



Part of  **NorthShore**

Dear Volunteer Applicant,

Thank you for your interest in volunteering at Northwest Community Healthcare. For the past 60 years, we have been dedicated to providing quality, compassionate healthcare services to the people of the northwest community. We are especially proud of our Volunteer Program – involving nearly 800 people of all ages, interests and abilities who all are passionate about giving back to our community. Our volunteers are an integral part of our organization and they contribute time and energy to a variety of areas throughout the hospital. The information desks, patient care areas, outpatient care centers, Breast Centers, supply and distribution, and physical rehab are just a few of the areas that currently benefit from the efforts of our volunteers.

The mainstays of our Volunteer Program are those who are regularly able to commit four or more hours a week to volunteering. This commitment allows for us to place them with one department of the hospital where they can make an ongoing contribution and develop a rapport with other hospital volunteers and employees. We do our best to match applicants' interests to areas within the hospital where volunteer opportunities are available.

Enclosed:

- **Volunteer Application Form** – Please complete both sides.
- **Medical Release Form** – Must be completed by your medical provider. You can include the completed form with your application or your physician can fax the completed form to us at (847) 618-4499. Note that the medical reference assists us in placing new volunteers in positions that are appropriately matched to their capabilities.
- **Volunteer Guidelines Acknowledgement Form**
- **Confidentiality Statement**

Upon receipt of all the required forms, we will review your application based on your interests and availability with our current openings and needs. **If we determine a match, we will contact you for an interview.** We appreciate your understanding that as much as we would like to accommodate all applicants, we are not able to accept everyone.

If you have any questions about our program or the application process, please call the Guest Services Office at (847) 618-4450, Monday - Friday from 7:30 am to 4:00 pm. Or you can email volunteer@nch.org. We look forward to hearing from you!

Sincerely,

Kelly Behrens
Manager – Volunteer Department
KBehrens@nch.org

NORTHWEST COMMUNITY HEALTHCARE • GUEST SERVICES
800 W. CENTRAL RD • ARLINGTON HEIGHTS, IL 60005 • 847.618.4450 • volunteer@nch.org

Updated 6/2023

NORTHWEST COMMUNITY HEALTHCARE ADULT VOLUNTEER APPLICATION

| | | | |
|-------------------------|---|-------------------|---|
| Name: | | | |
| | <i>LAST NAME</i> | <i>FIRST NAME</i> | <i>MIDDLE</i> |
| Address: | | | |
| | <i>ADDRESS</i> | <i>CITY</i> | <i>STATE</i> <i>ZIP</i> |
| Email: | | | |
| Primary Phone: | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | |
| Secondary Phone: | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | |
| Date of Birth: | | Gender: | <input type="checkbox"/> Female <input type="checkbox"/> Male |

VOLUNTEER PREFERENCES & INTERESTS

| | | | | | | | | | | |
|--|--|--|-------------------------------------|--|---|---------------------------------------|------------------------------------|-------|---|-------|
| Day Preference(s): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun | | | | | | | | | | |
| Time Preference(s): <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening Date Available to Start: | | | | | | | | | | |
| Are you volunteering to fulfill a requirement or an assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify class/program name & # of hours: | | | | | | | | | | |
| Why are you interested in volunteering? | | | | | | | | | | |
| Please list any skills, interests or hobbies that may help us place you in a volunteer position: | | | | | | | | | | |
| NCH offers many different volunteer opportunities. The below list includes general areas. There may be other open opportunities that are not listed. Indicating an interest does not guarantee an applicant a volunteer position. Please select your general interests: | | | | | | | | | | |
| <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Administrative/Clerical (i.e. filing)</td> <td><input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc)</td> </tr> <tr> <td><input type="checkbox"/> Data Entry</td> <td><input type="checkbox"/> Open to all/any areas</td> </tr> <tr> <td><input type="checkbox"/> Discharge/Escort/Wheelchair Assistance</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Gift Shop</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Information Desk/Way-Finding</td> <td>_____</td> </tr> </table> | <input type="checkbox"/> Administrative/Clerical (i.e. filing) | <input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc) | <input type="checkbox"/> Data Entry | <input type="checkbox"/> Open to all/any areas | <input type="checkbox"/> Discharge/Escort/Wheelchair Assistance | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Gift Shop | _____ | <input type="checkbox"/> Information Desk/Way-Finding | _____ |
| <input type="checkbox"/> Administrative/Clerical (i.e. filing) | <input type="checkbox"/> Nursing Floors (i.e. stocking supplies, distributing newspapers, etc) | | | | | | | | | |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Open to all/any areas | | | | | | | | | |
| <input type="checkbox"/> Discharge/Escort/Wheelchair Assistance | <input type="checkbox"/> Other: _____ | | | | | | | | | |
| <input type="checkbox"/> Gift Shop | _____ | | | | | | | | | |
| <input type="checkbox"/> Information Desk/Way-Finding | _____ | | | | | | | | | |

REFERRAL

| |
|---|
| How did you hear about volunteer opportunities at NCH? |
| Are you acquainted with anyone who is a volunteer or employee at NCH? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name & relationship: _____ Department: _____ |

EDUCATION

| |
|--|
| Completed Level of Education: <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate <input type="checkbox"/> Other: |
| Degree & Major: |
| <u>IF YOU CURRENTLY ATTEND SCHOOL, PLEASE COMPLETE THIS SECTION:</u> |
| Name of School: _____ Year in School: _____ |
| Career Desired: |
| When do you want to volunteer? (Check all that apply) <input type="checkbox"/> Summer <input type="checkbox"/> Fall Semester <input type="checkbox"/> Spring Semester |

WORK EXPERIENCE

| | |
|---|-----------------------|
| Are you: <input type="checkbox"/> Currently Employed <input type="checkbox"/> Looking for Work <input type="checkbox"/> Retired <input type="checkbox"/> Other: | |
| Present or Most Recent Employer Name: | |
| City/State of Employer: | Years Employed There: |
| Job Title/Description: | |

VOLUNTEER EXPERIENCE

| | |
|---------------|-------------------|
| Organization: | Year(s) Involved: |
| Job Title | Duties: |
| Organization: | Year(s) Involved: |
| Job Title | Duties: |

EMERGENCY CONTACT

| | | |
|-------|---------------|--------|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

REFERENCES: *(Not Relatives)*

Please give us the name of adults who are aware of your character and interests, who would be willing to serve as a reference.

| | | |
|-------|---------------|--------|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

PERSONAL HISTORY

| |
|---|
| Have you ever worked or volunteered at NCH? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what department did you work/volunteer? _____ Dates: _____ Job Title: _____ |
| Do you have any mental or physical restrictions which might prohibit you from volunteer job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please advise: _____ |
| Have you ever been convicted of a felony in this or any other state/country? (Do not include any sealed or expunged convictions): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ |

VOLUNTEER AGREEMENT:

- I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT MISREPRESENTATION OF INFORMATION PROVIDED BY ME IN THIS APPLICATION WILL RESULT IN DISQUALIFICATION FOR CONSIDERATION IN THE VOLUNTEER PROGRAM. I FURTHER UNDERSTAND THAT IF I PARTICIPATE IN THE VOLUNTEER PROGRAM, ANY MISREPRESENTATION OF FACTS, AS STATED OR IMPLIED, IS CAUSE FOR DISMISSAL.
- I UNDERSTAND THAT COMPLETING THIS APPLICATION DOES NOT GUARANTEE ME A VOLUNTEER ASSIGNMENT.
- IF ACCEPTED I WILL OFFER MY SERVICES WITHOUT MONETARY COMPENSATION.
- IF ACCEPTED I AGREE TO COMPLY WITH ALL THE HOSPITAL'S RULES AND REGULATIONS, AND THOSE SPECIFIC TO THE VOLUNTEER SERVICES DEPARTMENT.
- I UNDERSTAND AS A CONDITION OF INITIAL AND CONTINUED PARTICIPATION IN THE VOLUNTEER PROGRAM, I AGREE TO COMPLETE ALL HEALTH REQUIREMENTS AS DETERMINED BY EMPLOYEE HEALTH, AND MUST SHOW ABILITY TO PERFORM THE JOB, WITH OR WITHOUT ACCOMMODATION.

SIGNATURE: _____ DATE: _____

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Medical Release Form – Adult Volunteer



Please have your medical provider complete this form.

Completed Forms - can be faxed to 847-618-4499 or can be attached to the volunteer application.

TO BE COMPLETED BY VOLUNTEER APPLICANT:

| | | | |
|-------------------|--|-----------------------|--|
| Full Name: | | Date of Birth: | |
| Phone: | | | |

Dear Medical Provider – I am interested in participating in the Volunteer Program at Northwest Community Hospital. Please complete this form with the requested medical health history and include your recommendations about my abilities and/or possible restrictions. I authorize this release of information.

Volunteer Signature: _____

TO BE COMPLETED BY MEDICAL PROVIDER:

| | | | |
|-----------------------|--|---------------|--|
| Provider Name: | | Phone: | |
| Practice Name: | | | |
| Address: | | | |

Abilities & Restrictions:

1. Was the above person, at date of last examination, in good physical and mental health?
 Yes No Date of Last Exam: _____
2. Is the above person able to safely and satisfactorily volunteer in this setting without harm to others?
 Yes No
3. Do you have any recommendations regarding the amount of standing, walking, lifting, or pushing (wheelchairs) this individual can safely perform?
 Yes No If "Yes", please explain: _____

Immunization History:

Volunteers are required to submit record of all of the following health and immunization requirements. If health records are not available, titer testing is required for verification of communicable disease immunity. The health requirements ensure the safety of our patients and team members.

| | | |
|--|----------------------------------|----------------------------------|
| 1. MMR – Measles (Rubeola), Mumps, Rubella (German Measles) | Date: _____ | <input type="checkbox"/> Unknown |
| If no vaccination history - MMR Titer Testing | Date: _____ | Result: _____ |
| 2. Varicella | Date: _____ | <input type="checkbox"/> Unknown |
| If no vaccination history – Varicella Titer Testing | Date: _____ | Result: _____ |
| Or Shingles Vaccine | Date: _____ | <input type="checkbox"/> Unknown |
| 3. TDAP | Date: _____ | <input type="checkbox"/> Unknown |
| If no vaccination history – TDAP Titer Testing | Date: _____ | Result: _____ |
| 4. Influenza (Flu) - Required from September thru end of March | Date: _____ | <input type="checkbox"/> Unknown |
| 5. COVID-19 – Primary Vaccination Series (Pfizer, Moderna, J&J) | Date(s): _____ | <input type="checkbox"/> Unknown |
| 6. Tuberculosis – One-Step TB Test* | Date: _____ | |
| (*TB test is not required at time of application but needs to be completed before volunteer start date.) | Result: _____ | |
| <i>We will accept proof of a TB test from outside providers. A negative TB test performed within the last 90 days is acceptable (at time of Employee Health clearance appointment). TB Testing may be available by NCH Employee Health (this option can be discussed with the Volunteer Department).</i> | <input type="checkbox"/> Unknown | |

Individual will request a medical or religious exemption for the following immunization(s): _____

Medical Provider Signature: _____ **Date:** _____

Northwest Community Healthcare Volunteer Guidelines Acknowledgement

(For Adult Applicants)

Name: _____

Date: _____

If I am selected to be a volunteer at Northwest Community Healthcare, I agree that I will:

- Review and complete the Volunteer Orientation.
- Complete the online background check form.
- Complete the health requirements:
(Health requirements are not required during the application process.)
 - One-Step TB (tuberculosis) test. Will accept proof of test from outside provider. Must be negative reading performed within the last 90 days.
 - Proof of vaccinations that includes Varicella (chicken pox), Rubella (German measles), Rubeola (measles), Mumps. If health records are not available, titer testing is required for verification of disease immunity.
 - Proof of influenza (flu) vaccine or agree to receive the vaccine at our facility during the flu season (usually August through March).
- Volunteer regularly at a minimum of 4 hours per shift.
- Volunteer a minimum of 6 months to fulfill obligation. (Approximately 100 hours.)
- Comply and follow all NCH and Volunteer Program policies, procedures and standards.
- Arrive on time for my shift and volunteer according to agreed schedule.
- Notify my department supervisor/contact if I need to be absent or late on my assigned day(s).
- Complete all competency and training requirements. Including annual volunteer safety training.
- Upon completion of my volunteer services, notify the Volunteer Department / Guest Services and return my uniform and my ID badge.

I understand that if I do not fulfill these commitments, I will not qualify to remain in the program.

I also understand that if I do not fulfill these commitments, the Volunteer Department will not provide verification of hours or recommendation letters.

Volunteer Signature



Confidentiality Statement

I understand and agree that in the performance of my duties as an employee or volunteer of Northwest Community Hospital, or its affiliate, I will frequently have access to confidential information regarding patients, employees, volunteers and the Hospital, and I am expected to hold this information in confidence. Such information may only be read, taken, used, copied or discussed in conjunction with the direct performance of my duties. As an employee, I understand that any violation of this confidentiality of patient, employee, volunteer, or hospital information will result in corrective action, and may include termination of my employment. As a volunteer, I understand that any violation of this confidentiality of patient, employee, volunteer, or Hospital information will result in immediate dismissal from the Volunteer Program.

Signature

Date

Print Name