Volunteer Organization Application to Volunteer

Delivering Care, Saving Lives, and Healing

Since 1974 the Volunteer Organization has touched the lives of Witham Health Services customers.

When you give of yourself to help others, you make a difference.

Witham Health Services Volunteers

Make a difference!

We believe in our core values:

Quality	Commitment
Caring	Dedication
Respect	Confidentiality
Integrity	Financial Viability

Vision

Our vision is to be a vital and caring community hospital responding to the changing health care environment, as well as the diverse and changing needs of our growing community. We are committed to high quality care and continual learning and improvement. Our interactions with each other, our patients, and their families are characterized by mutual respect, honesty, integrity, and trust.

Please refer further questions to:

Volunteer Department
2605 N. Lebanon Street
Lebanon, IN 46052
Phone: 765-485-8175
www.witham.org

Our Mission, Our Community Role, Our Passion

Name: ______ *(Please print)* *Last* ______ *First* ______ *Middle Initial* ______

Date: ____/____/____

Name: ______________________________ Birthday: ______________

First *Middle Initial* *Last*

Address: ______________________ City: ______________ Zip: ________

Social Security # ______________ Phone: ______________________

Email Address: ____

Employed or retired: __________ If employed, name of employer: ______________________

Have you previously been employed by Witham? ☐ Yes ☐ No

If yes, which departments: ______________________________________

Skills (e.g., typing, creative, musical, mathematical, etc.): ______________________

Previous volunteer experience/training: ______________________________

Have you ever plead "guilty" or "no contest" to, or been convicted of a crime? ☐ Yes ☐ No

If yes, explain: ____

(Any Witham Health Services Volunteer position is subject to criminal background checks which include felonies and misdemeanors.)

Do you have any pending criminal charges? ☐ Yes ☐ No

List two (2) professional references:

Name: ______________________ Address: ______________ Phone: ____________

Name: ______________________ Address: ______________ Phone: ____________

List two (2) personal references:

Name: ______________________ Address: ______________ Phone: ____________

Name: ______________________ Address: ______________ Phone: ____________

If you are under 18, parental permission will be required for TB testing and will require parental signature. Refer to the Consent for Health Screening Exam Form that is included with this application packet.

Please check all areas you are interested in working:

☐ Comfort Care & Magazine Cart ☐ Dietary ☐ Greeter & Information Desk
☐ Office Assistant (various departments and responsibilities) ☐ Pastoral Care Team
☐ Physician Office ☐ Purchasing & Receiving ☐ Rehab
☐ Sales Associate in Gift Shop or Boutique

Availability: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
☐ Mornings ☐ Afternoons

Emergency Contact Information:

Name: ______________________________ Relationship: ______________

Address: ______________________________ Phone: ______________

I understand that I am required to abide by all rules and regulations of Witham Health Services and to comply with all policies and procedures in the policy or procedure manual or other communications to volunteers. I further understand policies and procedures and conditions are subject to modifications without notice. I understand that if I am 18 years old or older, I will be subject to a criminal background check.
I hereby acknowledge that I have read the above statement and I understand and accept these terms.

Signature of Applicant: ______________________________ Date: ____________

Signature of Parent / Guardian: ______________________________ Date: ____________
(If under age 18)

CONFIDENTIAL

Witham Volunteer Organization
Background Check Authorization

Print Name: ____
First Middle Last

Former Name(s) and Dates Used: ____

Current Address Since: ____
Mo / Yr Street City State/Zip

Previous Address Last 10 years : ____
Mo / Yr Street City State/Zip

List Mo / Yr; Street Address; City; State and Zip Code

____

____

____

____

____

Date of Birth: ____________________ **Telephone Number:** ______________________________

The information contained in this application is correct to the best of my knowledge. I hereby authorize Witham Health Services and its designated agents and representatives to conduct a criminal background check.

I hereby release Witham Health Services and its designated agents or representatives from any and all liability which may result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

____ ______________________

Signature **Date**

Witham Health Services
Volunteers – Background Check Authorization
Form #8690-1011-10

WITHAM HEALTH SERVICES OCCUPATIONAL HEALTH HISTORY
2605 NORTH LEBANON STREET ✹ Lebanon, IN 46052
Telephone (765) 485-8520 ✹ Fax (765) 485-8519 ✹ Hours 7:30 – 4:00 p.m.

Information for the following Health History is to be provided by the applicant.

Thorough and accurate responses to the information requested in this health history will contribute to sound employment decisions which will benefit both you and your potential employer. Please bring photo identification, immunization records, and current medications to your pre-employment physical.

I, the undersigned, do hereby consent to undergo a medical examination, including blood specimen, x-ray, skin test, immunizations, and other examinations which the medical examiner and employer may consider necessary to complete the medical evaluation. I further certify that all information I have provided is true and correct to the best of my knowledge, and I agree and understand that any omissions or falsification of information I have provided may cause forfeiture of my right to any employment.

_______________________________ Signature In Full

_______________________________ Date/Time Form Completed

HEALTH HISTORY

NAME (Last, First, Middle Initial)	Age	Sex (M/F)	Birth date (MM/DD/YY)	Social Security No.	Position/Department Start Date

ADDRESS (Street, City, State, Zip Code)	Contact Information: Work ( ) Cell ( ) Home ( ) E-mail Address:
Name of Person to Notify In Case of Emergency	Name and Full Address of Personal Physician ____________
Address	____________
Relationship / Telephone Number	Telephone Number ____________

Please Check If You Have Been Immunized For:	Yes	No	Unknown	Date(s)	Had Disease (year)
Childhood/Military Immunizations	☐	☐	☐	______	______
Diptheria/Pertussis/Tetanus (DPT)	☐	☐	☐	______	______
Hepatitis B Vaccine Series	☐	☐	☐	______	______
Hepatitis B Titer (Antibody)	☐	☐	☐	______	______
Result:: ______________					
Rubella (German, 3-Day Measles)	☐	☐	☐	______	______
Rubeola (Red Measles)	☐	☐	☐	______	______
Mumps	☐	☐	☐	______	______
Polio	☐	☐	☐	______	______
Varicella (Chicken Pox)	☐	☐	☐	______	______
Last Tetanus Booster mo/yr	☐	☐	☐	______	______

Please Check If You Have Ever Had:

☐ Chicken Pox/Shingles ☐ Polio ☐ Scarlet Fever
☐ Hepatitis Type: ____________ ☐ Rheumatic Fever ☐ Malaria
☐ TB (Tuberculosis) ☐ AIDS/HIV ☐ Herpes

Do You Have Any Allergies to Drugs, Dusts, Pollen, Grasses, Eggs, Feathers, Foods, Insect Stings, Latex Products, etc.?

☐ No ☐Yes If Yes, List:	Allergen		Date of Reaction	Describe Reaction

Please List Medications You Are Currently Taking (Include Vitamins, Birth Control Pills) **IF NEEDED, CONTINUE LIST ON REVERSE SIDE OF THIS FORM**		
NAME	DOSAGE	REASON FOR TAKING

Last visit to physician? _____/_____/_____ For What ? ____________________

Now under care of physician? If yes, describe reason: ____________________

Do you wear any prostheses or special devices? ☐No ☐Yes If yes, please check: ☐Ortho Braces ☐Special Shoes ☐Hearing Aid(s)
☐Glasses ☐Contact Lenses ☐Dentures ☐Other (specify) ____________________

Have you ever had a blood transfusion? ☐No ☐Yes Date(s): ____________________

Diagnostic Tests (within last 5 years)	YES	DATE m/y	LOCATION OF TEST & RESULT
Chest X-Ray	☐	______/______	
Colon X-Ray	☐	______/______	
Gall Bladder X-Ray	☐	______/______	
Kidney X-Ray	☐	______/______	
Stomach X-Ray	☐	______/______	
Treadmill/Electrocardiogram	☐	______/______	
Heart Catheterization	☐	______/______	
Hearing Test	☐	______/______	
Mammography	☐	______/______	
TB Skin Test	☐	______/______	

Other X-Rays and Tests (List): ____________________

MAJOR ILLNESSES/INJURIES/HOSPITALIZATIONS/SURGERIES (Include physical, psychological, and addiction-related ailments)

YEAR	ILLNESSES/INJURIES/HOSPITALIZATIONS/SURGERIES (INCLUDE LOCATION AND TREATING PHYSICIAN'S NAME)

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (If yes, please explain below.)

	GENERAL	**YES**	**NO**	**NOW**	**PAST**
1.	Usually tired or worn out	☐	☐	☐	☐
2.	Recently been drinking more water or fluids	☐	☐	☐	☐
3.	Weight gain or loss greater than 10 lbs recently	☐	☐	☐	☐
4.	Chills, fever, night sweats	☐	☐	☐	☐
5.	Heat intolerance	☐	☐	☐	☐
6.	Uncomfortable in confined places	☐	☐	☐	☐
7.	Cancer: cyst, tumor, growth **If YES, list type:	☐	☐	☐	☐
8.	Sickle cell trait/disorder	☐	☐	☐	☐
SKIN					
9.	Skin rashes, itching, hives	☐	☐	☐	☐
10.	Growths on your skin	☐	☐	☐	☐
11.	Slow healing of sores or wounds	☐	☐	☐	☐

EYES, EARS, NOSE & THROAT		YES	NO	NOW	PAST
12.	Eye problems	☐	☐	☐	☐
13.	Vision problems (blurring, double vision, etc.)	☐	☐	☐	☐
14.	Glaucoma	☐	☐	☐	☐
15.	Do you wear glasses/contact lenses	☐	☐	☐	☐
16.	Is your eyesight getting worse	☐	☐	☐	☐
17.	Hearing Problems	☐	☐	☐	☐
18.	Ringing or buzzing in your ears	☐	☐	☐	☐
19.	Sinus problems	☐	☐	☐	☐
20.	Chronic drainage down the back of your thyroid	☐	☐	☐	☐
21.	Frequent or severe nosebleeds	☐	☐	☐	☐
22.	Persistent hoarseness	☐	☐	☐	☐
23.	Goiter, thyroid disorder	☐	☐	☐	☐
CARDIOVASCULAR					
24.	Heart trouble, heart attack, murmur, palpitations	☐	☐	☐	☐
25.	Chest pain, angina, tightness or pressure	☐	☐	☐	☐
26.	Rheumatic fever	☐	☐	☐	☐
27.	Abnormal electrocardiogram (EKG)	☐	☐	☐	☐
28.	Stroke/TIA	☐	☐	☐	☐
29.	Blood clots in arms, legs, etc.	☐	☐	☐	☐
30.	High blood pressure	☐	☐	☐	☐
31.	Swelling of ankles, legs	☐	☐	☐	☐
32.	Varicose Veins	☐	☐	☐	☐
GASTROINTESTIONAL					
33.	Frequent indigestion or heartburn	☐	☐	☐	☐
34.	Stomach trouble, ulcer	☐	☐	☐	☐
35.	Frequent stools or diarrhea	☐	☐	☐	☐
36.	Feeling of fullness under your breastbone at night	☐	☐	☐	☐
37.	Blood in stools, or black tarry stools	☐	☐	☐	☐
38.	Recent change in your bowel movements	☐	☐	☐	☐
39.	Frequent nausea and/or vomiting	☐	☐	☐	☐
40.	Hemorrhoids	☐	☐	☐	☐
41.	Yellow jaundice, liver disease, gall stones	☐	☐	☐	☐
42.	Diabetes	☐	☐	☐	☐
RESPIRATORY					
43.	Frequent chest colds	☐	☐	☐	☐
44.	A constant or bothersome cough	☐	☐	☐	☐
45.	Coughing up blood	☐	☐	☐	☐
46.	Productive cough when not ill	☐	☐	☐	☐
47.	Difficulty breathing	☐	☐	☐	☐
48.	Wheezing or whistling in your chest	☐	☐	☐	☐
49.	Shortness of breath with rest or mild to moderate activity	☐	☐	☐	☐
50.	Lung Disease, asthma	☐	☐	☐	☐
51.	Tobacco Use **If YES list type, amount per day, length of use	☐	☐	☐	☐

MUSCULOSKELETAL		YES	NO	NOW	PAST
52.	Back pain, disc problems, scoliosis	☐	☐	☐	☐
53.	Arthritis **If YES, please list body part(s) affected:	☐	☐	☐	☐
54.	Fractures/bone injury	☐	☐	☐	☐
55.	Pain in legs or feet	☐	☐	☐	☐
56.	Shoulder pain, rotator cuff problems	☐	☐	☐	☐
57.	Joint pain, stiffness or swelling	☐	☐	☐	☐
58.	Trouble walking or using your hip or knee joints	☐	☐	☐	☐
59.	Night pain or numbness in hands, wrists or arms	☐	☐	☐	☐
CENTRAL NERVOUS SYSTEM		**YES**	**NO**	**NOW**	**PAST**
60.	Frequent or severe headaches	☐	☐	☐	☐
61.	Dizziness, faintness or lightheadedness	☐	☐	☐	☐
62.	Loss of consciousness	☐	☐	☐	☐
63.	Depression, anxiety, other nervous disorder	☐	☐	☐	☐
64.	Numbness or tingling in your arms, hands, legs or feet	☐	☐	☐	☐
65.	Tremor of hands, arms, legs	☐	☐	☐	☐
66.	Head Injury	☐	☐	☐	☐
67.	Convulsions, Seizures	☐	☐	☐	☐
68.	Alcohol Use ** If YES, list type of alcohol and frequency of use:	☐	☐	☐	☐
69.	Alcohol or drug treatment program	☐	☐	☐	☐
GENITOURINARY		**YES**	**NO**	**NOW**	**PAST**
70.	Difficulty with urination	☐	☐	☐	☐
71.	Frequent/painful urination	☐	☐	☐	☐
72.	Recurrent bladder infections	☐	☐	☐	☐
73.	Kidney trouble/blood in urine	☐	☐	☐	☐
74.	Women only: menstrual disorders	☐	☐	☐	☐
75.	Women only: are you now pregnant	☐	☐	☐	☐

PLEASE EXPLAIN ALL "YES" ANSWERS FROM THE QUESTIONS ABOVE. PLEASE NUMBER THE RESPONSES WITH THE NUMBER OF THE CORRESPONDING QUESTION.

Witham Health Services
Consent for Health Screening Exam

I, ____ understand the policy of Witham Health Services requires all persons associated with hospital service to be given a health screening exam to determine the absence of communicable disease.

I understand that the exam is to be completed before volunteer service will be considered.

I understand that the health screening exam will consist of the following tests/vaccinations:

PPD – for tuberculosis
Flu vaccine

I understand that the health screening exam will be provided at no cost by Witham Health Services, but that the hospital will not accept responsibility for treatment of conditions that may be discovered during the exam.

I further understand that if the results of the health screening exam indicate that I have a communicable disease, I will not be considered for volunteer services until the condition has been satisfactorily treated and I have received clearance from the Witham Health Services Employee Health Department.

Having read and understood the above information, I do hereby request and consent to the performance of a volunteer health screening exam by the employee health service.

____ ______________

Signature *Date*

____ ______________

Witness Signature *Date*

____ ______________

Parent/Guardian Signature *Date*