St. Augustine Health Ministries

7801 Detroit Avenue • Cleveland, Ohio 44102 • (216) 939-7601

**ST. AUGUSTINE HEALTH CAMPUS • HOLY FAMILY HOSPICE • CHILD ENRICHMENT CENTER**

# VOLUNTEER APPLICATION

**PLEASE PRINT**

| | | |
|---|---|---|
| **Today's Date:** | | |
| ❑ Mr. ❑ Ms. ❑ Mrs. ❑ Miss | First Name: | Last Name: |
| Birthday: | E-Mail Address: | |
| Street Address: | | Apt. # |
| City: | | Zip: |
| Preferred Phone: | Have you worked or volunteered for us before? ❑ No ❑ If yes, when? | |
| Occupation: | Name of Employer: | |
| Previous Work Experience/Special Training: | | |

**Volunteer Work Experience:**

| Agency or Organization | Assignment | Length of Time |
|---|---|---|
| | | |
| | | |

**Volunteer Areas of Interest / Special Skills:**

DIRECT RESIDENT/PATIENT CARE

- ❑ American Sign Language (ASL)
- ❑ Appointment Escort
- ❑ Cafeteria Assistant
- ❑ Child Care
- ❑ Eucharistic Minister / Sacristan
- ❑ Exercise / Stretching / Warmup
- ❑ Friendly Visitor
- ❑ Hospice / Vigil Sitter
- ❑ Massage

DIRECT RESIDENT/PATIENT CARE

- ❑ Music – Vocal or Instrumental
- ❑ Pet Therapy
- ❑ Recreation / Activities
- ❑ Wheelchair Assistance / Transport

INDIRECT RESIDENT/PATIENT CARE

- ❑ Gardening
- ❑ Laundry Assistant
- ❑ Sewing

ADMINISTRATIVE

- ❑ Clerical / Filing
- ❑ Computer / Data Entry
- ❑ Marketing / Fundraising
- ❑ Receptionist
- ❑ Social Media

❑ Other: _____

What languages (other than English) do you speak/write/read? _____

Do you belong to a church? ❑ No ❑ If yes, name of church: _____

Do you have any issues that could impact your ability to volunteer? ❑ No ❑ If yes, please explain:

_____

_____

How did you hear about us? _____

Why do you want to volunteer for us? _____

_____

Preferred Location: ❑ Health Campus (nursing home/assisted living/child care) ❑ Holy Family Hospice

**HOSPICE VOLUNTEERS:** If you've experienced the loss of a loved one in the last year, please share:

_____

_____

**Personal or Professional References (who have known you for at least one year, *excluding relatives*):**

| Name | Address, City, State, Zip | Phone |
|---|---|---|
| | | |
| | | |
| **Third reference required for Holy Family Hospice volunteers only.** | | |

**Emergency Contact:**

| Name | Relationship | Phone |
|---|---|---|
| | | |

I certify that the statements made in this Volunteer Application are true and correct and have been given voluntarily. I agree to abide by the organizations' rules and policies and I understand that opportunities for volunteers are provided without regard to race, color, national origin, religion, sex, age or disability. I understand the organization is neither obligated to provide a volunteer position nor am I obligated to accept the volunteer position offered.

Signature _____ Date _____

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# CRIMINAL BACKGROUND CHECK

| | |
|---|---|
| 1. | Have you ever been convicted and/or been found by a court of competent jurisdiction or a state agency of abusing, neglecting or mistreating patients or of misappropriating patients' property in this state or in any other state?<br>❑ No ❑ Yes If so, please describe the offense, the date and place of the conviction and the underlying circumstances or other information to help us evaluate your current fitness to become a volunteer. |
| 2. | Have you ever been convicted of (1) felony, (2) cruelty to persons, or (3) assault of a victim sixty years of age or older?<br>❑ No ❑ Yes If so, please describe the offense, the date of the conviction and the underlying circumstances or other information to help us evaluate you current fitness to become a volunteer. |
| 3. | Have you ever been sanctioned by a healthcare licensing agency in this or another state or in any other United States or foreign jurisdiction?<br>❑ No ❑ Yes If so, please identify the nature and the date of the action, the licensing agency involved, and the underlying circumstances or other information to help us evaluate your current fitness to become a volunteer. |

I hereby certify that I have not been convicted and/or found guilty of patient abuse, neglect, or mistreatment, or misappropriation of patient property in this state or in any state and that I am not listed in any resident or patient abuse registry in this state or in any other state. I understand that any offer to become a volunteer by St. Augustine Health Ministries is conditional upon verification of this information with the state patient abuse registry and that a listing on such a registry or registries of any other state may act as an automatic withdrawal of any such offer to become a volunteer.

_____ _____

Volunteer Applicant Signature Date

# AUTHORIZATION AND CONSENT

I hereby release from liability St. Augustine Health Ministries and all its representatives for their acts performed in connection with obtaining information and evaluating my qualifications to serve as a Volunteer for St. Augustine Health Ministries. I hereby release from liability any and all individuals and organizations that provide information to St. Augustine Health Ministries or its representatives concerning my competence, character or other qualifications required for acceptance as a Volunteer and I hereby consent to the release of such information.

I hereby certify that I have not been convicted and/or found guilty of patient abuse, neglect or mistreatment, or misappropriation of patient property, nor am I listed in any resident or patient abuse registry, in this state or any other state. Any offer to become a Volunteer is conditional upon verification of this information.

I hereby authorize St. Augustine Health Ministries to communicate with other entities and individuals concerning knowledge of my competence and character and agree to hold St. Augustine Health Ministries and its representatives free of liability therefore.

_____ _____

Volunteer Applicant Signature Date

_____

Print Name