VOLUNTEER APPLICATION

General Information:

Last Name:_____ First Name:_____ MI_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Employer:_____ Occupation:_____

Can you receive calls at work? Yes ☐ No ☐ Emergency Only ☐

Person to be notified in case of emergency:

Name:_____ Phone:_____

Applicant's level of education completed:_____

Please list any professional license, certification, or registration that you may have:

Type:_____ Number:_____

State(s):_____ Expiration Date:_____

Education/Special Training/Work Experience (Please list any training or experience relevant to the work):

Other special services/skills: (art, music, foreign language, cultural studies, grant-writing or research, public relations, manicurist, hairdresser, masseuse, etc.)

Volunteer History (where, capacity of volunteer duties, length of service):

How did you hear about the program?

Why so you want to be a volunteer?

Do you have access to transportation? Yes ☐ No ☐

Are you willing to be considered for out-of-town matches? Yes ☐ No ☐

If selected to be a patient care volunteer, can you commit to volunteering a minimum of three hours per week for

A year? Yes ☐ No ☐

Can you commit to attend every session of training? Yes ☐ No ☐

Please describe your availability for volunteer service:

Mornings ☐ Afternoons ☐ Evenings ☐ Weekdays ☐ Weekends ☐

Other_____

Phone:_____

Have you ever been convicted of a crime? Yes ☐ No ☐

(If yes, please explain)

Please note that a background check is required

Thank you for wanting to be a volunteer and taking the time to fill out the application.
The following is **required** to volunteer acceptance:

- Driver's license
- Current auto insurance
- Fingerprint card

Thank you for your interest in volunteering for MGRMC! Please read and sign below:

I certify that the information I provided in the Volunteer Application is true and complete to the best of my knowledge. I authorize MGRMC to contact my previous employers and other resources to investigate any of the facts set forth in this Application or resume. I specifically waive prior written notice of disclosure of any personnel record information, including disciplinary reports, letters of reprimand or other disciplinary action. In consideration of acceptance of my application, I release MGRMC and my previous employers of any claimed liability arising out of such response and disclosure.

_____ _____

Signature Date

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Mount Graham Regional Medical Center ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

_____ _____

Signature Date

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Mount Graham Regional Medical Center ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.
Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.
Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:
• In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

• A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
• By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

Signature _____ Date _____

Full Name (First/Middle/Last) _____ Social Security Number (SSN)* _____

Date of Birth* _____

*SSN and DOB will be used for identification purposes and will not be used as selection criteria.
FCRA:EMPLOYMENT:000292:201501

MT. GRAHAM REGIONAL MEDICAL CENTER
Safford, Arizona

Subject: CONFIDENTIALITY AGREEMENT

Volunteer Name:_____

CONFIDENTIALITY AGREEMENT

Any volunteer who violates HIPPA regulations, divulges, or discusses any information relating to a patient or any aspect of his/her care, beyond that necessary in the performance of the volunteer's job, may be dismissed immediately. The Physician is the only one who can give out this information. Also, volunteers of Mt. Graham Regional Medical Center are exposed daily to confidential information; none of this information may be discussed with employees or others except to those designated to receive such information. Violation of this policy may result in dismissal of volunteer work immediately.

_____ _____
Volunteer Signature Date