



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 Emergency Department, information desks, patient care areas, Jazzman's Café and Busse Center 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 family physician. 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,

A handwritten signature in cursive script that reads 'Stephanie Chan Vo'.

Stephanie Chan Vo
Director - Guest Services

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: _____

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

Medical Release Form

Please have your doctor complete this form.

The doctor can fax the completed form to our office or you can attach the completed form with your application.

Dear Doctor:

We have received an application from _____. He/she is interested in participating in the Volunteer Program at our hospital. In order to help us place this person in the most appropriate volunteer position for his/her capabilities, we will **need your recommendations** about this person's abilities and/or possible restrictions.

Should you have questions or concerns, please feel free to call.

Sincerely,

Guest Services

Phone - 847.618.4450 || Fax - 847.618.4499 || volunteer@nch.org

Physician Information:	
Name:	_____
Address:	_____
Phone:	_____
Fax:	_____

1. Was the above person, at date of last examination, in good physical and mental health?

Yes No

2. Is this applicant 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 should do?

Yes No

If "Yes", please explain:

4. Date of last known PPD (tuberculosis) skin test(s):

Date: Result: Unknown

5. Date of last known influenza (flu) vaccine. (Volunteer must have proof of flu vaccine or agree to receive the vaccine at our facility during the flu season, usually August through March.)

Date: Unknown Individual will request for an exemption

MD Signature: _____ **Date:** _____

Volunteer's Authorization to release information: _____



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 take-home Volunteer Orientation Guide.
- 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 if within the 12 months.
 - Proof of vaccinations (for those born after 1/31/1957) that includes Varicella (chicken pox), Rubella (German measles), Rubeola (measles), Mumps, or agree to have a blood test to assess immunity or receive those vaccines at our facility.
 - 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