



# Volunteer Application Ronald McDonald House Charities of El Paso, Inc.

Please check the appropriate box(es):

Ronald McDonald House Volunteer

Ronald McDonald Family Room Volunteer

Instructions: Please print and complete both sides of this form and sign before turning it in. If you have any questions, please feel free to ask a Ronald McDonald House Charities staff member.

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current Address, City, State, Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Volunteers work 4 hour shifts between 8:00 am and 8:00 pm every day of the week at the Ronald McDonald House and 9:00 am 9:00 pm at the Ronald McDonald Family Room. There are exceptions such as preparing snacks/meals for families or volunteering for special events. Please list the preferred days and times you would like to volunteer.

Preferred day(s) of week: \_\_\_\_\_ Alternate day(s): \_\_\_\_\_

Preferred time of day: \_\_\_\_\_ Alternate time: \_\_\_\_\_

In what language(s) are you fluent? \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Have you ever applied before? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Age (only if you are under 18): \_\_\_\_\_

Are you a student? \_\_\_\_\_ School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

## WORK EXPERIENCE

Please list your most recent paid work experience:

Name of organization                      Contact Person                      Phone                      Dates of Employment

1. \_\_\_\_\_

Please list job duties/responsibilities: \_\_\_\_\_

2. \_\_\_\_\_

Please list job duties/responsibilities: \_\_\_\_\_

## VOLUNTEER EXPERIENCE

Please list any previous volunteer experience (PTA, church, scouts, etc.):

Name of organization                      Contact person                      Phone                      Dates Volunteered

1. \_\_\_\_\_

Please list volunteer duties/responsibilities: \_\_\_\_\_

2. \_\_\_\_\_

Please list volunteer duties/responsibilities: \_\_\_\_\_

Which volunteer duties most interest you? Please check all that apply:

\_\_\_\_\_ Front desk (House) \_\_\_\_\_ House/Family Room tours \_\_\_\_\_ Family Room (in the hospital)  
\_\_\_\_\_ Computers \_\_\_\_\_ Outdoor Work \_\_\_\_\_ Cleaning/organizing \_\_\_\_\_ Activities  
\_\_\_\_\_ Other, please explain: \_\_\_\_\_

### BACKGROUND INFORMATION

For the safety of the families staying at the Ronald McDonald House or using the Ronald McDonald Family Room, we ask that you honestly answer these next few questions. The answers to these questions are kept confidential and will not necessarily exclude you as a volunteer.

Have you ever been convicted of a felony crime? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you on a registry for sex offenders / child abuse? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Do you currently have a contagious disease or a chronic infectious disease (for example, a cold, flu, tuberculosis, chronic bronchitis, etc.)? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever had Chicken Pox? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any other health or other related conditions for which you feel may limit your ability to perform certain volunteer duties? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

### REFERENCES

<u>Name</u>	<u>Company / Organization</u>	<u>Phone</u>	<u>Relation &amp; # Years Known</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

I hereby certify that the above information is accurate. If needed, I authorize proper authorities to release my records or information regarding me to the Ronald McDonald House at 300 E. California, El Paso, TX 79902, specifically, but not limited to any felony or criminal records I have.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18, Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please initial below if you agree with the following statement:

\_\_\_\_\_ I authorize RMHC El Paso to take and use photographs of me in the normal course of my activities as a volunteer of RMHC El Paso and use such photos with or without my name in newsletters, brochures, or any other promotional purposes on behalf of Ronald McDonald House Charities of El Paso and its programs.



**BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM**

**DISCLOSURE**

This form, which you should read carefully, has been provided to you because a Tenet Healthcare facility (the "Company") may request consumer reports on you from a consumer reporting agency. The Company will use any such report(s) solely for employment purposes, including those associated with contractors, students, volunteers, physicians and other performing work for the Company.

Consumer reports on you will be obtained by the Company from HireRight, Inc., ("HireRight") located at 2100 Main Street, Suite 400, Irvine, CA 92614. They can be contacted at 1 800-400-2761. Information that may be obtained includes social security number verification, criminal records, public court records, educational records, verification of employment positions held and verification of licensing and certifications. The information contained in these reports may be obtained by HireRight from private and/or public record sources including sources identified by you in your job application.

- A credit history will be procured *only* if the position you are applying for has fiduciary or cash handling responsibility, you would be issued a corporate credit card once employed, or if you will be entering into a relocation agreement.
- A driving records check will be procured *only* if the position you are applying for requires a valid driver's license.

With this Disclosure and Authorization form you are also being provided a copy of a "Summary of Your Rights Under the Fair Credit Reporting Act" as issued by the Federal Trade Commission.

**AUTHORIZATION**

By signing your name below you :

- Indicate you have carefully read and understand this Disclosure and Authorization form
- Consent to the release of consumer reports to the Company in conjunction with your job application
- Understand that if the Company hires you, your consent will apply throughout your employment unless you revoke or cancel your consent in writing by sending a signed letter or statement to the company
- Authorize the disclosure to HireRight of information concerning your employment history, earning history, education, criminal history, credit history (when pertinent to the position being applied for) and motor vehicle history (when pertinent to the position being applied for).

This Disclosure and Authorization form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth (for ID purposes only) \_\_\_\_\_

Present Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

For California Facilities and residents of California, Minnesota and Oklahoma: Please check the appropriate box below.

I would like a copy of the report.  I waive my right to receive a copy of the report.

If you live or are applying for a job in the state of California, please review this additional notice: You may view the file maintained on you by HireRight during normal business hours. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at HireRight's offices in person, during normal business hours and on reasonable notice, or by mail. You may also receive a summary of the file by telephone. HireRight has trained personnel available to explain your file to you, including any coded information. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification

**SIERRA PROVIDENCE HEALTH NETWORK**  
**Volunteer Ethics Guidelines Agreement**

**If accepted as a hospital volunteer, I agree that:**

- 1) I shall, hold as absolutely confidential all information I may obtain, directly or indirectly concerning patients, doctors or personnel and not seek to obtain confidential information from a patient.**
- 2) My services are donated to the hospital without expectation of compensation or future employment and are strictly for humanitarian or charitable reasons.**
- 3) I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies on hospital property or act as a runner or capper for any attorney in the solicitation business. I shall report all known occurrences of such solicitation to my supervisor.**
- 4) I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petitions or religious material on hospital premises unless I receive the express authorization of the hospital CEO to engage in these activities.**
- 5) I shall, if requested, submit to examinations, which may include chest X-rays, skin tests, appropriate lab tests and/or immunizations that may be necessary as part of my volunteer services. If requested, I hereby authorize my doctor(s) to furnish the hospital information concerning my health, including X-ray results.**
- 6) I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others and endeavor to make my work professionally in quality.**
- 7) I shall attempt to resolve any problems related to my volunteer activities with my supervisor.**
- 8) I shall do my best to fulfill my commitment to the hospital by completing all assignments that I accept.**
- 9) I shall at all times uphold the philosophy and standards of the hospital.**
- 10) I understand that the hospital reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules, and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; and (d) any other circumstances which, in the judgment of the department director, would make continued service contrary to the best interest of the hospital.**

**I have read each of the above conditions and I agree to be bound by them.**

**Volunteer Signature:\_\_\_\_\_ Date:\_\_\_\_\_**

## **SIERRA PROVIDENCE HEALTH NETWORK SEXUAL AND OTHER UNLAWFUL HARRASSMENT**

We are committed to providing a work environment free from discrimination and unlawful harassment. Action works, jokes or comments based on an individual's sex, ethnicity, age, religion, sexual orientation or any other legally protected characteristic will not be tolerated. As an example, sexual harassment (both overt and subtle) is a form of employee/volunteer misconduct that is demeaning to another person, undermines the integrity of the employment or volunteer relationship, and is strictly prohibited. Anyone engaging in sexual or other unlawful harassment will be subject to corrective action, up to and including termination of employment or volunteer placement.

Examples of unlawful sexual harassment include, but are not limited to, unwelcome sexual advances, requests for sexual favors and other verbal, visual or physical conduct of a sexual nature where:

- Submission to such conduct is and implies or expressed condition of employment.
- Submission to or rejection of such conduct is the basis for employment decisions affecting the individuals; or
- The conduct has the effect of interfering with an individual's work performance of creating an intimidating, hostile or offensive work environment.

Any employee/volunteer who wants to report an incident of alleged sexual or other unlawful harassment should promptly report the matter to his or her supervisor. If the supervisor is unavailable or the employee/volunteer believes it would be inappropriate to contact that person, the employee/volunteer should immediately contact his/her Human Resources Representative. Employees/volunteers may raise concerns and make reports without fear of reprisal. Employees/volunteers must utilize the Fair Treatment policy to resolve such issued.

The policy applies to all employees and volunteers, supervisors, managers and department heads as well as physicians, whether or not employed by Tenet. This policy also may, under certain circumstances, apply to agents and non-employees who have contact with our employees or volunteers.

If you have any questions concerning this policy, please feel free to contact your Director of Coordinator of Volunteer Services or a Human Resources Representative at any time.

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Signature

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Date

Reviewed 9/97  
Reviewed 10/98  
Reviewed 11/99  
Reviewed 5/00  
Reviewed 1/07

# **SIERRA PROVIDENCE HEALTH NETWORK**

## **ACKNOWLEDGEMENT/CONFIDENTIALITY STATEMENT BELOW**

I understand and agree that the performance of my duties as a volunteer of the Sierra Providence Health Network, I must hold in strictest confidence any observations I may make or hear regarding clients, client families or staff.

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, including termination, by Sierra Providence Health Network and/or possible legal action by others (ie. clients, families, or staff).

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, including termination, by Sierra Providence Health Network and/or possible legal action by others (ie. clients, families of clients, etc).

Violation of hospital policies and or infractions of Auxiliary Rules an Ethics could terminate your membership in the Auxiliary and/or Volunteer Program. Each Volunteer must realize that they represent the Auxiliary and/or Volunteer Program as well as the Sierra Providence Health Network and must act accordingly.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PLEASE NOTE:**

You will be scheduled for a Health Assessment Appointment upon completion of the Mini-Orientation session.

The next four "Health Assessment" pages need To be completed, signed and detached.

**(You will keep these with you)**

You will be required to bring these four forms With you to your Health Assessment appointment along with a copy of your immunization records (if you have a copy available)

The Occupational Health Nurse will have blood drawn (to measure your titers for immunizations) and you will receive a Tuberculosis (TB) test. You will be required to return to the Occupational Nurse within 48 hours to have your TB test read.

Once this has been completed, you will receive a badge and Your schedule will be discussed.

Thank you.

## TUBERCULOSIS TESTING PROCEDURE

(for Volunteers)

Name: \_\_\_\_\_

SSN# \_\_\_\_\_

Dept.: \_\_\_\_\_

Date: \_\_\_\_\_

### Complete Tuberculosis testing procedure (PPD or Chest X-ray) on:

1. All prospective employees/volunteers prior to reporting to work or attending orientation.
  2. Annually for all employees involved in direct patient care activities.
  3. Annually for all staff not involved in patient care.
  4. Employees exposed to active Tuberculosis. Test at time of exposure and 70 days later.
- \*\*Potential and current employees/volunteers are exempt from the TB testing procedure if they have documentation of PPD or Chest x-ray performed within the past month. Chest x-rays of staff who are candidates for TB skin testing are not accepted as a substitute for skin testing. All new employees are new volunteers will follow the 2 step procedure.\*\**

Candidates for PPD skin testing:

- Persons with a history of negative reactions to PPD
- Persons with a history of BCG vaccination
- Pregnant personnel
- Employees and volunteers only

Candidates for Chest x-ray

- New employees and volunteers whose PPD is positive
- Persons with a history of Tuberculosis infection, active disease or positive PPD
- Persons with symptoms suggestive of TB (bloody sputum, night sweats, productive cough, weight loss and fever)
- Converters

Administration and interpretation of PPD skin tests:

1. Administration: Administer 0.1 ml of PPD (5 TU) just beneath the skin surface on the anterior surface or the forearm. A discrete pale elevation of the skin (a wheel) that is 6-10 mm in diameter should be produced. If a wheel is not produced, administer a second skin test at an alternate site.
2. Interpretation: Read skin test between 48 to 72 hours after injection by Employee Health Office.
  - a. Self-reading PPD test result is not accepted.
  - b. Results are not recorded as a "Positive" or "Negative." Record the transverse (crosswire) diameter of induration (area of hardness) in millimeters. Do not measure redness of erythema.
  - c. If any induration is noticed, chest x-ray will be taken and referral to EPCCHD.
3. Do you have any of the following?

Persistent cough	___ Yes	___ No
Bloody Spetum/phlegm	___ Yes	___ No
Fever	___ Yes	___ No
Night sweats	___ Yes	___ No
Unexplained weight loss	___ Yes	___ No
General fatigue	___ Yes	___ No

PPD #1	PPD #2
Date given: _____ Site: _____	Date given: _____ Site: _____
Lot # _____ Exp. Date: _____	Lot # _____ Exp. Date: _____
Date read: _____ Results: _____ mm	Date read: _____ Results: _____ mm

Date of Chest X-ray \_\_\_\_\_

Results: \_\_\_\_\_

Referral to EPCCHD \_\_\_\_\_

Appointment: \_\_\_\_\_

Date of completion of chemotherapy: \_\_\_\_\_ Mask fit testing size: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

OHS Signature: \_\_\_\_\_ Date \_\_\_\_\_







**SIERRA PROVIDENCE HEALTH NETWORK  
OCCUPATIONAL HEALTH SERVICES  
EMPLOYEE LAB ORDERS**

SMC\_\_\_\_\_

PMH\_\_\_\_\_

SPPRH\_\_\_\_\_

Employee's Name:\_\_\_\_\_

SSN:\_\_\_\_\_ DOB:\_\_\_\_\_

Male:\_\_\_\_\_ Female\_\_\_\_\_ Date:\_\_\_\_\_ (Void after 30 days)

Order Number:\_\_\_\_\_

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\_\_\_\_CBC

\_\_\_\_HbsAB/HEMP

\_\_\_\_CHEM12

\_\_\_\_RUBELLA TITER

\_\_\_\_LIPID PROFILE

\_\_\_\_RUBEOLA TITER

\_\_\_\_DIRECT LDL

\_\_\_\_VARICELLA TITER

\_\_\_\_LIPID INTERPRETATION

\_\_\_\_OTHER

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DONNA KINCAID, RN\_\_\_\_\_

KRIS HOWARTH, RN\_\_\_\_\_

RANDALL VAN STONE, RN\_\_\_\_\_

This form revised April 1, 2005. All other versions are now obsolete.  
Please do not accept any other laboratory request form for Occupational/Employee Health Nurse accounts.