Memorial
HEALTH SYSTEM

Dear Sir or Madam:

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
Project 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.

Choose where you want to volunteer: ○ **Memorial Hospital Gulfport** ○ **Memorial Hospital Biloxi**

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: Convicitions 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 volunteeer 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:

- ○ Gift Shop
- ○ Cancer Resource Center
- ○ Escorts
- ○ Flower Delivery
- ○ Surgery Waiting Room
- ○ Same Day Admit
- ○ Vendor Sales
- ○ Cardiac Cath Lab Waiting Room
- ○ Infusion Clinic (CHF) Waiting Room
- ○ Emergency Department
- ○ Pet Therapy (requires certification)
- ○ ICU Waiting Room

5. How did you hear about the Memorial Auxiliary?

_____

6. When can you start volunteering? _____

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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 knowlege and understand that references will be checked.

Applicant Signature_____Date_____

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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 employement, and given with humanitarian, religous 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 occurances 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:_____

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Fingerprint Request Form

_____
(Date)

This is to request fingerprinting on a ☑ 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 notice[1] 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 utilizies 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_____

[1]Written notification includes electronic notification but exclude oral notification
[2]See 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).

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Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal Statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigatin, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Record Access and Amendment

Your fingerprints will be used to check the criminal history records of the FBI. You have the opportunity to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34. You can find additional information on the FBI website at https://www.fbi.gov/services/cjis/identity-history-summary-checks.

Your signature on 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 Signature**_____

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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? ○No ○Yes

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? ○No ○Yes

If yes, please explain:_____

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

Please check any disease you have had in the past:

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

Have you had any broken bones/injuries? ○No ○Yes 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? ○No ○Yes

If yes, explain:_____

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

Are you now drawing disability benefits from the Government or an insurance company? ○No ○Yes

If yes, explain:_____

Do you take medicine regularly? ○No ○Yes

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_____

Diptheria 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? ○No ○Yes

If yes, describe:_____

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

_____ _____ _____, RN _____

Employee Signature *Date* *Reviewed by* *Date*

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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	
MEASLES				Drug Screen Completed
MUMPS				
RUBELLA				
CPOX				

INITIAL: DATE_____ BP_____ P_____

PERIODIC: DATE_____ BP_____ P_____

PERIODIC: DATE_____ BP_____ P_____

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EMPLOYEE HEALTH SERVICES DATA FORM CONTRACT

NH ☐ RH ☐

Health Assessment:

SSN	
NAME:	
BIRTH DATE:	
SEX:	○ Male ○ Female
ADDRESS:	
CITY, ST, ZIP:	
PHONE:	
PERSONAL EMAIL ADDRESS:	
JOB TITLE:	
LICENSE OR CERT TYPE/ STATE OF ISSUANCE:	
LICENSE/ CERT#:	
DEPARTMENT:	
EMPLOYMENT DATE:	
COMPANY NAME:	

Online Orientation:

Acknowledgement of:
HIPAA Education and Documentation

This information is designed to introduce yo 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.

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VOLUNTEER NAME BADGE REQUEST

Name:_____Date:_____

Job Title: Volunteer

Department:_____

Contract: Yes_____

Hire Date: _____

___X___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:_____

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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 Heatlh 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
HEALTH SYSTEM

MS SAFER

(Mississippi Screening Assurance for Employee Enrollment and Registries)

Fingerprint Authorization Form

MS SAFER Criminal History Fingerprint Check
143B LeFleurs Square
Jackson, MS 39211
Phone: (601) 364-1102
Website: www.msdh.ms.gov

Letter Generated Date:_____

Applicant:_____ _____ _____
Last Name First Name Middle Name

Date of Birth (DOB): _____
Month / Day / Year

Social Security Number (SSN): _____

Facility Name: Memorial Hospital at Gulfport - HC0100025

Facility Address: 4500 13th Street Gulfport, MS 39501
Street or PO Box City State Zip Code

Reason for Fingerprints:

- [X] Healthcare (43-11-13 ORI-MS920500Z)
- [ ] Childcare (43-20-8 ORI-MS920080Z)
- [ ] Medical Cannabis (42-SB-2095 ORI-MSITN5000)

Facility ID Code: HC0100025

Determination ID: _____

Signature of Person Fingerprinted: _____

- [√] By checking this box, I affirm that the applicant understands that he/she is giving the Mississippi State Department of Health permission to conduct a state and national criminal history record check.

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MS SAFER

(Mississippi Screening Assurance for Employee Enrollment and Registries)

Name: _____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____ Apt./Lot:_____

Please confirm this is your correct mailing address; be sure to include any apartment/lot number associated with your address.

SSN:_____

DOB:_____

Race: _____

Gender:_____

Height:_____

Weight:_____

Hair Color:_____

Eye Color:_____

Are you a U.S. Citizen? ○Yes ○No

State of Birth:_____

Have you ever lived in any other state (other than your current state) in the last two years?

○Yes ○No

Previous state(s) lived in the last 2 years:

From:_____ To: _____

From:_____ To: _____

Please list any other names/aliases you last have gone by (if applicable)

First:_____ Last: _____

First:_____ Last: _____

Please provide your vehicle tag number for your parking decal:_____

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HEALTH SYSTEM

CONTINGENT STAFF ATTESTATION FORM

Company:_____

Employment Services is excited that your staff has accepted the work assignment at Memorial Health System. Please complete the questionnaire below, to confirm your employee follows hospital and regulatory requirements. By selecting "Yes" to the items below, you are attesting to having this information available to Memorial Health System, if requested.

Contingent Staff Name: _____

Job Title:_____

1. Completed Application/Resume	○Yes	○No
2. Completed 10-Panel Drug Screen	○Yes	○No
3. Reviewed and Signed Job Description	○Yes	○No
4. Covid vaccination	○Yes	○No
If answered No, do you have an exemption approvaled on file?	○Yes	○No
5. Completed Background Check to include:		
a. Criminal Background Check		
(minimum 7-year felony misdemeanor search)	○Yes	○No
b. Verified highest level of education completed	○Yes	○No
c. Verfied Work History	○Yes	○No
6. Does the individual listed above possess the knowledge, experience, and competence to perform assignment?	○Yes	○No

Memorial Health System will complete a fingerprint, health assessment (if outlined in our contract), OIG, and primary source verification of license and/or certification per hospital policy. Your employee will receive orientation to Memorial's policies and procedures.

_____ _____

Signature of Company Representative and Job Title Date

Rev. 4/2022