



**DUKE UNIVERSITY HOSPITAL
VOLUNTEER SERVICES APPLICATION**

- All volunteer candidates should plan to schedule a face-to-face interview before being accepted into a program.
- To obtain the application forms and information regarding the available programs and opportunities for volunteering at Duke, please visit our website at:
http://www.dukehealth.org/patients_and_visitors/volunteer_services/volunteering_at_duke
- Please return the entire completed application packet to the program coordinator in your area of interest:
- A completed application packet includes:
 - Application form
 - Two written references from non-family members
 - Signed background check form
 - Blue "Volunteer Clearance form" from Employee Health. (We cannot accept private medical information with your application.)

Name: _____
(Last) (First) (Middle)

Maiden Name or Alias: _____ Home Phone _____ Cell Phone _____

Current Address: _____
(Street)

(City) (State) (Zip) (County)

Vest size: _____

Home Address _____
(City) (State) (Zip)

Email address: _____

Are you at least 18 years of age? _____ Date of birth _____

(If NO, you must apply through the Junior Volunteer process.

Please see our website for specific information regarding this program.)

How did you learn about our Volunteer Program? **(Please provide the name of the resource you used to learn about our programs)**

Friend _____ Organization _____ Internet _____ Duke Hospital website _____ Current
Duke Employee _____ Other (please specify) _____

Volunteer Program to which you are applying: _____ (*please apply to only
ONE volunteer program*)

Please list your Duke Unique ID if you currently have one: _____

Emergency Contact Person: _____ Relationship: _____

Telephone number: _____ (please list whether this is a home, work, or cell phone number)

EMPLOYMENT: If currently employed, please list your current employer's name and address below.

How long have you been with this employer? _____

May we contact you at work? Yes ☐ No ☐ N/A ☐ If yes, please provide your work phone

Are you presently enrolled at a school or university? **If yes, list school and graduation year.**

What is your current area of study? _____

EXPERIENCE/SKILLS:

Have you had previous volunteer experience? _____ Are you involved in other community service organizations? _____
(Churches, Clubs, Service Organizations)

If so, please provide the following information for each volunteer experience/organization:

Volunteer Experience/Service Organization	Program Supervisor and Phone Number	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you previously volunteered at Duke Hospital? _____

If yes, please list volunteer program name(s) and dates of service _____

Please list any educational, personal, or professional experience that you would like us to consider in your volunteer application:

Can you speak fluently, read or write a language other than English? _____

If yes, please list specific language(s) below:

Language(s) _____ Speaks Fluently _____ Read/Write _____

AVAILABILITY: (* **All Volunteers are asked to commit 4 hours per week for one year***)

Days and Hours available to volunteer:

<input type="checkbox"/> Monday	<input type="checkbox"/> Friday	<input type="checkbox"/> 8:30 AM-12:30 PM
<input type="checkbox"/> Tuesday	<input type="checkbox"/> Saturday	<input type="checkbox"/> 12 NOON- 4:00PM
<input type="checkbox"/> Wednesday	<input type="checkbox"/> Sunday	<input type="checkbox"/> Other _____
<input type="checkbox"/> Thursday		

INTERESTS:

Please describe activities that you participate in: _____

Please describe the factors that influenced your decision to volunteer at Duke University

Hospital: _____

REFERENCES and BACKGROUND CHECK

Please see the attached forms to give to two (2) references for completion. Ask that attached forms be returned in a sealed envelope with his or her signature across the back of envelope. Please list references below. Family members cannot serve as references.

Reference Name	Phone Number	Email
1. _____	_____	_____
2. _____	_____	_____

Background:

Have you ever been convicted of a crime other than a minor traffic offense? Yes _____ No _____

Note: ALL volunteer positions at Duke University Hospital require a Court Record Release/Background Check

Volunteer Services Agreement

In connection with my activities as a volunteer I agree to hold confidential all information to which I may have access. This includes, but is not limited to, information on current, former, or prospective patients, employees, students, and scholars. *Disclosure of such information to unauthorized persons is prohibited and may result in my dismissal from the volunteer program and may have additional legal consequences.*

I am aware that DUKE HEALTH does not provide insurance coverage for volunteers if personally injured or if damage occurs to personal property while acting as a volunteer. I further understand that I am not entitled to worker's compensation benefits, health insurance benefits, or any other benefit available to employees of Duke University. I agree that I will not hold DUKE HEALTH or its officers or agents thereof liable for any injury sustained to person or property while acting in a volunteer capacity.

The information provided in this application for volunteering is true, correct and complete. If accepted as a volunteer, any misstatement or omission of fact on this application may result in my ineligibility for volunteering, or if accepted as a volunteer may result in my dismissal. I hereby authorize Duke University Hospital to determine my suitability and justification for my role as a volunteer, to contact any or all of my references.

I authorize schools, employers and references named in this application to provide Duke University Hospital with any relevant information that may be required to arrive at a decision regarding being accepted as a volunteer. In connections therewith and in consideration of the undertaking of Duke University Hospital to review this application for volunteering and to consider me for a volunteer position, I hereby release and acquit Duke University Hospital from any liability whatsoever for any damage which I may suffer or sustain by reason of its use of any such information.

I understand that should I be offered a volunteer position, I am required to have a volunteer health screening prior to beginning work. The volunteer health screening is provided by the hospital. I realize that Duke University Hospital conducts background checks when considering applicants for positions and that I will be requested to complete a background check form which requires date of birth and social security number to facilitate the background check. I understand that volunteer positions at Duke University include a commitment of 4 hours each week for one full, continuous year unless otherwise specified.

I have completed the above information to the best of my ability and understand that any falsification of the information provided above may disqualify me to become a volunteer.

Signature of Volunteer

Date



**Duke University Hospital Volunteer Services
Request for Reference**

***To be completed by applicant:** Please fill out your name and volunteer program.

_____ has applied to be a volunteer with the
(Applicant Name)

_____ Volunteer Program.
(Volunteer Program)

NOTE: Please have recommender place reference form in sealed envelope with his or her signature across the back of the envelope and return with completed application.

Please respond to the following questions with care and be as complete as possible.

1. In what capacity have you known the Volunteer applicant, and for how long?
2. Briefly, how would you describe the applicant?
3. What strengths do you believe the applicant will bring to this position as a volunteer?
4. What do you think may be the applicant's greatest challenge in volunteering here?
5. We have very strict policies on confidentiality for our volunteers, do you think the applicant will be able to understand and follow these policies? Why or why not?
6. On a scale of 1 to 5, 1 being Poor and 5 being Excellent, rate the applicant on the following:

Ability to work in a team	_____	Ability to work independently	_____
Use of conflict resolution skills	_____	Ability to take direction	_____
Flexibility	_____	Communication	_____
Dependability	_____	Honesty/Integrity	_____
Organizational Skills	_____	Multi-Tasking Skills	_____
7. Would **you** have this applicant volunteer with your organization or business? Why or why not?

I VERIFY THE ABOVE INFORMATION TO BE CORRECT

Printed Name

Signature

Date

E-Mail Address

Contact Phone



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I VERIFY THE ABOVE INFORMATION TO BE CORRECT

Printed Name

Signature

Date

E-Mail Address

Contact Phone



Background Screening for Duke University Hospital

NOTE: ALL FIELDS MUST BE COMPLETED or application will not be processed.

***Are you a current Duke employee with an employment status that can be verified through Duke HR?**
_____ (this does not apply to Duke Student employees)

Please PRINT Clearly

*First Name: _____

*Full Middle Name: _____

*Last Name: _____

*Social Security Number: _____ - _____ - _____

*Date of Birth: ____/____/____

*State: _____ *County Volunteer is currently living in: _____

*Email: _____

*Contact Phone: _____

Please list **all prior states** you have lived in
(required): _____

If you do not know the following information, please do NOT submit this form until you have been interviewed and accepted to a specific volunteer program, as it will delay your volunteer service at Duke Hospital.

*Volunteer Program: _____

*Volunteer Coordinator & Contact Information: _____

Signing this form gives Duke Hospital Volunteer Services express permission to check any and all background databases regarding applicant.

*Signature of volunteer: _____ Date: _____



Volunteer – Health Review Sheet

Instructions

- Please fill out this form and **take it to your appointment** with Duke Employee Occupational Health and Wellness (EOHW) to complete the required Health Review.

Employee Occupational Health and Wellness Clinic Information/Location

**** Please call to schedule your appointment ****

***New volunteers will be scheduled between the hours of 8:00am – 3:00pm by appointment only Monday – Friday ***

Located in Duke Clinic

Orange Zone (sub-basement) or enter from Flowers Drive

Telephone: 919-684-3136 – option #2

- **Bring any official vaccine records you may have to your appointment.**
- Upon completion of your EOHW process, you will be given a Volunteer Health Recommendation form.
 - **It is your responsibility to take the Volunteer Health Recommendation Form that you receive from Employee Health to your coordinator before you sign up for training and orientation with your assigned area.**
- **Flu Vaccine is now an annual requirement in order to volunteer at Duke University Hospital. You will receive flu vaccine as part of your Employee Health volunteer screening and/or every fall. There is no additional cost to you.**

Demographic Information

Coordinator to complete the areas with asterisks *

Name _____

Last	First	Middle

Duke Unique ID#	Date of Birth
-----------------	---------------

Address _____ City _____ State _____ Zip _____

Home/Cell Phone	Work Phone
-----------------	------------

Email address:

*Volunteer Program	Volunteer Coordinator
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*Will the volunteer duties involve close interaction with children under 18 months of age? Yes No

*If yes, Describe duties

Are you a Duke University or Duke Health System employee? Yes No

This form is to be completed by Duke Employee Occupational Health and Wellness. This **Volunteer Health Review Sheet** is mandatory for your participation in the volunteer program. The health review information is important in protecting the health and safety of the Duke University Medical Center volunteers, patients, students and visitors. Upon completion of your health review, Employee Occupational Health and Wellness will provide your **Volunteer Health Recommendation Form**.

Communicable Disease/Immunization History

Before clearance is granted prospective volunteers must submit documentation of the following:

- 1. TB testing must be performed 6 months prior to your volunteer application date.** PPD OR TSpot OR QuantiFERON Gold are accepted. If any of the tests are positive a chest x-ray report, discussion of latent TB and INH treatment recommendations must be documented and attached to volunteer health review sheet. History of a positive TB test also requires a chest x-ray performed within the last 12 months. TB testing must be performed within the U.S.

Tuberculin Skin Test: Date placed: ____/____/____ Date read: ____/____/____ Result: ____ # of mm induration OR

QuantiFERON (QFT-G) or T-Spot: Date: ____/____/____ Result: _____ (lab report must be included)

- 2. Proof of immunity to Measles, Mumps and Rubella.** Two doses on or after the first birthday, and at least 28 days apart. If there is no record of MMR, positive antibody titers of Measles, Mumps, and Rubella will be accepted.

MMR #1 ____/____/____ **MMR #2** ____/____/____ **OR MMR Titer** (lab reports must be included)

- 3. Proof of immunity to Varicella.** Two doses OR a positive antibody titer.

Varicella #1 ____/____/____ **Varicella #2** ____/____/____ **OR Varicella Titer** (lab report must be included)

- 4. Tdap** ____/____/____ **Td booster** required if last dose of Tdap was greater than 10 years. ____/____/____

- 5. 2017-2018 Influenza vaccine** ____/____/____ (required during flu season)

Form must be completed by a MD, DO, PA, NP, RN or LPN, NOT a family member. Official stamp from a doctor's office, clinic or health department AND an authorized signature must appear on this form.

Clinician Name (print): _____ **Title:** _____ **Phone #** _____

Clinician Signature: _____ **Date:** ____/____/____

Address/Official Stamp Here: _____