contact # _____

I certify that this application is correct to the best of my knowledge and understand that references will be checked.

Applicant

Signature _____ Date _____

If accepted as a hospital Volunteer, I agree that:

1. I shall hold absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not to seek to obtain confidential information from a patient.
2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious or charitable reasons.
3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off hospital property or act as a runner or capper for an attorney in solicitation of business. I shall report all known occurrences of solicitation of for attorneys to the Manager of Community and Corporate Relations.
4. I shall not sell or attempt to sell goods or services, request contributions or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Manager of Community and Corporate Relations to engage in these activities.
5. I shall be punctual and conscientious; conduct with dignity, courtesy and consideration of others and endeavor to make work professional in quality.
6. I shall attempt to resolve any problems related to my Volunteer activities with the Manager of Community and Corporate Relations.
7. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
8. I shall, at all times, uphold the philosophy of the hospital.
9. I understand the Manager of Community and Corporate Relations reserves the right to terminate my Volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; (d) any other circumstances, which in the judgment of the department manager, would make my continued service as a Volunteer contrary to the best interests of the hospital.

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

Applicant Signature: _____

MS SAFER

(Mississippi Screening Assurance for Employee Enrollment and Registries)

- Name: _____
- SS#: _____
- DOB: _____
- Race: _____
- Gender: _____
- Height: _____
- Weight: _____
- Hair Color: _____
- Eye Color: _____
- Are you a U.S. Citizen: YES NO
- Place of Birth: _____
- Have you lived in any state (Other than your current state)
in the last two years? YES NO
- Previous state(s) lived in in the last 2 years:
 - _____ From: _____ To: _____
 - _____ From: _____ To: _____
 - _____ From: _____ To: _____
- Please list any other names/aliases you have gone by (If Applicable):
 - _____
First Last
 - _____
First Last

Mississippi State Department of Health

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification¹ that your fingerprints will be used to check the criminal history records of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations CCFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.²

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.³

The Mississippi State Department of Health will provide you with a copy of your Mississippi and FBI criminal history record for review and possible challenge. Should you lose or misplace the provided record, you may obtain a copy from MSDH by submitting a request for the duplicate record which includes appropriate identifying information and a \$15 fee.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the state agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the state agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

Your signature on the fingerprint card and/or this document indicates that you have been informed of your privacy rights and understand that your fingerprints are being run through the criminal history records of the FBI.

Date _____ Applicant's Signature _____

¹ Written notification includes electronic notification but excludes oral notification.

² See 28 CFR 50.12(b).

³ See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV (c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

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Fingerprint Request Form

(Date)

This is to request fingerprinting on an applicant employee volunteer

Name: _____
(First) (Middle) (Last)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Phone Number: _____ Manager: _____

Agency Privacy Requirements for Noncriminal Justice Applicants

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint-based criminal history record check on an applicant for noncriminal justice purposes (such as job or license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notice and other information and that the results of the check are handled in a manner that protects the applicant's privacy.

- Officials must provide to the applicant written notice¹ that his/her fingerprints will be used to check the criminal history records of the FBI.
- Officials using the FBI criminal history record (if one exists) to make the determination of the applicant's suitability for the job, license, or other benefit must provide the applicant the opportunity to complete or challenge the accuracy of the information in the record.
- Officials must advise the applicant the procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- Officials should not deny the job, license, or other benefit based on information in the criminal history record until the applicant has been afforded reasonable time to correct or complete the record or has declined to do so.
- Officials must use the criminal history record solely for the purpose requested and cannot disseminate the record outside the receiving department, related agency, or other authorized entity.²

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, the courtesy will save the applicant time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found in 28CFR 16.30 through 16.34. It will also allow the officials to make a more timely determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant notice, what constitutes "a reasonable time" for the applicant to correct or complete the record, and any applicant appeal process that is afforded the applicant. Such documentation will assist State and/or FBI auditors during periodic compliance reviews or use criminal history record for noncriminal justice purposes.

Signature of Applicant _____ Date _____

¹Written notification includes electronic notification but exclude oral notification

²See 5 U.S.C. 552a (b); 42 U.S.C. 14616, Article IV (c); 28 CFR 20.21 (c), 20.33 (d), 50.12 (b) and 906.2 (d).

Memorial

EMPLOYEE HEALTH SERVICES

"HealthCheck"

(HealthCheck Form 2000)

Name: _____ Date of Birth: _____ Sex: _____ Job/Dept. _____

Physical History

Have you suffered any serious health problems in the past year? Yes ___ No ___ If yes, describe them. _____

Are there any persons living in the same household as you or with whom you have frequent contact that have a communicable disease? Yes ___ No ___ If yes, please explain. _____

When is the last time you saw a doctor? _____ Why? _____

Please circle any disease you have had in the past and initial by the circle:

Measles	Mumps	Chicken Pox	Whooping Cough	Diphtheria	Polio
Scarlet Fever	Pneumonia	Brucellosis	Malaria	Typhoid	TB
Salmonella	Shigella	Hepatitis	Rubella		

Have you had any broken bones/injuries? Yes ___ No ___ If yes, please describe. _____

What accidents have you had: In jobs? _____

At home? _____ While driving? _____

Have you ever had any trouble with a strained back? Yes ___ No ___ If yes, explain. _____

Were you ever compensated for on-the-job injury or disease? Yes ___ No ___ If yes, describe the disability, cause, duration. _____

Are you now drawing disability benefits from the Government or an insurance company? Yes ___ No ___ If yes, explain. _____

Do you take medicine regularly? Yes ___ No ___ If yes, please list them. _____

List known allergies (drugs, vaccines, food, etc) _____

Date of last Tuberculin Test _____ Result: Positive ___ Negative ___ Never Tested _____

Dates of previous immunizations:

Tetanus Toxoid _____ Polio _____ Measles _____ DPT _____

Diphtheria Tetanus _____ Mumps _____ Influenza _____ Hepatitis B _____

List of operations and approximate dates: _____

Do you have any physical problem that will prevent you from fully performing the duties of the job for which you have been selected or for which accomodation must be made? Yes ___ No ___ (Please initial the response marked) If yes, describe: _____

Describe the state of your health: _____ Name of family doctor: _____

_____, RN _____

Employee Signature _____ Date _____ Reviewed by _____ Date _____



HEALTH CHECK NOTES EMPLOYEE HEALTH

Name _____
(Last) (First)

DOB _____

Last 4 SS _____

Job _____

Dept _____

Allergy _____

**Note any disease, injury, operation, immunizations found pertinent to this visit.

TB	Date/Site/Initial	Date Read/Result/Initial
2 STEP NH1		
NH2		
NH 48-72		
TBA 48-72		
TBA 48-72		

HEP B	Series	HBSAB	VIS Given	Declination
FLU VAC			VIS Given	Declination
TD/TDAP			VIS Given	Declination

RESP FIT	HX	F	N/A

	DISEASE	VACCINE	TITER	Drug Screen Completed
	MEASLES			
	MUMPS			
	RUBELLA			
	CPOX			

INITIAL: DATE _____ BP _____ P _____

PERIODIC: DATE _____ BP _____ P _____

PERIODIC: DATE _____ BP _____ P _____

Memorial

EMPLOYEE HEALTH SERVICES DATA FORM CONTRACT

NH RH

Health Assessment:

SSN	
NAME:	
BIRTH DATE:	
SEX:	<input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS:	
CITY, ST, ZIP:	
PHONE:	
JOB TITLE:	
DEPARTMENT:	
EMPLOYMENT DATE:	
COMPANY NAME:	



**Acknowledgement of:
HIPAA Education and Documentation**

This information is designed to introduce you to the Hospital HIPAA policies, and to familiarize you as they pertain to you as a volunteer. They provide general guidelines on responsibilities, patient privacy and other issues that may arise in connection with your position here.

By signing below, you acknowledge that you have received a copy of privacy education and information materials, HIPAA Education and Documentation, and have had the material further explained to you by a privacy representative of Memorial Health System. You understand that it is your responsibility to read, comply and practice the policies contained within it and any revisions made to it.

Signature

Date

Please print your full name

Please sign this acknowledgement form, it will be placed in your file.

Memorial

VOLUNTEER NAME BADGE REQUEST

Name: _____ Date: _____

Job Title: Volunteer

Department: _____

Contract: Yes _____

Hire Date: _____

Green Badge

Green Badge (Pink Border)

White Badge

Orange - Emergency Management Agency (EMA)

Hold Name Badge for Orientation

Distribute Name Badge

Community Relations Signature: _____

Security Officer Signature: _____

Security Officer Employee Number: _____

Date: _____