

Hospice Volunteer Application Form

Effective: 11/01/2013

Reviewed: 11/29/2021

Forms Revised: 11/29/2021

Version: 2

Hospice

We are an equal opportunity employer and do not discriminate against otherwise qualified applicants on the basis of age, ancestry, color, creed, disability, gender, handicap, marital status, national origin, race, religion, or veteran status. Please print all information requested except your signature. The acronym "NA" represents the words "Not Applicable" and should only be used to signify a question cannot be applied.
INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED FOR ANY PURPOSE.

Date:	Full Name (Last, First, MI):	Email:
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Social Security Number(optional):	Date of Birth:
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Street Address (Street, City, State, & Zip):
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Mailing Address (Street, City, State, & Zip):

Phone numbers and type:	Ok to call?	Best time of day?
Home:		
Work:		
Cell:		

Have you ever been employed by the location or an affiliated company? **YES NO** If yes, what was your reason for leaving?

Are you over the age of 18? YES NO	Are you able to perform the essential functions of the job for which you are applying with or without reasonable accommodations? YES NO	Are you lawfully employable in the United States either by virtue of citizenship or by having authorization from the Bureau of Citizenship and Immigration Services and the United States Labor Department? YES NO
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Do you require any reasonable accommodation to assist you in completing the application process? **YES NO** (If yes, please describe the reasonable accommodation request.)

Have you ever been discharged from employment or been asked to resign? **YES NO** If yes, please explain.

Have you ever been known by or worked by another name? **YES NO** If yes, please list your other names for employment reference checks.

Do you have personal responsibilities that will interfere with your ability to meet volunteer requirements, including regular attendance or notification if chosen as a volunteer? **YES NO** If yes, please explain.

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Have you ever been convicted of a crime other than a minor traffic infraction? **YES NO**
 *Please note a DUI is a criminal offense and a plea bargain or a plea of *no lo contendere* to any crime is considered a guilty disposition. Any "first offender" or "youth" court conviction, plea bargain or a plea of *no lo contendere* to any crime is considered a guilty disposition. If you have been convicted of a crime, please include what, when, where, and the disposition of the case. Every criminal conviction must be accurately and completely disclosed below. Please request an additional sheet if necessary. Failure to disclose all criminal convictions on this form could determine an employment decision.

Please list ALL languages you are able to speak, read, write, and/or sign.

Do you have diplomas, degrees, certificates, or professional licenses in a particular field of study? **YES NO**
 (If yes, what are they?)

What schools have you received them from? **N/A**

Do you have military education, training, or experience? **YES NO**

If so, what branch of the Uniformed Service of the United States did you serve? **N/A**

Were you honorably discharged? **YES NO N/A**

What was your rank at the time of discharge? **N/A**

Please list three references.

Name:		Phone Number:			Time Known:	
Please list your available hrs.	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
						Saturday

What date will you be able to begin volunteering?

Work History

Are you currently employed? YES NO	Who is/was your current/most recent employer?
What is/was the name of your supervisor?	What is/was your job title?

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What do/did you like best about your job?	May we contact your current/most recent employer? YES NO (If yes, please provide contact information such as name, phone number, and length of employment.)
What are/were your job duties?	Describe your most significant accomplishment.
Do you have any special talents or gifts (i.e., art therapy, music therapy, pet therapy, etc.) that you would like to share with a hospice patient?	

I hereby authorize the location to investigate all information given in this application and specifically to obtain information concerning me from prior employers and from any person listed as a reference. I certify the information given on this application is correct. I understand any misrepresentation or omission of facts called for in this or any other location document completed either prior to or during the employment relationship, will be cause for immediate dismissal without notice. I release the location and all representatives, employees, and agents thereof from and any and all liability or damages in connection with efforts to verify or investigate such information. I release all third parties and all persons providing information to the location in connection with this application from any and all liability or damage on account of having obtained or furnished the same.

The location may require applicants to undergo testing for the presence of illegal drugs as a condition of employment. Any applicant with a confirmed positive test will be not be considered as a volunteer. Applicants who refuse to submit to the location's substance abuse testing procedures will not be considered for volunteering. By signing this application form, the applicant hereby consents to the administration of any drug tests and hereby releases the location from any and all liability and damage related thereto.

I understand acceptance as a volunteer can be rescinded if it is determined I cannot perform the essential functions or requirements with or without reasonable accommodation, or that I pose a direct threat to the health or safety of others or myself in the workplace. I further understand the location will make reasonable efforts to accommodate a covered disability to the full extent of the law. I also understand all medical or disability related information supplied by or concerning me will be held in strict confidence by the location, subject to certain disclosures permitted by applicable law. I understand that the COVID vaccine is a requirement for hospice volunteers and will provide proof of full vaccination within 30 days of this application and prior to volunteering in any patient care areas.

I understand and agree if the location accepts me as a volunteer, investigative background inquiries will be conducted. The background inquiries may include but are not limited to the following: background checks, Social Security Number trace reports, and OIG/GSA sanctioned searches. I understand acceptance can be rescinded based upon the results of the investigative background inquiries. I understand the location or its authorized agent requests information from various federal, state, and other agencies that maintain records concerning my past activities relating to my driving, criminal, civil, and other experiences.

I agree to comply with all the rules and regulations of the location in effect now and any others that may be instituted at a later date.

I understand if accepted as a volunteer that my status may be terminated for any reason or no reason at the option of the location or myself. I understand no management representative or other person had any authority to enter into any agreement for any specific period of time or to make any agreement contrary to the foregoing, or to enter into any oral contracts or any other term or condition of participation as a volunteer in the volunteer program. I further understand no written policy statements, handbooks, memoranda or any other materials provided to me by the location are intended to serve as written or implied acceptance into the volunteer program.

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Date

Signature of Applicant

The potential volunteer has been informed that volunteer acceptance is conditional upon completion of screenings, trainings, and vaccination record. All questions on the application form have been Completed: **Yes No**

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Date

Signature of Volunteer Coordinator/Designee

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Applicant Sanction Check Consent and Authorization Form

Issued: December 2003
Revised: 7/08; 4/09

UHS-Pruitt
HR 2.105a
Version: 3

Policy: Partner Sanction Checks

Applicant hereby certifies that he/she:

- Has never been excluded, suspended, debarred or otherwise deemed ineligible to participate in Federal and/or State healthcare programs.
- Has never been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in the healthcare programs after a period of exclusion, suspension, debarment, or ineligibility.

Clearly Printed Name of Applicant: _____

Signature of Applicant: _____ Date: _____

Applicant further acknowledges that he/she:

- Has never been excluded, suspended, debarred or otherwise deemed ineligible to participate in any and all federal procurement programs.
- Hereby authorizes _____
(Name of Company)
to review, on an ongoing basis while a partner of _____,
(Name of Company)
pertinent government databases to make sure the eligibility status of the partner as required by relevant federal and state mandates.

Signature of Applicant: _____ Date: _____

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