Grundy County Memorial Hospital
UnityPoint Health

GCMH Volunteer Application

Name: _____ Date: _____

Address: _____ City/Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

E-mail Address: _____ Birthday: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City/Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Educational History

High School: _____ Graduation Year: _____

College: _____ Graduation Year: _____

Degree Earned/Area of Study: _____

College: _____ Graduation Year: _____

Degree Earned/Area of Study: _____

Work History

Business: _____ Contact: _____

Work Performed/Title: _____

Business: _____ Contact: _____

Work Performed/Title: _____

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other state? _____

If yes, please explain: _____

Volunteer Experience

Organization: _____ Contact: _____

Work Performed: _____

_____

Organization: _____ Contact: _____

Work Performed: _____

_____

Organization: _____ Contact: _____

Work Performed: _____

_____

Volunteer Interest

How did you hear about volunteering at GCMH: _____

Why would you like to volunteer at GCMH: _____

_____

_____

_____

Please indicate which you would be willing to share as a volunteer with GCMH:

Clerical
- ___ Computers
- ___ Cash register
- ___ Making copies/filing
- ___ Phone receptionist

Communication
- ___ Speaking to community groups
- ___ Journalism
- ___ Photography
- ___ Graphic design

Patient Care
- ___ Reading aloud
- ___ Visiting/listening

Personal
- ___ Drawing
- ___ Painting
- ___ Knitting
- ___ Crocheting
- ___ Sewing
- ___ Crafts
- ___ Gardening
- ___ Baking
- ___ Repair person
- ___ Musical instrument/Singing
- ___ Planning/Hosting special events

Please list any additional hobbies, skills, or interests you have that might be helpful in your volunteer work:

_____

_____

Volunteer Preferences
Volunteer times vary by area of interest. Please read descriptions below and mark your interests.

____ **Welcome Desk:** Monday-Friday, 8:00 a.m. – 12:15 p.m. or 12:15 – 4:30 p.m.
Welcome Desk schedules are made monthly and shifts volunteers choose to work are flexible.

____ **Long Term Care:** Weekdays or weekends, morning, afternoon, and evenings.
Long Term Care activity times are posted monthly and volunteers can choose when to help based on their interests and availability. Long Term Care volunteers work directly with residents during activities (ex: Bingo, Sunday worship, craft time, painting nails)

____ **East J Café:** Monday-Friday, 8:00 – 11:00 a.m. or 1:00 – 4:00 p.m.
East J Café volunteers are asked to work the same shift either every other week or every week.

____ **Physical Therapy:** Monday-Friday, mornings or afternoons.
Physical Therapy volunteers are asked to work the same shift either every other week or every week.

References
Personal or professional references (please exclude relatives):

Name: _____ Phone: _____

Address: _____ E-mail: _____

Relationship: _____

Name: _____ Phone: _____

Address: _____ E-mail: _____

Relationship: _____

Statement of Agreement (please read carefully)
I am interested in serving as a volunteer at Grundy County Memorial Hospital and I am prepared to devote a minimum of one year to this organization. I agree to abide by the Policies and Procedures of the hospital and follow the Dress Code. I agree to keep all patient/resident information completely confidential and uphold all confidentiality requirements. I understand that I must complete the application in its entirety, receive a TB test, attend Orientation, and strictly adhere to the Volunteer Services guidelines.

I understand that this organization is not obligated to provide a placement, nor am I obligated to accept the position offered. All information in this application is accurate. I will hold this organization blameless if I incur an injury as a result of my work as a volunteer. I agree to return my photo ID badge when I leave the Volunteer program.

_____ _____
Applicant's Signature Date

GCMH Volunteer Health History Form

Name: _____ Date: _____

Address: _____

Date of Birth: _____ ___ Male or ___ Female

Please answer the following

1) Do you now or have you ever had:
   ___ TB
   ___ Hepatitis
   ___ Chicken pox
   Explanation: _____

2) Have you been diagnosed with a latex allergy?
   ___ Yes
   ___ No

3) Do you develop numbness, tingling, or swollen lips when you blow up a balloon or wear latex gloves?
   ___ Yes
   ___ No

4) Are you currently under treatment for any health condition or disease that may affect your ability to perform your volunteer job?
   ___ Yes
   ___ No
   Explanation: _____

5) Are you currently taking prescribed or over the counter drugs that may affect your ability to perform your volunteer job?
   ___ Yes
   ___ No
   Explanation: _____

6) Please list all allergies:
   _____
   _____

I understand that I will receive a skin test for tuberculosis (PPD), administered and interpreted by a Nurse at GCMH. I understand that this test is required at the beginning of each volunteer's service, will be administered twice (two weeks apart), and as deemed necessary after by GCMH policy. In some highly sensitive persons, strong positive reactions may cause redness, swelling, soreness, vesiculation, or ulceration at the actual test site. I understand that I may also have this test done by a physician of my choice, at my expense, and then furnish proof of testing to the Volunteer Services office.

_____ _____

Applicant's Signature Date

Grundy County Memorial Hospital Volunteer Services
Medical Information Release Form

I hereby authorize my physician: _____ to provide Grundy County Memorial Hospital with the requested information regarding my health.

_____ _____
Volunteer's Signature Date

Volunteer Name: _____ Date of Birth: _____

The above named person:

____ DOES NOT have any physical, mental, infectious, or medical disability which the Volunteer Services Manager should be aware of before assigning this person to an area in a hospital.

____ DOES have physical, mental, infectious, or medical disability which the Volunteer Services Coordinator should be aware of before assigning this person to an area in the hospital.

Explanation: _____

_____

_____

This person should NOT perform the following tasks:

____ Sitting (4 hours)

____ Standing/walking (4 hours)

____ Pushing wheelchairs

____ Lifting over _____ pounds

_____ _____
Physician Signature Date

STATE OF IOWA
Criminal History Record Check Request Form

DCI Account Number: _____
(if applicable)

To: **Iowa Division of Criminal Investigation**
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

From: _____

_____

_____

Phone: _____

Fax: _____

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	**First Name** (mandatory)	**Middle Name** (recommended)
Date of Birth (mandatory)	**Gender** (mandatory)	**Social Security Number** (recommended)
	☐ **Male** ☐ **Female**	

Waiver Information: **Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.**

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature: _____

Iowa Criminal History Record Check Results

(DCI use only)

As of _____, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI #_____

DCI initials_____

DCI-77 (08/25/10)

Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person for whom information is requested and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

☐ Child Abuse Registry ☐ Dependent Adult Abuse Registry ☒ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☐ Fax ☐ Email

Section 1: ***To be completed by the person or agency requesting the information.***

Requester: Last First Agency Name			Telephone Number ( )
Address			Fax Number ( )
City	State	Zip Code	Email

List the name and address of the person whose information is being requested:

Name (last, first, middle)		Birth Date	Social Security Number	
Address	City	County	State	Zip Code

List maiden name, previous married names, and any alias:

What is the purpose of your request for child or dependent adult abuse information?

I have read and understand the legal provisions for handling child and dependent adult abuse information which is printed on the second page of this form.

Signature of Requestor	Date

Section 2: ***To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information.***

I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (Iowa Code section 235A.15) or dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct.

Signature of Person Authorizing	Date

Section 3: ***To be completed by the Central Abuse Registry or designee.***

☐ The person whose information is being requested is listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.

☐ The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult.

☐ This request for information is denied because the form is incomplete.

Signature of Registry Staff or Designee	Date

Comments