Revised December 2015

Chaplain Volunteer Application

Dear Community Friend:

Thank you for your interest in volunteering at Slidell Memorial Hospital (SMH). Volunteering can be quite rewarding and, of course, is a great help to the hospital and community.

The goal of the Volunteer Department is to help SMH grow from a good hospital to a great hospital! If you are willing to help us reach this goal, I invite you to join our volunteer team!

The following information will help guide you through the application process:

- Application Packet which includes the following should be filled out and returned:
  - Application
  - Volunteer Agreement
  - Authorization and Consent for Release of Information (Background Check Form)
  - Health Assessment
  - Interest and Skills Form
  - Confidentiality Form
  - As a chaplain, you are required to submit a minimum of one of the following:
    - Certified copy of graduation diploma/certificate from an accredited theology school.
    - Letter of certification of pastorship from a local church
    - Certification of state licensure.
- Once you have been accepted into the program, you will be scheduled for orientation which is held twice a month. <u>Attendance is required by all volunteers</u>, and you will be notified of date and time. During orientation:

  - A TB Health Screening test will be administered. It will have to be checked by a registered nurse 2-3 days later. Full instructions will be provided at orientation.
  - A Color Blindness test will be administered.
  - Instructions for taking the drug screen test will be provided.

- Your criminal background check will be processed shortly after orientation.
- As a Chaplain, you will receive additional one-on-one training with another SMH Chaplain.

Additional Information:

- Probationary Period – All volunteers are placed on a 60 day probationary period. During this time, you will be mentored by a "Lead Volunteer" and trained at one of the Welcome/Information areas. This will allow you to learn about all areas of the hospital, meet staff and other volunteers and most importantly learn about the many volunteer opportunities available to you after your probationary period.
- Dress Code – All volunteers are to dress in "business casual" attire. This means slacks or pants, dresses or skirts and comfortable walking shoes. Please do not wear jeans or shorts. You will be issued a Volunteer Jacket or Polo shirt—depending on your volunteer assignment.
- Parking – Volunteers are authorized to park in the parking garage, but if physically able, we ask that you park behind Founders on Robert Rd., and take the SMH shuttle. Additional information will be given during orientation.
- Smoking Policy – Because we care, SMH is tobacco-free. To protect and promote good health, smoking and the use of other tobacco products is not permitted anywhere on hospital property, both inside and outside. This policy applies to everyone including staff, volunteers, patients, visitors, vendors and contractors.

Your interest in volunteering at Slidell Memorial Hospital is greatly appreciated. Please feel free to contact Vernita or me at 985-280-8531 if you have any questions. I look forward to hearing from you soon.

Sincerely,

Laurie Manley

Laurie Manley
Volunteer Coordinator

Enclosures

Volunteer Chaplain

The Volunteer Chaplain visits patients/families of all denominations, providing prayer and comfort, acts as a liaison between the patient's church and the patient when requested, assists family at time of death with issues of grief and loss, and provides emotional and spiritual support in crises. A Chaplain may be a pastor, priest or other clergy with a personal set of doctrines and beliefs, but these views do not affect the spiritual care of patients with different views.

Benefits of Volunteering at Slidell Memorial Hospital

Perhaps the first and most important benefit you will get from volunteering at Slidell Memorial Hospital is the satisfaction you will feel by helping others and making a true difference in our community. The intangible benefits alone—such as pride, satisfaction, and accomplishment—are worthwhile reasons to serve.

Here at SMH, when you share your time and talents, you also receive the following benefits:

- Friendships—with staff and other volunteers
- Educational opportunities; appropriate skills training; CPR (if desired)
- Annual Tuberculosis screening
- Annual flu vaccine
- Inclusion in many hospital social functions
- Recognition pins and certificates
- Appreciation activities during National Volunteer and National Hospital Weeks
- Free meal in the Café with every 4-hour shift worked ($8 limit)

Thank you for joining our Team!

Revised December 2015

VOLUNTEER CHAPLAIN APPLICATION

DATE: ________________ T-shirt/Polo size: ___________________

NAME: ____ DATE OF BIRTH: ________________
Last First Middle

HOME ADDRESS: ____
Street City/State ZIP

PHONE: ______________________________ (h) ___________________________________ (c)

E-MAIL ADDRESS: ____

Church Affiliation if applicable: ____

Reference from Church Affiliation if application: ___________________________________

HOW MANY <u>TOTAL</u> DAYS PER WEEK DO YOU WANT TO VOLUNTEER: ___________________

<u>DAYS AND TIMES AVAILABLE TO VOLUNTEER (check all that apply):</u>

Monday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Tuesday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Wednesday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Thursday:	____8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Friday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Saturday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight
Sunday:	____ 8am – 1pm	____ noon - 5pm	____ 4 - 8pm	___ 8pm - midnight

PRIOR VOLUNTEER SERVICE AS A CHAPLAIN – IF APPLICABLE:

AGENCY	POSITION	DUTIES

EMPLOYMENT HISTORY: *Please attach a resume if you have one available.*

EMPLOYER	DATES WORKED	DUTIES

Are you retired? ◻ Yes ◻ No **If yes, from where?** ______________________________

Were you ever employed by Slidell Memorial Hospital? ◻ Yes ◻ No

If yes, please indicate dates employee dates: ____________ to ___________________

Are any of your relatives currently employed by Slidell Memorial Hospital?

◻ Yes Relatives' Name/Relationship: __________________________ ◻ No

Revised December 2015

Notice of Substance Detection Policy

The purpose of the Substance Detection Program is to promote optimum safety and well-being of volunteers, employees, patients, and visitors. SMH is committed to providing a safe, productive, healthy, and wholesome environment. We are committed to taking reasonable and necessary steps to provide our hospital community with an environment that is free from the adverse effects of substance abuse, through creating and maintaining a drug-free workplace.

Are you willing to undergo a drug screen test (at our expense) prior to volunteering for SMH?

□ Yes □ No

BACKGROUND CHECK:

We consider the safety and security of our patients, visitors and employees to be of the utmost importance. Applicants must complete an Authorization and Consent for Release of Information form to be screened at our cost for criminal background offenses by state and/or federal agencies. The existence of a criminal record does not constitute an automatic bar from volunteering, but will be considered in relation to volunteer assignment and position requirements.

Have you ever been convicted of a felony or misdemeanor offense? □ Yes □ No

Are there any pending charges on your criminal background report? □ Yes □ No

Have you ever been sanctioned for Medicare fraud? □ Yes □ No

REFERENCES:

NAME	RELATIONSHIP	PHONE NUMBER

IN CASE OF EMERENCY CONTACT:

____
Name   Home Address   ZIP

RELATIONSHIP: _________________ E-mail: ____

Phone: ______________________________ (h) ________________________________ (c)

WHY DO YOU WANT TO VOLUNTEER AT SLIDELL MEMORIAL HOSPITAL?

____

____

____

____

____

____

I certify that the statements made in this volunteer application are true and correct. I authorize Slidell Memorial Hospital and its agent acting on its behalf to investigate all statements contained in this application. I understand that this information may be disclosed to any party with legal and proper interest and I release Slidell Memorial Hospital from any liability whatsoever for supplying such information. **I understand that I will not be paid for my services as this is strictly volunteer work.** I have read and understand the above statements.

SIGNATURE OF APPLICANT:_______________________________________ DATE: _________

Please return application package to:

Slidell Memorial Hospital
Attention: Volunteer Services
1001 Gause Blvd.
Slidell, LA 70458

Revised December 2015

Department: Volunteer Services

PLEASE READ CAREFULLY

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

We truly welcome your application to volunteer with, **SLIDELL MEMORIAL HOSPITAL,** (hereinafter referred as "Company"). We're proud that our success is the result of the quality and caliber of our volunteers. You are applying for a position whose acceptance will place you in a category of recognized Professionals. In pursuit of that excellence we require, as a condition of placement, and/or continued placement, that all applicants consent to and authorize a pre-volunteer verification of the background information submitted on their application or resume.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of volunteering is true and complete to the best of my knowledge. I understand that if I am accepted as a volunteer any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this company may now, or at any time while you are a volunteer, administer a personality profile, conduct a verification of your education, previous employment/work history, credit history, contact personal references, require that you provide a urine specimen to be tested for the presence of drugs or alcohol, motor vehicle records, worker's compensation from the Department of Labor and/or the Worker's Compensation Commission, and to receive any criminal history record information pertaining to me which may be in the files of any Federal, State, or Local criminal justice agency in any State and/or other information as deemed necessary to fulfill the job requirements.

In conformance with the Americans Disabilities Act, I acknowledge by my **signature** ________________________________ that I have been offered a volunteer position, contingent upon a satisfactory background investigation, and therefore, worker's compensation information obtained from the Department of Labor and/or the Worker's Compensation Commission is hereby authorized. If blank, the obtaining of worker's compensation information is not authorized. The results of this verification process will be used to determine eligibility under this Company's employment policies.

I authorize Employment Research Services, (hereinafter referred as "ERS"), and any of its agents/designated by Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of this Company.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide ERS and Slidell Memorial Hospital with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge the Company, our agent, ERS, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if volunteering was denied based on information obtained by SMH, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

Volunteer: Please Print

_________________, ________________ _________________ ____ **SS#:** ____________________________________

Last **(Maiden)** **First** **M.I.** **U.S. Citizen:** **Yes**_________ **No**_________

Address: ____

____ **Date of Birth:** ______________________________

Telephone **# Home**__________________________ **Cell**_____________________________ **Alternate**_____________________

Excluding current residence, list the last two City, State and ZIP codes that you have lived in:

____

____

Signature: ____ **Date:** _______________________________

1001 Gause Boulevard
Slidell, Louisiana 70458-2987
(985) 280-2200
www.slidellmemorial.org

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Client # : ___402-H25____

HEALTH ASSESSMENT

NAME: ____ PHONE: _________________

ADDRESS: _______________________________________ STATE: _____ ZIP CODE _________

DEPARTMENT: VOLUNTEER SERVICES / VOLUNTEER

Circle YES or NO if you have had any of the following:

Alzheimer's	Yes	No	Head Injury	Yes	No
Congestive Heart Failure	Yes	No	Nervous Breakdown Anxiety / Depression	Yes	No
Dementia	Yes	No	Ionizing Radiation Injury	Yes	No
Walk with the use of a cane/walker	Yes	No	Compressed Air Sequel	Yes	No
Epilepsy	Yes	No	Sore Neck / Neck Pain / Neck Ache	Yes	No
Diabetes Hyperglycemia	Yes	No	Bronchitis / Asthma Emphysema	Yes	No
Arthritis	Yes	No	Headache (migraine)	Yes	No
Amputation Foot/Arm/Leg	Yes	No	Heart Disease	Yes	No
Loss of Sight –Total / Partial	Yes	No	Muscular Dystrophy	Yes	No
Poliomyelitis	Yes	No	Arteriosclerosis	Yes	No
Cerebral Palsy	Yes	No	Thrombophlebitis	Yes	No
Osteomyelitis	Yes	No	Varicose Veins	Yes	No
Multiple Sclerosis	Yes	No	Heavy Metal Poisoning	Yes	No
Parkinson's Disease	Yes	No	Brain Damage	Yes	No

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Tuberculosis	Yes	No	Surgical Removal of Lumbar / Cervical Disc	Yes	No
Knee Pain / Soreness	Yes	No	Spinal / Cervical Fusion	Yes	No
Mental Disability	Yes	No	Silicosis	Yes	No
Hemophilia	Yes	No	High Blood Pressure	Yes	No
Asbestosis	Yes	No	Rotator Cuff Injury	Yes	No
Shooting Pain / Numbness Tingling	Yes	No	Arthroscopy	Yes	No

Have you had any type of surgery / injury? Yes No

If yes, please explain: ____

____

Are you aware of any condition that might limit or impair your ability to perform the duties assigned to you? Yes No If yes, explain: ______________________________________

____

Are you on any medication - please list all meds below - ***MUST COMPLETE*** – Use additional paper if necessary: ____

____

____

____

____

____

____

I have read and fully understand the above: ____
Print Name

Signature:____ Date:__________________

Employee Health Coordinator: ______________________________ Date: _________________

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(985) 280-2200
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VOLUNTEER AGREEMENT

As a Volunteer at Slidell Memorial Hospital (SMH):

- I understand that I am not entitled to and will not receive any compensation, salary, benefits or payments in exchange for my providing volunteer services to SMH.
- I understand that my volunteer services is donated without contemplation of future employment, and given with humanitarian, religious or charitable reasons.
- I understand that as a volunteer, I am not covered by any state or federal wage and hour laws, nor am I eligible for workers' compensation, unemployment insurance benefits, or any other benefit available to employees.
- I release, discharge and relieve SMH from any and all claims whatsoever of any nature arising as a result of my volunteer services and all related activities.

Furthermore, as a Volunteer at Slidell Memorial Hospital (SMH), I agree to:

- Respect all patient or hospital related information as confidential.
- Adhere to <u>all</u> hospital policies, rules and standards of conduct that apply to hospital employees and independent contractors including the hospital's policy on confidentiality which I have signed and submitted.
- Report to my assignment as scheduled or notify the department supervisor.
- Avoid seeking out or visiting with friends who are patients or who are working in other departments during the hours of my assignment.
- Be neat in appearance and in uniform when on assignment, with name tag clearly visible.
- Be courteous and pleasant to patients, visitors, staff and other volunteers.
- Follow instructions carefully. Ask questions if unsure of an assignment.
- Uphold the good name of SMH to the community.
- Discuss any problems with the volunteer coordinator so that we can work together to solve them or understand them.
- Attend two volunteer meetings a year.
- Attend educational seminars sponsored by SMH yearly.

I understand that during my 60 day probationary period, I will be assigned to a Welcome/Information area for training. After that time, I will be able to move into other volunteer opportunity areas that may be open and/or seeking volunteers.

I also understand that the Coordinator of Volunteer Services reserves the right to terminate my volunteer status if I fail to follow policies, rules and regulations; if I am absent without prior notice; or if I have unsatisfactory attitude or appearance. Finally, I understand that I can be terminated for giving unsatisfactory service or for any other circumstances which, in the judgment of the Coordinator of Volunteer Services, would make my continued service contrary to the best interests of Slidell Memorial Hospital.

____ ______________________

Volunteer Signature Date

______________________________ ________________________________

Volunteer Name (Print) Volunteer Coordinator's Signature

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Slidell, Louisiana 70458-2987
(985) 280-2200
www.slidellmemorial.org

Revised December 2015

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

IMPORTANT: Please read all information below. If you have any questions regarding this agreement, please ask them of the Volunteer Coordinator or the Director of Human Resources before signing. A copy of this agreement will be provided to you.

ACKNOWLEDGMENT

I recognize and acknowledge the following:

- The services Slidell Memorial Hospital ("SMH") performs for its patients/providers are confidential;
- To enable SMH to render those services, its providers/patients furnish to SMH confidential information concerning their affairs;
- The goodwill of SMH depends, among other things, upon keeping such services and information confidential;
- Because of my duties, I may come into possession of information concerning the services performed by SMH for its patients/providers even though I do not take any direct part in or furnish the services performed for those patients/providers;
- Disclosure of any such information by me may cause irreparable injury to SMH and the owner of the information; SMH or the owner of the information may seek legal remedies against me;
- Computer information belonging to SMH, its patients, providers or vendors is confidential; and disclosure of such information, revealing passwords, PIN numbers, etc., or granting access to such information by me, may cause irreparable injury to SMH or the owners of such information;
- Violations of my duty to maintain the confidentiality of all confidential information will subject me to appropriate disciplinary action according to SMH's progressive discipline policy (HR-770), up to and including dismissal, or such action allowed by law or contract.

AGREEMENT

I accordingly agree that, except as directed by Administration:

- I will not at any time during or after my volunteer service to SMH, disclose of any such services or information to any person or permit any person to examine or make copies of any reports or documents prepared by me or coming into my possession or under my control;
- I will retain all information belonging to any vendor, provider, patient or SMH in strictest confidence, and will not release such information or materials to anyone or use any such information for any purpose except to perform my duties at SMH;
- I will at all times comply with the confidentiality and information systems security policies in effect at SMH.

I have read and understand all of the above sections of this agreement.

_____________________________________ _______________

Signature Date

____

Print Name

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