Volunteer Application

Applicant's Name _____

Address _____ City _____

State _____ Zip _____ Phone _____

Notify in Case of Emergency

Name _____

Address _____ City _____

State _____ Zip _____ Phone _____

Employment/Volunteer Experience

Employer _____

Position _____

Dates: From _____ To _____

Employer _____

Position _____

Dates: From _____ To _____

Employer _____

Position _____

Dates: From _____ To _____

Have you ever been arrested? ☐ Yes ☐ No

If yes, explain _____

How many hours can you donate? _____ Day, _____ Week, _____ Month

On what days would you be available: _____, _____, _____

What time of day would you be available? Morning ☐ Afternoon ☐ Night ☐

Do you have any special talents you wish to share with our residents? Yes ☐ No ☐

If yes, describe: _____

Do you play any musical instruments? Yes ☐ No ☐

If selected to participate in our volunteer program, do you agree to abide by the rules and regulations established by this facility? Yes ☐ No ☐

_____ Date

Signature of Applicant

_____ Date

_____

FRANKLIN COUNTY
FCMC
MEDICAL CENTER

FRANKLIN COUNTY MEDICAL CENTER
VOLUNTEER SERVICES APPLICATION

6.Please check any skills, interests, and talents you have and please add any not listed:

ID#	SKILLS		ID#	INTERESTS		ID#	TALENTS	
05	Accounting		290	Analyzing		500	Artist	
10	Banking		300	Article-writing		510	Creative	
20	Bilingual		310	Leadership		520	Decorator	
30	CPR		320	Learning		530	Dependable	
40	Clerking		330	New Experiences		540	Displays	
50	Computer		340	People		550	Energetic	
60	Drug Abuse Counseling		350	Planning		560	Enthusiastic	
70	Filing		360	Problem Solving		570	Good Listener	
80	Instrumental Music		370	Research		580	Honest	
90	Nursing		380	Social Functions		590	Innovative	
100	Secretarial		390	Speaking		600	Painter	
110	Vocal Music		400	Teaching		610	Risk taker	
120	Work with Deaf/Signing		410	Telephoning		620	Planning	
130	Laboratory Skills		420	Travel				
140	Journalism		430	Health Care				
150	Crafts							
160	Woodworking							
170	Sewing							
180	Drafting							
190	Engineering							
200	Surveying							
210	Topography							
220	Teaching							
230	Child Care Training							
240	Program Development							
250	Management/Admin							
260	Government							
270	Domestics							
280	Driver							

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Confidentiality Statement –Volunteer

I understand that information concerning patients, their illnesses or their families is private. I preserve this right to privacy by not discussing their conditions, treatments, or any other private matters in public settings either in the Hospital or outside of the Hospital.

Any information obtained from the patient's medical record will be used only for authorized purposes. I will preserve and protect contents of the records and any other confidential information obtained.

Information concerning employees and employee records is private and confidential. I understand that this private information shall be distributed only to authorized personnel. Financial information of patients shall be distributed only to authorized personnel.

Computer access codes are recognized as electronic signatures to access automated patient and employee records. I understand that due to the confidential nature of the documentation in the medical record, my password should not be shared with another person. I hereby agree not to reveal my password, nor will I attempt unauthorized access to the system. If I suspect the security of my password has been compromised, I agree to report this to the Security Officer immediately.

I understand that any violation of these rules of confidentiality may cause my association with Franklin County Medical Center to be terminated. I understand that a breach in confidentiality may be in violation of federal and/or state statutes and regulations, and subject to prosecution under the law.

_____ _____

Signature Date

_____

Printed Name