Dear Prospective Volunteer,

Thank you for your interest in Providence Health's Volunteer Services program.

It takes a special calling to be a volunteer and becoming a part of our Providence family will be a richly rewarding experience for you. Guided by our mission to Make Communities Healthier by Extending Christ's Healing Ministry, our volunteers model the healing ministry of Jesus Christ. Through our volunteers' dedication, their compassion and their service, our volunteers play an integral role in helping Providence Health provide compassionate care to those we serve.

Enclosed is an Application for you to complete and return to Volunteer Services, either in person or by fax, mail, or email to leigh.mckie2@providencehospitals.com .

The required "Physician's Release Form" document (included) does *not* require a new physical examination, it is simply a statement that you are in sufficient physical and emotional health to perform volunteer work is sufficient. Please have your doctor complete and sign the required physician portion and have it returned to the Employee Health Department.

Program Application Requirements:

Adult Program **(17 years of age and older)**
Application
One (1) reference
Volunteer Security Release form
Physician's Release Form
Medical Health Questionnaire
Orientation

As soon as all of these materials have been received, a representative from Volunteer Services will contact you to schedule an initial visit to get acquainted and discuss volunteer opportunities.

We believe you will enjoy being a volunteer at Providence Health and will find it to be a rewarding and fulfilling experience. If you have any questions, please call, Volunteer Services at 803.256.5824 or visit our web site at http://yourprovidencehealth.com/for-patients-visitors/volunteer .

Thank you again for your interest in the Volunteer Services program at Providence Health. We look forward to welcoming you into our family!

Sincerely,

Volunteer Services
2435 Forest Drive • Columbia, SC 29204
P 803.256.5824 • F 803.227.4191

Volunteer Application

SECTION I: GENERAL INFORMATION

Name: Last First Middle Nickname

Address City State Zip Code

Home Phone_____ Work Phone_____
Mobile Phone_____

E-Mail_____ Date of Birth:_____

EMERGENCY CONTACTS:

1. _____
   Name Relationship Phone #
2. _____
   Name Relationship Phone #

How did you become interested in our volunteer program?

_____

_____

If you were referred by another volunteer, please list his/her name.

_____

Availability: ☐ Morning ☐ Afternoon ☐ Evening

Will you volunteer weekends? ☐ YES ☐ NO

SECTION II: EDUCATION & BACKGROUND

School Name and Location	Dates Attended	Graduated	Degree / Diploma
High School -			
College & major -			
Special Training, professional or technical school -			

Have you volunteered with Providence Health before? ☐ YES ☐ NO
If yes, when and in what capacity?

_____

Have you been or are you now employed with Providence Health? ☐ YES ☐ NO
If yes, when and in what capacity?

_____

Volunteer Experience:

_____
_____
_____

Work Experience:

_____
_____
_____

Please list any special skills, experiences, hobbies and/or interests:

_____
_____

SECTION III: REFERENCES

Please list one (1) person who you authorize us to contact for a reference. **PLEASE NO RELATIVES**

NAME_____

ADDRESS_____

CITY/STATE/ZIP_____

PHONE_____

RELATIONSHIP_____

Physicians Release Form

AUTHORIZATION FOR RELEASE OF Personal Health Information (PHI)

I authorize _____

(Name of physician or physician practice)

to release personal health information as listed below and is related to my application for Volunteer Services at Providence Health.

_____ _____

Print Volunteer Applicant Name & Signature Date

(This section to be completed by clinical staff)

Dear Physician,

Your patient has applied for hospital Volunteer Services with Providence Health. In order to volunteer the individual must be in good physical and mental health and free from infectious diseases. You are listed as the family physician and the applicant has requested that this information be obtained from you.

Please answer the questions below and return this signed document either directly to the applicant or to **Employee Health via fax (803) 256-5945**. The information will be regarded as confidential and maintained in the volunteer's health record in Employee Health. This information will be discussed as part of their health assessment process and provided to regulating agencies upon request.

1. ____ Yes ____ No To the best of your knowledge, is this applicant in sufficient good physical and emotional health to perform hospital volunteer duties with Providence Health?
2. ____ Yes ____ No Is this applicant free of any communicable disease(s)?
3. ____ Yes ____ No Has this applicant undergone a physical examination within the last year?
4. ____ Yes ____ No Does this applicant have any physical or mental limitation(s)?

If **YES**, please indicate physical and/or mental limitation(s) below:

	Mobility (i.e. walking, pushing, pulling, etc.)		Lifting and carrying limits: _____pounds
	Sight		Sedentary duties only
	Hearing		Other: (please explain in detail)
	Mental recall / dementia		
	Sitting or standing		

Additional Comment:_____

_____

_____

Print Physician's Name Physician's Signature Phone Number Date

Providence Health
Employee Health
2435 Forest Drive
Columbia, SC 29204
(803) 256-5308

Medical History Questionnaire

Name: Last First Middle
Nickname

Address City State Zip Code

Home Phone_____ Work Phone_____
Mobile Phone_____

E-Mail_____ Date of Birth:_____

EMERGENCY CONTACTS:

3. _____
   Name Relationship Phone #
4. _____
   Name Relationship Phone #

PERSONAL PHYSICIAN:

Personal Physician Phone Number

Physician's Office address City State Zip Code

Answers to the following questions are for our records only and will be considered confidential			
	YES	NO	Explanation / Remarks
Have you ever had a positive reaction to a tuberculosis (TB) skin test?			
• If yes, have you ever taken INH?			
My last physical examination was on_____			
My last chest X-ray was on_____			
Was your last chest X-ray read as normal?			
Are you now under the care of a physician? If yes, please explain.			
Have you ever had any serious illness or operation? If yes, please explain.			
Have you ever been hospitalized or had a serious illness within the past five (5) years? If so, please explain.			

Do you have or ever been told you had any of the following diseases or problems?	YES	NO	Explanation / Remarks
Heart trouble, heart attack or high blood pressure?			
Pain in chest on exertion?			
Arteriosclerosis?			
Varicose veins or thrombophlebitis?			
Persistent cough or cough up blood?			
Pulmonary disease?			
Silicosis?			
Epilepsy, fainting spells or seizures?			
Cerebral palsy?			
Multiple Sclerosis?			
Parkinson's Disease?			
Muscular Dystrophy?			
Brain damage?			
Diabetes?			
Any bleeding/blood disorder, hemophilia or anemia?			
Sickle-cell anemia?			
Jaundice, hepatitis or liver disease?			
Cancer?			
Hodgkin's disease?			
Have you had surgery or radiation treatment for a growth or other condition?			
Loss of sight of one or both eyes, glaucoma or any other eye problem?			
Deafness or hearing difficulty?			
Arthritis, joint pain or stiffness?			
Chronic osteomyelitis?			
Ankylosis of joints?			
Backache, back injury, ruptured intervertebral disc or back surgery?			
Amputated foot, leg, arm or hand?			
Residual disability from poliomyelitis?			
Psychoneurotic disability?			
Alcohol abuse?			
Drug abuse?			
Have you desired or had psychiatric help?			
Skin rash or itching?			
Headache?			
Rectal bleeding or bloody/tarry stool?			
Blood in urine?			
Bleeding between menses?			
Venereal disease?			
Have you ever been treated for any disease or condition not referred to above?			

Please list ALL current medications that you are taking:			Explanation / Remarks
Are you allergic or have reacted adversely to:	YES	NO	Explanation / Remarks
Local anesthetics?			
Penicillin or other antibiotics?			
Sulfa drugs?			
Barbiturates, sedatives or sleeping pills?			
Aspirin?			
Iodine?			
Codeine or other narcotics?			
Other?			
Allergy:	YES	NO	Explanation / Remarks
Hay fever or skin rash?			
Asthma?			
Communicable disease history: Have you ever been immunized against…	YES	NO	Explanation / Remarks
Measles?			
Mumps?			
Rubella?			
Poliomyelitis?			
Diphtheria?			
Hepatitis B?			
Chicken Pox?			
When is the last time you received a Tetanus Toxoid or TDAP injection?			
Women:	YES	NO	Explanation / Remarks
Are you pregnant?			
Do you have any problems associated with your menstrual period?			
Have you ever…	YES	NO	Explanation / Remarks
Been seriously injured?			
Been refused employment for health reasons?			
Been forced to give up a job because of health reasons?			
Been injured on your job? If yes, who was your employer, what was the approximate date of injury,			

and what body part was injured?			
Received Workers Compensations?			
Received Permanent Disability?			
Have you been rejected for military service for health reasons?			
Received a pension or disability?			
Been refused life insurance?			
Been made ill by your work?			
Been refused a drivers' license for health reasons?			
Injured your back?			
Worn a neck brace?			
Worn a knee brace?			
Worn a truss?			
Had a hernia or rupture?			
Been treated with radiation?			
Worked with radioactive material?			
Worked in a dusty trade?			

The above statements are true to the best of my knowledge; I understand that any misstatement of fact is grounds for termination and could result in my not receiving benefits for any injury sustained while volunteering.

_____

Signature of Volunteer Applicant Date

I certify that the information I have given on this application is true and complete and agree that any false information including that given at the time of physical examination is cause for dismissal. The company, schools and person(s) named above may give information regarding me and I release them from all liability for doing so. I understand that any offer by the Volunteer Services Department is conditional on satisfactory replies from references, background check, health reference and physical examination. This is not a contract for the Volunteer Services Department and Providence Health has the right to separate you from the volunteer program at any time as you have the right to leave at any time. If accepted for volunteer service, I agree to abide by the rules and regulations of Providence Health, the policies, and procedures of the Volunteer Services Department and the department to which I am assigned. I will respect the confidentiality of patient information and abide by all HIPAA guidelines.

_____

Volunteer Applicant Signature Date