Bayfront Health
Port Charlotte • Punta Gorda

APPLICATION FOR THE ADULT VOLUNTEER PROGRAM

Please Check location you wish to volunteer at ☐ Port Charlotte ☐ Punta Gorda

Date: _____ ☐Yearly ☐Seasonal ☐College

Name: _____ DOB: _____ Sex: M/F

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Mobil Phone: _____ ☐ Include me in the phone directory

Do you speak any foreign languages? [ ] No [ ] Yes- If yes, please list. _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ City & St. _____

Tel. No:_____-_____-_____ Cell:_____-_____-_____ Work #:_____-_____-_____

QUESTIONNAIRE

Do you have any mental or physical handicaps or illnesses that may limit your performing certain duties?

☐ Yes ☐ No If yes, please explain:_____

List community affiliations and other volunteer work: _____

_____

Special training, work experience, talent, skill: _____

_____

Are you physically able to transport patients in a wheelchair? Yes [ ] No [ ]

Type of volunteer service preferred (please check all that apply):

☐ Patient Services ☐ Admitting/Discharge ☐ Reception/Information Desk
☐ Computer ☐ Clerical Assistance ☐ Gift Shop
☐ Other:_____

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning 8a-12p							
Afternoon 12p-4p							
Evening 4p-8p							

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REFERENCES: Please include 2 references

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

OTHER:

1. Have you ever been convicted or entered a guilty/no contest to a felony? Yes [ ] No [ ]

2. Have you ever been convicted or entered a guilty/no contest to a misdemeanor? Yes [ ] No [ ]

VOLUNTEER CONDITIONS

Please initial by each statement that you agree and understand. Sign and date once complete.

_____ I certify that the information on this application is true and complete to the best of my knowledge. I understand that any misrepresentation or omission of facts on this application will be sufficient cause for disqualification of this application.

_____ I give permission to Bayfront Health Port Charlotte to verify any information provided in this application and I authorize my references to answer all questions concerning my ability, character, reputation and previous employment record. I release all such persons from any liability or damages resulting from having furnished such information.

_____ If seasonal resident, I must be available for a minimum of four (4) months for a min of 60 hours.

_____ I understand that I must complete a tuberculosis evaluation, which will include a skin test.

_____ I understand that I must complete a drug screen and background check before I can begin my volunteer work.

_____ I understand that I may be asked to volunteer days and/or hours other than those specified at the time of initial placement.

_____ I agree to abide by all the rules and policies of the Volunteer Services program here at Bayfront Health Port Charlotte. I will attend orientation, complete health office requirements and complete all necessary training. I will observe the volunteer dress code and the code of ethics and keep all patient information confidential.

Print Name:_____ Date:_____

Signature:_____

FOR OFFICE USE ONLY:

Service Assigned:	Day and Time Assigned:	
Will Train With:	Start Date:	
Orientation Date:	TB Testing Date:	Drug Screen Date:
☐Signed Confidentiality Policy	Background Submission Date: Background Return Date:	

DISCLOSURE AND AUTHORIZATION

I understand and I authorize the Company and any persons and entities associated with it (the Company"), to conduct a background investigation related to my application which will include the obtaining of Investigative Consumer Reports and Consumer Reports. Such investigation may also include obtaining information about me such as my employment(s), personal history, character, general reputation, criminal, licensure/certification, credit and driving histories.

In connection with this investigation I authorize, without reservation, the Company to obtain information from other persons and entities (such as other employers, companies, schools, government entities and credit agencies) for information about me, and for those persons or entities to release it, without reservation.

This Authorization, in original, electronic or copy form, shall be valid for this and any future investigation(s) conducted by the Company including, if I am employed, for promotion, reassignment or retention of employment.

I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

_____ _____ _____
Print Legal First Name Middle Name Last Name

_____ _____
Applicant Signature Date

Address _____

Telephone Number (_____)_____-_____

_____-_____-_____ _____/_____/_____
Social Security Number Date of Birth

_____ _____
Driver's License # State Issued
(Include Copy of Driver's License)

_____ _____
Health License/Certificate # State Issued
(If Applicable)

AUTHORIZATION

I authorize the Facility (including its employees and agents) to procure consumer reports and/or investigative consumer reports about me. I understand such reports may include information such as my character, general reputation, personal characteristics or mode of living, criminal, credit, and professional licensure and/or certification.

I authorize any entities or individuals with which I have been associated, including any government entities, to supply the Facility with any information that is requested and I release any entities or individuals from all liability whatsoever related to the information or its furnishing. I also agree to execute any additional consents that any entities or individuals may also require in order to release the information to the Facility.

THIS IS A DRUG FREE WORKPLACE. I MUST PASS A PRE-EMPLOYMENT DRUG TEST. IF EMPLOYED, I WILL ALSO BE TESTED ON A RANDOM, SITUATIONAL, CAUSE, AND/OR RANDOM BASES, AS A CONDITION OF EMPLOYMENT. I STILL CHOOSE TO APPLY FOR EMPLOYMENT.

If employed, I understand that any employment relationship is voluntary for each party and that it is of no defined duration. Either party may choose to end the relationship without any reason at any time, however the other party still retains the right to choose to end the relationship at an earlier time.

_____ _____ _____

Print Legal First Name Middle Name Last Name

_____ _____

Applicant Signature Date

Address

_____

_____

Telephone Number

(_____)_____-_____