



VOLUNTEER SERVICES APPLICATION

NOTE: All Volunteers will be required to participate in a face-to-face interview, submit an application, provide professional references for checking, complete a background check, health screening, attend an orientation, and complete a training program prior to placement. Applicants who provide false information or have a negative background check may be disqualified for, or terminated from, service.

Completed application and references must be submitted together in one packet. Please return the completed packet to the program coordinator in your area of interest. A completed application packet includes: 1) application form 2) names and telephone numbers of references on form 3) background check form and 4) blue "Volunteer Clearance form" from Employee Health or Student Health.

Please do not submit any medical records with your application. We are unable to accept incomplete applications.

To obtain 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

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

Maiden Name or Alias(es) _____ Home Phone _____ Cell Phone _____

Current Address: _____
(Street)

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

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

Email address: _____

Are you at least 18 years of age? _____ Last 4 Digits of SS# _____
(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 list your Duke Unique ID if you currently have one: _____

Emergency Contact Person: _____ Relationship: _____

Home Number: _____ Work Number: _____ Cell 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 languages below:

Language _____	Speaks Fluently _____	Read/Write _____
Language _____	Speaks Fluently _____	Read/Write _____

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

Days and Hours available to volunteer:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday
- 8:30 AM-12:30 PM
- 12 NOON- 4:00PM
- Other _____

INTERESTS:

Please describe activities that you participate in: _____

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

Hospital: _____

REFERENCES and Criminal Check

3 references are required below: (coordinator must telephone references and complete reference sheet for each volunteer)

Reference Name	Phone Number	Relationship (do not list family members)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Background:

Have you ever been convicted of a crime other than a minor traffic offense? _____

If Yes, when, where, and nature of offense, disposition: _____

Note: ALL volunteer positions at Duke University Medical Center 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 Medicine 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 Medicine 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 and includes drug testing. 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.

By my signature below, I certify that I am not a foreign national of any of the following sanctioned countries: Cuba, Sudan, Iran, North Korea, Syria, Belarus, Burma (Myanmar), Democratic Republic of Congo, Iraq, Ivory Coast, Liberia, Libya, Somalia, Zimbabwe, Afghanistan, Cyprus, Eritrea, Fiji, Haiti, Vietnam, China, Venezuela, Yemen, Sri Lanka, or Lebanon.

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. **I understand that my required volunteer commitment is 4 hours each week for one (1) full, continuous year.**

Signature of Volunteer

Date



3-D 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: _____

*Contact Phone: _____

*Email: _____

*Social Security Number: _____ - _____ - _____

*Date of Birth: ____/____/____

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

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. Please call (919)684-3136 to schedule your volunteer clearance appointment.

Bring any official vaccine records you may have to your appointment.

Students will schedule an appointment with Duke Student Health.

You must submit this Health Review Sheet to the EOHW office at the time of your initial appointment. This health review information is important in protecting the health and safety of Duke University Medical Center volunteers, patients, students and visitors. The nursing staff in the Duke Employee Occupational Health and Wellness department will assist you, if needed, in completing the section below. This information will not appear on any other medical record you may have at Duke Medicine.

Upon completion of your EOHW or Student Health clearance process, you will be given a Volunteer Health Recommendation form. **It is your responsibility to take this Volunteer Health Recommendation Form to your coordinator before you sign up for training and orientation with your assigned area.**

- **Flu Vaccine is now a requirement in order to volunteer at Duke University Hospital. You will receive flu vaccine as part of your Employee Health volunteer screening. There is no additional cost to you for this vaccine.**

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 _____ E-mail _____

*Volunteer Program _____ Volunteer Coordinator _____

*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 employee? Yes ____ No ____

Health History

Do you have any physical condition or health related illness that would prohibit you from performing the volunteer duties in chosen area? ____ Yes ____ No

If yes, please explain _____

Communicable Disease / Immunization History

Have you ever tested positive for TB? Yes No Have you received BCG Vaccine? Yes No
If yes, what treatment did you receive? _____ Approx. Date of Treatment _____

****If TB Test was previously positive, official documentation of the results is required. If no documentation is available, a repeat TB skin test can be performed. Bring any documentation of TB treatment (INH, Rifampin) with you to the appointment.**

If TB Test was previously positive, have you had a Chest X-Ray? Yes No
If yes, provide official documentation of chest x-ray results. If results not available, you will need to obtain a chest x-ray and bring a copy of chest x-ray results to your appointment. Results can be obtained from the provider that ordered the test or hospital/clinic where performed.

***NOTE* It is important for all volunteers to be immune to Measles, Mumps, Rubella, Varicella (Chicken pox), and Pertussis. Please bring any official documentation of all immunizations that you have received with you to your initial appointment.**

*** Measles, Mumps, Rubella, and Varicella** - If you do not have official documentation with you at the time of your appointment, the nursing staff will perform a Blood Titer Test (A vaccine titer is the measure, or level, of antibodies in the blood stream) in order to determine your current immunity.

If you were born before 1/1/57, past history of disease for Measles, Mumps, and Chickenpox is acceptable.

***The Pertussis vaccine (Tdap)** is a one-time adult booster required only for volunteers working closely with children ages 18 months or younger. *Credit for the required Tdap must be official medical documentation where vaccine received.

*Suggested Sources for Obtaining Official Documentation of immunity to Measles, Mumps, Rubella, Varicella, and Tdap (Pertussis) include: School records, previous employee health records, Health Department records, Military records or Obstetrician or Primary Care records.

If born before 1/1/1957, have you ever had the following diseases?

- | | |
|---|--|
| 1. Chicken pox (varicella) <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Measles (old fashioned, red) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Polio <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have official documentation for the following vaccines / blood titers? *If yes, to receive credit, you must bring official documentation to appointment.*

- | | | |
|---|--|---|
| 1. Measles vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Mumps vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Rubella vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Varicella <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Tdap Adult Booster <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 6. Flu Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ | Where Vaccinated _____ |

(Written proof of flu vaccine, signed by provider, is required if received at a different location than Duke Employee Health)

Are you Requesting Medical or Religious Exemption for the flu vaccine? Yes No
*EOHW Staff -Offer correct form if applicable.

Signature of Volunteer Applicant _____ Date _____

EOHW Staff Reviewer _____ Date _____

Employee Occupational Health and Wellness Clinic Information/Locations

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

Clinic Hours: 7:30 am – 4:30 pm Monday – Friday: Closed 12:00pm – 2:00 pm on Wednesdays

Duke EOHW (South)-Outpatient Duke Clinics
200 Trent Drive
Ground Level, Red Zone, Room 04290
Telephone 919-684-3136 – option #2

Durham Regional Hospital - EOHW
3643 North Roxboro Road
Telephone 919-470-5350