



APPLICATION FOR VOLUNTEERISM

UNC Health Blue Ridge ensures all applicants equal opportunity and consideration for volunteerism. They do not discriminate based on age, race, color, religion, gender, national origin, disability, disabled or Vietnam era veteran status, or any other legally protected status.

Today's Date:

Date Available:

APPLICANT INFORMATION

Full Name:


Last First M.I.

Address:


Street Address Apartment/Unit #


City State ZIP Code

Home phone:


 Is your home number a desirable method of communication for you? YES NO

Cell phone:

 Is your cell number your primary contact number? YES NO

 Is text messaging a desirable method of communication for you? YES NO

Email:

 Is email a desirable method of communication for you? YES NO



Please complete the following information:

- | | | |
|---|---------------------------------|--------------------------------|
| | YES | NO |
| Are you 18 years or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been fired or dismissed by a former employer? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| Have you ever worked for a UNC Health Blue Ridge affiliate? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |

If yes, which facility and when:

List any relatives currently employed by UNC Health Blue Ridge or Affiliate. Please include name, relationship, and facility/department:

Have you ever been convicted of any criminal violation of the law (misdemeanor, alcohol or drug-related traffic, or felony), or are you now under pending investigation of charges for breach of any criminal law?

YES

NO

If yes, please explain:

Have you ever been the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency for either conduct based on performance-based measures?

YES

NO

If yes, please explain:



AVAILABILITY AND INTERESTS

✚ Do you have a strong desire to volunteer in a patient-facing role, or would you prefer a primarily non-patient-facing volunteer opportunity? Uncertain? _____

✚ Number of Hours Available: _____

✚ Preferred day(s) of week: Mon. Tues. Wed. Thurs. Fri.
 Sat. Sun.

Preferred shift (Check all that apply):

- 8:00 am to 12:00 pm
- 12:00 pm to 4:00 pm
- 4:00 pm to 6:00 pm
- Morning
- Midday
- Evening

SHARE YOUR VOLUNTEER HISTORY WITH US



SPECIAL SKILLS

Please list any special skills that you feel might be an asset to the volunteer role. (i.e., sign language, bilingual, medical terminology, computer skills, typing, newsletter composition, event planning, meeting minutes, financial skills, customer service, clerical skills, sewing/crafting, musical talents, etc.)

PERSONAL REFERENCES

Please list three personal or professional references we can reach out to regarding your application.

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____



PLEASE READ CAREFULLY BEFORE SIGNING

I hereby certify that all the information I have provided in this application is true and accurate to the best of my knowledge. I understand that falsification, misrepresentation, or concealment of any information in the application will disqualify me from volunteering and may result in my immediate discharge if discovered at a later date.

Except as otherwise noted on this application, I authorize the facilities to contact employers and references named by me and allow those employers and references to give the Facilities any and all information concerning my history. I understand that the Facilities may act on the information received from these references at its discretion, and I hereby release the Facilities and all previous employers and references from any liability in furnishing or using this information.

I hereby authorize the Facilities and/or its authorized agents to make an independent investigation of my background, reference, character, past employment, education, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application for Volunteerism and/or obtaining other information which is material to my qualifications for volunteerism. I understand that my application will not be considered complete until the conclusion of any required or necessary investigations, examinations, or inquiries, including receipt by the Facilities of any related reports or results. I understand that the Facilities may act on these reports or results and hereby release the Facilities and all providers of the information from any liability in furnishing or using this information.

I understand that I may be asked to demonstrate how I can do the essential functions of the service chosen. I believe I can fulfill the duties of a hospital volunteer with reasonable accommodation.

I understand that I may be asked to provide a physician's statement acknowledging that it is safe for me to undertake the activities associated with being a UNC Health Blue Ridge volunteer if I have a medical condition or am undergoing any treatment that limits my ability to conduct volunteer duties.

This application will remain active for 90 days. I understand if I am not selected to volunteer within 90 days, this application is no longer active, and I must reapply for volunteerism if I wish to be considered.

Print: _____

Signature: _____

Date: _____



CONFIDENTIALITY/HIPPA STATEMENT

I recognize and acknowledge that I may have access to confidential information regarding UNC Health Blue Ridge, patients, residents, doctors, employees, or others. Such information must not be discussed except as necessary in the performance of my services/duties. Therefore, except as directed by my director, I will not at any time disclose any confidential information (be particularly careful about the conversation in cafeteria, elevators, and other public places) to any person whatsoever or permit any person to examine or make copies of any information coming into my control. Disclosure of such information may result in the termination of my services.

Signature: _____ **Affiliation:** Volunteer _____

Print Name: _____ **Date:** _____