

Dear Prospective Volunteer:

Thank you for your interest in the volunteer program at Spotsylvania Regional Medical Center. We appreciate your interest in fulfilling our mission to provide the highest level of service to our patients and guests. To date, more than 350 volunteers have contributed more than 33,000 hours of service.

At SRMC, volunteers make a difference in more than 30 different roles, ranging from clinical areas to office settings. Whether you prefer to direct guests upon their entrance to the hospital, serve our customers in the gift shop or provide support for our patients and our staff, we have a role that fits your strengths and your schedule. Opportunities are available for individuals who are at least 14 years old and willing to share at least four hours of service a week for six months.

To become a volunteer, you must complete and sign the attached application and agreement and return them to the Guest Services Office at Spotsylvania Regional Medical Center, 4600 Spotsylvania Parkway, Fredericksburg, VA, 22408. Once these documents and two completed reference forms have been received, you will be called for a personal interview. At that time, we will review your interests, commence a background check and discuss the necessary tuberculosis testing and immunization records that are required.

Before starting their assignments, all volunteers will attend a volunteer orientation, where important information about safety, patient safety, confidentiality, and infection control will be taught. Please note that the process from application to starting as a volunteer may take several weeks.

If you have any questions, please feel free to call me at 540-498-4142. We look forward to having you join our team!

Sincerely,

Rob Toonkel
Senior Leader, Guest Services

Questionnaire: (please use additional paper if necessary)

1. Are you presently charged with any violation of the law? (if yes, please explain) _____ Yes _____ No
2. Have you ever been convicted of a crime? (if yes, please explain) _____ Yes _____ No
3. Do you have any physical, mental, or medical limitations
that could interfere with your performance as a volunteer? (if yes, please explain) _____ Yes _____ No

4. Do you have a specific volunteer role in mind? _____

5. What has led to your interest in volunteering at SRMC? _____

6. How long of a commitment to our program are you prepared to make? _____

7. Over the next three months, how many volunteer shifts do you expect to miss because of illness,
vacation, or other commitments? _____

8. What experiences have you had that have prepared you to work at SRMC? _____

9. How do you believe you can contribute as a volunteer? _____

10. What goals do you hope to achieve by volunteering? _____

11. One thing I hope I never get asked to do as a volunteer is: _____

12. Please list some of your spare time activities or hobbies: _____

13. Please add any comments you think may be helpful in the consideration of your application:

Availability:

Please list some blocks of time when volunteering would most fit with your schedule. As shifts are four hours in length, please limit requests to those where you will be available for four or more hours.

	<u>Day of Week</u>	<u>Time Period</u>
First choice:	_____	_____
Second choice:	_____	_____
Third choice:	_____	_____
Fourth choice:	_____	_____

References:

Two personal references are required from individuals who have known you for at least 18 months. Please list the references below and give one of the enclosed forms to them with instructions to complete and return to the address listed. Please do not use family members as references.

<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>	<u>Yrs. Known</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Emergency Contact:

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Do you have any allergies? If so, please list here: _____

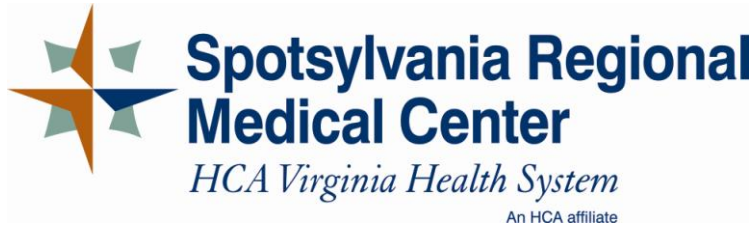
I certify that the statements made in this volunteer application are true and correct, and have been given voluntarily. I understand that my responses may be verified by Spotsylvania Regional Medical Center and that misrepresentation, falsification or omission of information may disqualify me from volunteer service.

Signature of Applicant Date

Parent/Guardian Signature for Volunteers Less than 18 Years of Age

As a parent/guardian, I have read and understood the requirements and commitment for my child to volunteer at Spotsylvania Regional Medical Center and hereby grant full permission for his/her participation in the program.

Signature of Parent/Guardian Date



Volunteer Agreement

As a volunteer at Spotsylvania Regional Medical Center:

- I will be punctual and conscientious in the fulfillment of my duties, and if for any reason I cannot serve at the assigned time, I will notify the Guest Services Department.
- I will dress appropriately while working as a volunteer, which includes a clean uniform and hospital identification badge.
- I will endeavor to make my work of the highest quality.
- Under no condition will I provide medical assistance or advice to a patient, visitor or staff member.
- I agree not to engage in any manner of religious, commercial or political solicitation while in the hospital or on hospital property.
- I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and doctors or personnel and not seek to obtain confidential information.
- I will not disclose my computer password to anyone or allow anyone to access the computer system using my password.
- I agree to read the volunteer handbook and job description which I will obtain from the volunteer office at the hospital and pay strict attention to the following policies and procedures: Customer Services, Infection Control, Age-Specific Competencies, Safety/Fire Safety, HIPAA, Right-to-Know Laws, Reporting Accidents/Incidents and Confidentiality.
- I will attend any volunteer department continuing education programs which are required.
- I shall make my best effort to fulfill my commitment to the hospital by volunteering for at least four hours per week for six months, and by completing all assignments I accept. I am aware that the option to volunteer every-other-week is not available at this time.
- I understand my services are donated to the hospital without contemplation of compensation or future employment.
- I understand that the volunteer services department reserves the right to terminate my volunteer status as a result of (1) failure to comply with hospital policies, rules and regulations (2) absences without prior notification (3) unsatisfactory attitude, work or appearance; or (4) any other circumstances which, in the judgment of the Guest Services Leader, would make my continued service as a volunteer contrary to the best interests of the hospital.

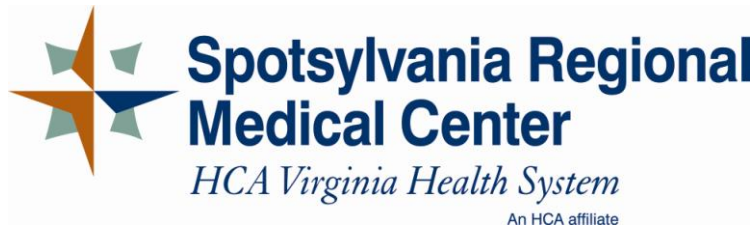
Signature of Applicant

Date

Parent/Guardian Signature For Volunteers Less than 18 Years of Age

Signature of Parent/Guardian

Date



Volunteer Callout Policy Agreement

Volunteering is a commitment to the hospital, the patients, the staff, and the Guest Services program. It is essential that all volunteers understand that they are expected to show up for their volunteer shifts each week and they are expected to uphold their commitment. While illnesses, appointments and emergencies are understandable *occasionally*, volunteers who incur frequent absences will be dismissed from the program. If you are unable to make a full commitment at this time, please submit this application after your schedule has more available space.

Please read and initial by the following statements, indicating understanding of each policy item:

* Volunteer shifts are four hours in length and the commitment is to be made each week. There are no shifts available shorter than four hours, and the option to come in every-other-week or as needed is **not** available. Volunteers who request to shorten their shifts to less than four hours will be asked to resign from the program until their schedule has more available time.

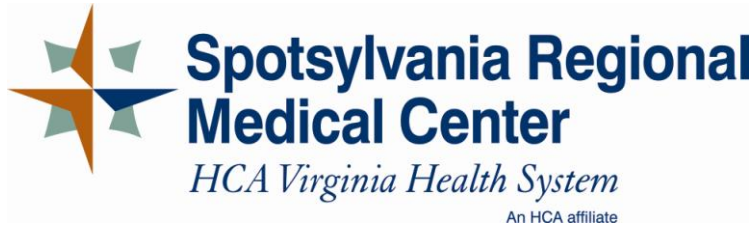
Please initial here → _____

* Volunteers are expected to make all of their shifts during their first four weeks of volunteering. If an absence is necessary during any of the first four weeks, the volunteer must take another shift that same week. If a volunteer is unable to make a shift and does not make up for it in one of his/her first four weeks, s/he will be removed from the program.

Please initial here → _____

* Volunteers who miss more than two shifts in the first five weeks, or three shifts in the first ten weeks, regardless of whether they are made up or not, will be removed from the program.

Please initial here → _____



Reference Form

APPLICANT: Please write the name and address of your reference then send this form to that individual. Remember to fill in your name and sign to authorize your reference to share the information requested.

Name of Reference: _____

Street Address _____ **City** _____ **State** ___ **Zip** _____

The applicant (name) _____ has given your name as a reference in his/her volunteer application with Spotsylvania Regional Medical Center. Kindly respond to the questions herein and feel free to make any comments you feel will be relevant. All information you provide will be kept in strict confidence. Please return this reference to the address below.

I authorize release of information about my character, work performance & attendance as applicable.

Applicant's Signature _____ **Date** _____

* * * * *
REFERENCE: Kindly complete this form and return it to the address below.

How long have you known the applicant? _____

In what capacity have you known him/her? _____

Please rate the applicant's performance as to:

	Excellent	Good	Average	Fair	Poor	Unknown
Attendance & dependability						
Motivation & spirit						
Ability to get along with others						
Communication skills						
Ability to follow directions						
Completion of assigned tasks						
Quality & accuracy of work						

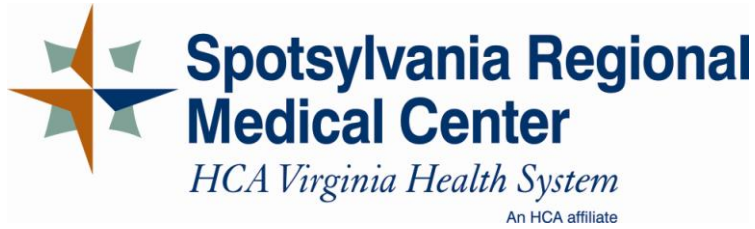
Do you have any additional comments that would be helpful to our consideration of this applicant?

Signature of Reference

Printed Name

Date

Please return this completed reference form directly to: Guest Services Office, Spotsylvania Regional Medical Center, 4600 Spotsylvania Parkway, Fredericksburg, VA 22408. Questions? Call 540-498-4142.



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