Volunteer Application

Thank you for considering volunteer opportunities at Holy Cross Health. Please be aware there are US Government regulations that apply to volunteering in a Health Care Organization.

The Department of Volunteer Services provides people who wish to donate their time and actively engage in community service an opportunity to provide support to Holy Cross Health's Mission.

Volunteer Criteria for Adults and College Students*

- Must be 18 years old
- Must have a desire to provide comfort and support to patients and their families
- A commitment of eight (8) hours per week for a minimum of six (6) months
- Required to complete a background check
- Completion of QuantiFERON Gold Tuberculosis test (provided on site)
- Annual Flu Shot required (provided on site prior to flu season)
- Recommendation letter from a previous employer or volunteer organization

Volunteer Requirements for Teenagers*

- Must be the child of a Holy Cross Associate or Physician
- Must be at least 16 years old

*Please note: We do not accept court appointed hours.

*Due to hospital policy, only non-Holy Cross Colleagues are permitted to volunteer.

We will call you to schedule an interview once we receive your completed application.

Please return your completed application to: Christina.Turner@holy-cross.com or mail it to Holy Cross Health, Attn: Volunteer Services 4725 North Federal Highway Fort Lauderdale, FL 33308. If you have any questions regarding this application, please call 954-542-3171

Thank you for choosing Holy Cross Health, where rewarding volunteer experiences await you.

Volunteer Application

Last Name: _____ First Name: _____

Gender (Circle One): Male Female

Date of Birth: _____

Street Address/City/Zip: _____

Home Phone: _____ Cell Phone:_____

Email Address:_____

Emergency Contact Name & Number _____

DL#: _____ Vehicle Make/Model: _____

Previous Or Current Occupation: _____

Availability Date: _____ Available all year: Yes No

Preferred Schedule: Morning Afternoon Evening

Monday __ Tuesday __ Wednesday __ Thursday__ Friday__ Saturday __ Sunday __

Physical Considerations: Please Describe Any Limitations or Concerns

OFFICE USE

1st Interview: _____ 2nd Interview: _____

Assignment(S): _____

Scheduled Day(S): _____ Schedule Time(S): _____

Volunteer Application

Are you currently in the military or a military veteran? Yes No

Are you a college student? Yes No

Name of School you attend: _____

Are you interested in a Healthcare Career: Yes __ No __

If Yes, what are you interested in?

_____

_____

_____

_____

Briefly Describe why you've chosen Holy Cross Health for your volunteer service:

Volunteer Application

Have you ever been convicted of a felony, pleaded no contest to a felony, or been found guilty of a felony? Include all instances even if adjudication was withheld. **Yes No**

If YES, give dates and details:

DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND INVESTIGATION

FOR EMPLOYMENT (VOLUNTEER) PURPOSES

Holy Cross Hospital, Inc. may request from a consumer reporting agency and for employment-related purposes, a "consumer report(s)" (commonly known as "background reports") containing background information about you in connection with your employment or application for employment (including independent contractor or *volunteer* assignments, as applicable).

Sterling a First Advantage company ("First Advantage") will prepare or assemble the background reports for the Company.

To request a free copy of any employment history report(s) prepared in your name, visit https://care.fadv.com. Trained representatives are available to answer your questions and to assist you with obtaining a copy of your consumer report.

The background report(s) may contain information concerning your character, general reputation, personal characteristics, mode of living, or credit standing. The types of background information that may be obtained include, but are not limited to: criminal history; litigation history; motor vehicle record and accident history; social security number verification; address and alias history; credit history; verification of your education, employment and earnings history; professional licensing, credential and certification checks; drug/alcohol testing results and history; military service; and other information.

Authorization

I hereby authorize Holy Cross Hospital Inc. to obtain the consumer reports described above about me.

Applicant Name _____

Applicant Signature_____ Date _____

Volunteer Application

First Advantage Disclosure / Authorization I Release of Information

First Name
Middle Name
Last Name
Suffix
Other First Name
Other Last Name
Applicant Contact Information
Country
Street Address
City
State
Zip Code
Dates of Residency (Month / Year)
Phone
E-mail
Applicant Identification
Date of Birth
Re-Enter Date of Birth
Social Security Number
Gender

Volunteer Application

Volunteer Service Application Certification

******Please read carefully before acknowledging***

VOLUNTEER SERVICE APPLICATION CERTIFICATION I certify that this application was completed by me and that all statements made by me are true, correct and complete. I understand that false or misleading information may jeopardize my opportunities for volunteer service or, if selected, may be reason for termination of service. While this application will

be given every consideration, its receipt does not imply or guarantee that I will be selected. If selected, in consideration of my volunteer service placement, I agree to adhere to the policies and procedures of Holy Cross Hospital, Inc. I understand that volunteer service is for an indefinite duration and is terminable at will by either the Hospital or myself and that this application does not constitute a contract for volunteer service. I further understand that any offer of volunteer service placement tendered because of this application may be contingent upon the following: a test for the illegal use of drugs, a fitness-for-duty assessment, previous employment and/or volunteer service history, felony conviction history, and personal references. By signing this application, I authorize Holy Cross Hospital, Inc. and its agents to investigate information I have given in this application or during the interview process and to conduct a background investigation. I hereby release Holy Cross Health, its officers, agents, trustees or colleagues, and any person or agent supplying information, from any claims and liability relating to or arising out of the aforementioned investigation. This application when completed and signed becomes the property of Holy Cross Health

I agree ☐

Signature _____ **Date** _____

E-Mail Address: _____

Phone Number: _____

You will be contacted within a week of receipt of this application.

Email this completed application back to: **Christina.Turner@holy-cross.com**