



UNITYPOINT HEALTH- ALLEN HOSPITAL

READY TO VOLUNTEER?

*Student Volunteer
Application Form*

FALL
DEADLINE:
JULY 30TH
SPRING
DEADLINE:
NOVEMBER 15TH
SUMMER
DEADLINE:
MAY 1ST

THE PROCESS

Students must have their application completed and returned by the deadline date to be considered for an interview to become a volunteer. Once the student is accepted after the interview, the student will need to complete an immunization review with our Occupational Health Department, and pass a background check completed by our office.

Each student will need to complete an application **EACH** term. We have 12 available spots for applicants and will review and interview all applications prior to choosing.

Fall & Spring Availability:

Monday, Tuesday, Wednesday, 4-6pm

4 students each available day

Summer Availability: To be determined per need

4 students each available day

With this new process, it will ensure everyone gets a chance to apply and be considered to be a student volunteer. We will also choose students that convey our FOCUS values, and will be a good fit for our department.

THE EXPECTATIONS

- Students must be at least 14 years of age
- Students must be in good standing with their school
- Students must have a letter of reference
(from an adult that is not a family member)
- Students must have their parents permission
- Students must commit to the full desired term
- Students may only have 3 unexcused absences. After the third unexcused absence, the student will no longer be able to volunteer for the term.
- Students must comply with the dress code, or will be asked to go home.

By signing below I agree to abide by the expectations and FOCUS values.

Student Signature

Parent Signature (if student is under 18)

Date received: _____
 Date interviewed: _____
 FOR OFFICE USE ONLY

Volunteer Application

Name (First, Middle, Last):	4-Digit PIN:	Birthdate:
Home Address (Street, Apartment Number):	Adult__ College__ High School__	
City, State, Zip:	Telephone No. Home/Work/Cell:	
Emergency Contact: 1. 2.	Relationship and Phone Number:	Social Security # : Email:

Physician: _____ City: _____

Work or Volunteer Experience
1.
2.
3.
4.
5.

References (Not Relatives)		
Name	Address, City, State, Zip	Telephone Number

Volunteer Areas of Interest:

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? Yes No

If yes, please specify: _____

Allen Hospital will consider all qualified individuals interested in contributing volunteer service without regard to race, religion, disability, color, age, sex or national origin.

Please Read

By signing below, I certify that the answers and information set out on the previous page are accurate and complete, to the best of my knowledge. I acknowledge that if any answer or information is not accurate, or complete, I may not be asked to provide volunteer services.

1. I authorize Allen Hospital to investigate all statements contained in this application for volunteer service, as well as my character and qualifications. I release Allen Hospital from all liability for acts performed in good faith and without malice in connection with the investigation of my background and evaluation of my application.
2. I authorize my past and present employers, volunteer organizations and others with information regarding my work, volunteering or my character to provide Allen Hospital with all information requested and to cooperate fully with the inquiry of my character qualifications. I also release those employers, references, and others from all liability for providing information in good faith and without malice.
3. I understand and agree that the relationship between myself and Allen Hospital may be terminated at any time by either party.
4. I understand that my acceptance to volunteer in patient contact areas depends on Allen Hospital ensuring that I have no health problems which would prevent me from volunteering effectively and with complete safety for myself and Allen Hospital patients, employees and visitors. Accordingly, I agree that if my health changes, I will submit a new medical clearance form from my physician and that my acceptance to volunteer will depend upon approval of Allen Hospital.
5. I understand that as a volunteer, I must conform to all Allen Hospital rules and regulations including those in the orientation manual. I also understand that I will be required to obtain and wear appropriate volunteer uniform. This uniform includes a name tag and a shirt, jacket or vest.
6. Please note that your volunteer commitment at Allen Hospital includes commitment to confidentiality. Names, diagnoses, and other patient/client information must not be shared. Discussing a patient/client or the patient's/client's condition is strictly prohibited and could create legal liability for Allen Hospital and you. This commitment to confidentiality extends to all communications taking place not only in the hospital but also outside the hospital.
7. I hereby give permission to Allen Hospital to conduct an Iowa criminal history and dependent/child abuse registry check with the Division of Criminal Investigation.

Signature _____

Date _____

Please return completed form to Volunteer Services, Allen Hospital.