# Hospice Volunteer Application

Date _____

Name _____ DOB _____ Social Security # _____

Home Phone _____ Work Phone _____

Address _____ City _____ State _____ ZipCode _____

Email Address _____

**Do you have a valid driver's license?:** ☐ Yes ☐ No **State:** ☐ Georgia ☐ South Carolina

## Education

| School(s) Attended | Degree | Major |
|---|---|---|
| | | |
| | | |
| | | |

## Why do you want to be a hospice volunteer?

## Times available for volunteer work:

☐ Days ☐ Evenings ☐ Weekends

## Previous volunteer experience:

| Year | Location |
|---|---|
| | |
| | |
| | |

## What are some of your special talents / services:

☐ Calligrapher ☐ Musician ☐ Notary ☐ Computer Skills ☐ Knit / Crochet ☐ Crafts / Needlework

☐ Other (please explain:) _____

**Do you speak a foreign language?** ☐ Yes ☐ No If yes, please list. _____

## Do you have any special skills / hobbies?

**What would you like to do for hospice?** (check all that apply)

- ☐ Volunteer service to patient and family (respite, errands, companion, support)
- ☐ Nursing Home Volunteer
- ☐ Office work (data entry, mailings, etc)
- ☐ Transportation
- ☐ Fundraising Opportunities
- ☐ Community Awareness
- ☐ Bereavement
- ☐ Inpatient Unit Volunteer
- ☐ Support to children
- ☐ Childcare
- ☐ Special Events
- ☐ Other: _____

**Has someone close to you died recently?** ☐ Yes ☐ No

If yes, please explain:

_____

**References** - should be 3 people you have known for at least 1 year and is <u>not</u> a family member

Name _____ Relationship _____

Address _____ City _____ State _____ ZipCode _____

Home Phone _____ Email Address _____

Name _____ Relationship _____

Address _____ City _____ State _____ ZipCode _____

Home Phone _____ Email Address _____

Name _____ Relationship _____

Address _____ City _____ State _____ ZipCode _____

Home Phone _____ Email Address _____

**Thank you for your interest in being a hospice volunteer. We will process your application and be in touch with you soon.**

**If you have questions about our company, please visit our website at www.THAgroup.org.**

☐ *By checking this box, you admit the info you provided is accurate.*

**Office Use Only:**

☐ Beaufort ☐ Bluffton ☐ Hilton Head
☐ Savannah ☐ Skidaway ☐ Statesboro ☐ Richmond Hill

Date Received:
Orientation Date:

THAGroup
The Healthcare Alternative

# RELEASE AUTHORIZATION

## APPLICANT COMPLETE THE FOLLOWING

I. In connection with my application for employment, I understand that a consumer report or an investigative consumer report may be requested that will include information as to my character, work habits, performance, and experience, along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job described, you may be requesting information from public and private sources about my: workers' compensation injuries, driving record, court record, education, credentials, credit, and references.

If company policy requires, I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.

II. Medical and workers' compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and given the name and address of the agency or the source which provided the information.

III. I acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original. This release is valid for most federal, state and county agencies including the Minnesota Department of Labor.

IV. Minnesota, Oklahoma and California applicants only. If you want a copy of the reports(s) ordered, Check this box ❑. The report(s) will be sent by the reporting agency to you at the address below. The reports will be processed by: ADP Screening and Selection Services, 301 Remington Street, Fort Collins, Colorado 80524, 800/367-5933.

V. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by _____ or its agent, to furnish the information described in Section 1.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes. I hereby release the employer and agents and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the requests for or release of any of the above mentioned information or reports.

Please print your full name LAST FIRST MIDDLE

Please print other names you have used

Home Address

City State Zip Code

Social Security Number Date of Birth

The following states require sex and race to obtain information:
AL, AR, FL, GA, IA, IL, IN, MI, OR, TX, WI

Sex: ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other

Drivers License Number State Issuing License

Name as it appears on license

☐ on-line applicants check this box

Signature Today's Date

IF REQUIRED, NOTARIZE HERE

When using an embossed seal, please shade and pencil before faxing.

Subscribed and sworn before me:

Name

Date

Notary Public

My commission expires

***THIS PAGE CONTAINS SENSITIVE INFORMATION. KEEP ONLY IN SECURE FILES, SEPARATELY FROM PERSONNEL RECORDS!***

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The Healthcare Alternative

# Disclosure to Employment Applicant Regarding Procurement of A Consumer Report

In connection with your application for employment, we may procure a consumer report on you as part of the process of considering your candidacy as an employee. In the event that information from the report is utilized in whole or in part in making an adverse decision with regard to your potential employment, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the law.

Please be advised that we may also obtain an investigative report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested. Such disclosure will be made to you within 5 days of the date on which we receive the request from you or within 5 days of the time the report was first requested.

The Fair Credit Reporting Act gives you specific rights in dealing with consumer reporting agencies. You will find these rights summarized on the reverse side of this document.

By your signature below, you hereby authorize us to obtain a consumer report about you in order to consider you for employment.

This report will be processed by:
ADP Screening and Selection Services
301 Remington Street
Fort Collins, Colorado 80524
800/367-5933

Applicant's Name: _____
(Please Print)

Applicant's Address: _____

City/State/Zip: _____

Signature: _____

Social Security Number: _____

Give copy with Summary of Rights to applicant. Retain a copy for your files.

| PRE-EMPLOYMENT DRUG TESTING CONSENT AND RELEASE FORM | **Last Revision:** | August 25, 2004 |
|---|---|---|
| | **Applies To:** | THA Services; Island Health Care, Inc.; Independent Life at Home; Island Hospice; and Ideal Health Link |

I hereby consent to submit to urinalysis and/or other tests as shall be determined by Island Health Care in the selection process of applicants for employment, for the purpose of determining the drug content thereof.

I agree that Quest Diagnostics, Doctor's Care, or LabCorp may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by Island Health Care for analysis.

I further agree to and hereby authorize the release of the results of said tests to Island Health Care.

I understand that it is the current use of illegal drugs that would prohibit me from being employed at Island Health Care.

I further agree to hold harmless Island Health Care and its agents (including the above named laboratory) from any liability arising in whole or part, out of the collection of specimens, testing, and use of the information from said testing in connection with Island Health Care's consideration of my application of employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

**APPLICANT:**

Name (Please Print): _____ SS#: _____

Signature: _____ Date: _____

☐ on-line applicants check this box

**WITNESS:**

Print Name: _____

Signature: _____ Date: _____

# EMPLOYEE CERTIFICATE OF AGREEMENT

I do hereby certify that I have received and read Island Health Care's Substance Abuse and Testing Policy and have had the Georgia Worker's Compensation Drug-Free Workplace Certification Program (O.C.G.A. 34-9-410) explained to me. I understand that if my performance indicates it is necessary, or in the case of random testing, I will submit to a substance abuse test. I also understand that failure to comply with a substance abuse test request, or a positive result may lead to termination of employment and denial of unemployment benefits. I understand that failure to submit to a substance abuse test, or a positive test result may affect my right to obtain workers' compensation benefits. I further agree to and hereby authorize the release of the results of said tests to Island Health Care. This consent form is not a contract between the parties.

Name (Please Print): _____

Signature _____ Date: _____

☐ on-line applicants check this box

Click to print
(or save and e-mail to volunteer@thagroup.org)