VOLUNTEER APPLICATION

HOUSTON Methodist® THE WOODLANDS HOSPITAL

Amy Ginder
Director, Volunteer Services & Gift Shop

Houston Methodist The Woodlands Hospital 17201
INTERSTATE 45 SOUTH
THE WOODLANDS, TEXAS 77385
OFFICE: 936.270.2189
EMAIL: HMTWVolunteerServices@houstonmethodist.org

PLEASE PRINT CLEARLY

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____

EMPLOYMENT INFORMATION

CURRENT EMPLOYER (IF APPLICABLE) _____

ADDRESS _____

PHONE _____ POSITION _____ HOURS _____

MAY WE CALL YOU AT WORK IF NECESSARY? YES NO

EMPLOYMENT EXPERIENCE

_____

_____

EDUCATION

HIGH SCHOOL _____ TRADE SCHOOL _____ COLLEGE _____

MAJOR OR FIELD OF INTEREST _____

_____

_____

PRIOR VOLUNTEER EXPERIENCE _____

_____

_____

HOW DID YOU HEAR ABOUT THE PROGRAM? _____

_____

_____

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PERSONAL DATA

SPECIAL SKILLS, TALENTS, HOBBIES, AND INTERESTS _____

_____

_____

LANGUAGES _____

Why do you want to volunteer at Houston Methodist The Woodlands? _____

_____

_____

Would you be interested in helping with extra projects, such as fundraising or special events? _____

PLEASE LIST TWO LOCAL PERSONAL REFERENCES (OTHER THAN FAMILY MEMBERS)

NAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

NAME _____ PHONE _____

ADDRESS _____ CITY _____ ZIP _____

Have you ever been convicted of, or been on deferred adjudication for, or are you now either awaiting trial for, or on deferred adjudication for a felony or misdemeanor? _____ Yes _____ No

If yes, describe, including charges, dates, and locations _____

_____

Are you now, or have you ever been excluded, debarred, suspended or otherwise declared ineligible to participate in federal or state healthcare program?

_____

CONVICTION WILL NOT NECESSARILY BAR VOLUNTEER SERVICE.

PUBLIC LAW 91-508 REQUIRES THAT WE ADVISE THAT A ROUTINE INQUIRY MAY BE MADE WHICH WILL PROVIDE INFORMATION CONCERNING YOUR CHARACTER, REPUTATION AND PERSONAL CHARACTERISTICS, AND MODE OF LIVING. YOU MAY OBTAIN A COPY OF THIS INFORMATION UPON WRITTEN REQUEST.

I HEREBY CERTIFY THAT THE INFORMATION I SUPPLIED IN THIS APPLICATION IS TRUE, COMPLETE, AND CORRECT, TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY INFORMATION I WITHHELD OR FALSELY PROVIDED IN CONNECTION WITH THE FOREGOING SHALL BE CAUSE FOR REJECTION OF THIS APPLICATION OR TERMINATION OF VOLUNTEER STATUS. I HEREBY AUTHORIZE THE HOUSTON METHODIST HOSPITAL SYSTEM, WITHOUT LIABILITY, TO CONTACT PRIOR EMPLOYERS (PRESENT EMPLOYERS IF AUTHORIZED) SCHOOLS OR REFERENCES, I HAVE GIVEN AND AUTHORIZE SAID EMPLOYERS, SCHOOLS OR REFERENCES TO MAKE FULL RESPONSE TO ANY INQUIRIES BY THE HOUSTON METHODIST THE WOODLANDS HOSPITAL IN CONNECTION WITH THIS APPLICATION FOR VOLUNTEER SERVICES.

VOLUNTEER SIGNATURE _____ DATE _____

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IF ACCEPTED AS A VOLUNTEER, I AGREE:

YOUR NAME _____

CONFIDENTIALITY AGREEMENT

I agree to use confidential or proprietary information only as needed to perform my volunteer duties. This means I will not access confidential or proprietary information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential or proprietary information belonging to Houston Methodist The Woodlands. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.

YOUR SIGNATURE _____ DATE _____

PLEASE PLACE YOUR INITIALS IN EACH OF THE DESIGNATED BOXES BELOW.

- ☐ My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious, or charitable reasons.
- ☐ I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off hospital property, or act as a runner or capper for an attorney in the solicitation business. I shall report all known occurrences of solicitation for attorneys to the Director of Volunteer Services.
- ☐ I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petition on hospital premises, unless I receive the express authorization of the Director of Volunteer Services to engage in these activities.
- ☐ I understand that a background check will be completed prior to my serving as a volunteer.
- ☐ I shall submit to examinations, which includes drug screen, TB skin test or chest x-ray, influenza vaccination and/or appropriate laboratory test and immunizations, as part of my on-boarding for volunteer services. TB testing must be repeated annually. I also authorize the person(s) making tests or x-rays films to report the results to the hospital.
- ☐ I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
- ☐ I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and, if unsuccessful, attempt to resolve any such problems with the Director of Volunteer Services.
- ☐ I shall make my best effort to fulfill my commitment to the hospital by contemplating all assignments that I accept.
- ☐ I shall at all times uphold the mission of the hospital.
- ☐ I understand that the volunteer services department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules, and regulations; (b) 3 absences without prior notification; (c) unsatisfactory attitude, work, or appearance; or (d) any other circumstance which, in the judgment of the department's manager, would make my continued service as a volunteer contrary to the best interest of the hospital.

I HAVE READ EACH OF THE ABOVE CONDITIONS AND I AGREE TO BE BOUND BY THEM.

VOLUNTEER SIGNATURE _____ DATE _____

WITNESS CLAUSE

I agree that I have explained each of the conditions of volunteer services to the applicant who has signed this form.

DIRECTOR OF VOLUNTEER SERVICES SIGNATURE _____ DATE _____

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INDICATE TIME AVAILABLE TO WORK

	7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM	12:00 PM	1:00 PM	2:00 PM	3:00 PM	4:00 PM	5:00 PM	6:00 PM	7:00 PM
MONDAY													
TUESDAY													
WEDNESDAY													
THURSDAY													
FRIDAY													
SATURDAY													
SUNDAY													

IN AN EMERGENCY NOTIFY

NAME _____

RELATIONSHIP _____ PHONE (HOME) _____ PHONE (CELL) _____

PHYSICIAN'S NAME _____ PHONE _____

MAILING ADDRESS _____

When I leave the Volunteer Services Department, I am required to give two (2) weeks notice and turn in my badge. _____ (initial)

BELOW FOR OFFICE USE ONLY

COMMENTS: