Newman Regional Health
Volunteer Services
1201 West 12th Avenue
Emporia, KS 66801
(620) 343-6800 ext 22525
www.newmanrh.org

Volunteer Application

Name_____Date_____
First Middle Last

Work or Cell Phone_____

Address_____Home Phone_____
Street City State Zip

EMAIL: _____

EMERGENCY CONTACT:

_____
Name Address Phone Relationship

_____
Name Address Phone Relationship

Work Status:_____ Employed_____ Student_____ Unemployed_____
Current or last place of Employment: _____Years Employed_____
Have you been employed by Newman Regional Health? No____ Yes_____ If yes, dates_____
Do you know any reason you can not perform the essential functions of the volunteer position you are applying for, with or without accommodations? Yes___No___
Please describe any accommodations required: _____
_____

Service Area Opportunities – (Check all areas of interest)

____Baking at Home
____Medical Plaza Information Desk
____Surgery Information Desk
____Snack Bar
____Gift Shoppe
____Fundraisers

Areas of Interest: Patient Contact ____Public Contact ____Clerical ____
Other_____
How did you hear about Newman Regional Health Volunteer Program?
Friend_____ Newspaper_____Brochure_____ Other_____

List Previous Volunteer Experience. _____
_____

VOLUNTEER AVAILABILITY (Mark days and times you are available to work)
___Monday ___Tuesday ___Wednesday ___Thursday ___Friday
Shifts Available: ___Mornings (8-12) ____Afternoons (12-4) or _____Gift Shoppe and Snack Bar (10-2:30)
Comments_____
_____

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HEALTH INVENTORY:
Chronic illness or health problems: _____

_____

Past Medical History

Immunizations:

Vaccine	Date
Hepatitis A	_____
Hepatitis B	_____
Influenza	_____
Pneumonia	_____
Tetanus/Diphtheria	_____
COVID (Required)	_____

Applicant:
I affirm that all information on this application is true and accurate.

I understand that before I begin my volunteer service, I will complete the application requirements, submit to a reference check, fulfill orientation obligations and training sessions if required, and submit to a Tuberculosis Skin Test if working in the hospital.

I understand that this application does not guarantee a volunteer placement at Newman Regional Health and that if accepted, I will not receive payment for my service.

_____ _____
Signature of Applicant Date

Newman Regional Health is an Equal Opportunity Employer. Opportunity for volunteer service is provided without regard to race, color, religion, sex, national origin, or disability.

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CONFIDENTIALITY STATEMENT

Newman Regional Health Volunteers

As a Volunteer for Newman Regional Health, confidential information may be available to me. Information that may be available to me can include a patient's protected health information and/or hospital proprietary information. This information must be kept in strict confidence. This information must not be repeated or discussed with anyone outside of the direct care of the patient.

Any of the above information must not be disclosed to unauthorized sources within or outside of Newman Regional Health.

I further understand that Newman Regional Health has policies and procedures to assure compliance with regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA). I agree to abide by all such policies and procedures.

I understand that some penalties for breaches of confidentiality are subject to certain provisions of state and federal laws. I understand that violation of any breach of Newman Regional Health policies that is related to confidentiality will result in the immediate removal of my Volunteer status at Newman Regional Health.

I understand that should a legal or ethical concern arise; it is my responsibility as a Volunteer to report these concerns to the Legal Compliance Officer. I further agree that should a possible conflict of interest arise during my Volunteer position with Newman Regional Health, I will immediately disclose that potential conflict to the Legal Compliance Officer.

This statement will remain on file in the Volunteer Coordinator's office of Newman Regional Health.

_____

Print Name

_____ _____

Volunteer Signature Date

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NEWMAN REGIONAL HEALTH

IMPORTANT NOTICE: This form is NOT part of the application.

By signing this form you are authorizing us to perform a thorough check into your background, which is a requirement.

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT

I, the undersigned consumer, do hereby authorize **Newman Regional Health**, by and through its independent contractor, **ADP SCREENING AND SELECTION SERVICES ("ADP"),** to procure a consumer report and/or investigate report on me.

These above-mentioned reports may include, but are not limited to, information as to my character, general reputation, personal characteristics and mode of living, discerned through employment and education verifications; personal references; personal interviews; my personal credit history based on reports from any credit bureau; my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **ADP**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above disclose the same to **Newman Regional Health**, by and through **ADP**, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release **Newman Regional Health**, **ADP** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative report hereby authorized. I understand that the Authorization/Release form shall remain in effect for the duration of my volunteer time with said Company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application for volunteering will be terminated based on any false, omitted or fraudulent information.

Signature _____ Printed Name _____ Date: _____

Current Address _____

Street/PO Box City State Zip Code County Dates

Former Address _____

Street/PO Box City State Zip Code County Dates

Social Security # _____ Daytime Telephone # _____

Driver's License # _____ State of Issuance _____ Date of Birth* _____ Gender*_____

- Have you ever been convicted of a crime or convicted in military court martial? Yes___ No___
- Have you even been sanctioned or had your license suspended or revoked? Yes___ No___
- Are you currently under any investigation or pending charge? Yes___ No___

*This information will enable us to properly identify you in the event we find adverse information during the course of our background search.

If you answer yes to any of the above questions please explain here:_____

_____

_____

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