



Dear Prospective Volunteer,

Thank you for your interest in the Volunteer program at Northern Regional Hospital by helping the professional staff provide quality care. Volunteers greet patients and visitors, deliver flowers and mail, assist with patient transportation, serve patients meal trays, and a variety of other tasks.

Not only is a volunteer's commitment important to the individuals they serve, but also to the community as a whole. A well-run hospital is an asset to any community and we are fortunate to have an excellent facility in Surry County from which to obtain quality health care services.

Volunteers can be an invaluable addition to the hospital team when you consider the volunteer opportunity to be a priority in your schedule. All volunteers should approach their work with the goal of providing excellent service to the patients, visitors and staff of our hospital.

While the Hospital appreciates the countless hours of service that have been provided by volunteers to our patients and staff, we also recognize the need to maintain a safe environment for everyone present in the hospital. For this reason, only individuals who are able to walk without an assistive device will have volunteer hours scheduled in the hospital in any capacity. Specifically, those requiring walkers, crutches, canes, or other hand-carried supportive devices for walking will not be qualified to perform volunteer hours in the hospital. Those who are wheelchair-bound and able to maneuver safely and independently, however, will be allowed to work as scheduled.

Please return the completed application to the Volunteer Coordinator. After your application has been reviewed, the Coordinator will be in touch concerning a screening interview. Once you have secured a volunteer position, you must attend an orientation session, as well as pass a criminal background check, drug screen, and TB screening.

Again, thank you for your interest in the Volunteer program at Northern Regional Hospital. For questions, please contact the Department of Volunteer Services by phone at 336-783-8196 or by email at tbeasley@nhsc.org. We look forward to welcoming you as one of our newest volunteers.

A handwritten signature in black ink that reads "Tina L. Beasley".

Tina L. Beasley
Volunteer Coordinator
Northern Regional Hospital
830 Rockford Street
P.O. Box 1101
Mt. Airy, NC 27030



VOLUNTEER BENEFITS

In recognition of their willingness to donate their time and/or present or past service to the Hospital in an official capacity, this policy outlines the benefits available to all volunteers who serve Northern Regional Hospital of Surry County:

- Privilege to make cash purchases at the Northern Regional Hospital pharmacy
- Free flu vaccine annually and free Hepatitis B Vaccine series
- A 20% discount on merchandise in the Gift Shop (excluding sale merchandise)
- Free meal in the cafeteria on the day you work. Meal cannot exceed \$7, and you must work a minimum of 4 hours
- Uniforms furnished at no cost
- Annual Recognition during Volunteer Week
- Invitation to annual Recognition Banquet in the spring
- Access to Employee Health Clinic, including free blood pressure checks
- Free Gym Membership for volunteer and spouse at Northern Wellness & Fitness



NORTHERN REGIONAL HOSPITAL

ADULT VOLUNTEER APPLICATION

Please Print. Entire Application Must Be Completed.

Date ____/____/____

Name _____
(Last) (First) (Middle)

Male or Female _____ Date of Birth ____/____/____ Email _____

Current Home Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Cell) _____

Education Completed: High School Some College College Graduate School

Are you presently employed? Yes No Retired

If employed, please complete:

Employer's name: _____ Your position: _____

Employer's address: _____

Have you ever been employed by Northern Regional Hospital? Yes No

Are you currently a student? Yes No If yes, where? _____

Do you have any relatives employed at Northern Regional Hospital? Yes No

If yes, please list their name(s) and relation: _____

Days Available: M Tu W Th F Time Available: AM PM

Uniform Size: S M L XL 2XL 3XL



Security: Your response to any of these security questions will not automatically disqualify you from volunteering. However, if you answer “No” and a criminal history is found or you answer “Yes” but did not include all convictions you will be disqualified from consideration.

Have you ever been convicted (pleaded guilty or been found guilty) of a misdemeanor or felony? *(List any and all convictions and provide dates of each including, but not limited to, major traffic violations, writing bad checks, and DWI)* Yes No

If yes, explain:

Presently, are you charged with committing a criminal offense, misdemeanor or felony?

Yes _____ No _____

If yes, explain:

What are your reasons for wanting to become a volunteer at Northern Regional Hospital?



References: List two people other than relatives who would be willing to serve as personal references.

Name	Telephone Number
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Street Address	City	State	Zip Code
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E-mail Address

Name	Telephone Number
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Street Address	City	State	Zip Code
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E-mail Address

Emergency Contact: In the event of an emergency, please list the person you would want notified.

Name	Relationship
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Home Telephone Number	Business Telephone Number	Cell Phone Number
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Applicant Agreement

I acknowledge that the answers on this application, and in any interviews that may follow, are true, and that any misrepresentation or false information on my part will be grounds for exclusion from this program. I understand that volunteers are a part of Northern Regional Hospital, and are subject to all rules, regulations and proper authority. My signature also indicates my approval for you to contact my references.

The Volunteer Services Department is not obligated to provide a placement, nor are you obligated to accept the position offered. We do not accept anyone required to perform court-ordered community service. All applications are held for 90 days. The first 90 days of the volunteer experience will be probationary.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex.

Applicant Signature Date



STATEMENT OF CONFIDENTIALITY

In the process of performing your duties at Northern Regional Hospital, it is possible to become aware of and/or overhear many things regarding our patient's confidential health information. **All** of the information concerning patients or hospital business must be held in the strictest confidence and must not be discussed with others in the hospital who do not have a "need to know" or with any individual outside the hospital, or used by employees for personal reasons.

Volunteers who violate the confidentiality of Northern Regional Hospital information and/or patient information **will be subject to IMMEDIATE termination of clinical privileges.**

General inquiries concerning patients should be referred to the information desk or the nurse in charge of the unit who will only release information about the general condition of the patient. Calls from the media should be forwarded to the Director of Physician/Community Relations or the Administration Office.

It is your responsibility as an employee or affiliate of Northern Regional Hospital to protect our patients and their families at all times by adhering to this statement.

I, the undersigned have read, heard an explanation, and understand this statement of confidentiality of patient and/or hospital information and agree to hold such information in strictest confidence.

Applicant Signature

Date

Witness Signature

Date



VOLUNTEER INTEREST QUESTIONNAIRE

Please identify the activities that you would like to participate in:

- | | | | | |
|----|-------------------------|---------------|--------------|--------------------|
| 1. | Information Desk | ___ very much | ___ somewhat | ___ not interested |
| 2. | Surgery Waiting | ___ very much | ___ somewhat | ___ not interested |
| 3. | Emergency Room | ___ very much | ___ somewhat | ___ not interested |
| 4. | OB Department | ___ very much | ___ somewhat | ___ not interested |
| 5. | General Office | ___ very much | ___ somewhat | ___ not interested |
| | --typing | ___ very much | ___ somewhat | ___ not interested |
| | --photocopying | ___ very much | ___ somewhat | ___ not interested |
| | --filing | ___ very much | ___ somewhat | ___ not interested |
| | --stuffing envelopes | ___ very much | ___ somewhat | ___ not interested |
| | --answering phones | ___ very much | ___ somewhat | ___ not interested |
| 6. | Delivering Flowers/Mail | ___ very much | ___ somewhat | ___ not interested |
| 7. | Gift Shop | ___ very much | ___ somewhat | ___ not interested |
| 8. | Patient Transportation | ___ very much | ___ somewhat | ___ not interested |
| 9. | Physician Offices | ___ very much | ___ somewhat | ___ not interested |

Please enter any questions or comments you have concerning the program. Also, please list any special skills that you have that may be useful to the patients, visitors, or staff of our hospital (piano, singing, computer skills, flower arranging, etc.)

Applicant Signature

Date



MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Address: _____

Telephone #: _____ Date of Birth: _____

Personal Physician: _____

Past and present medical history:

Have you ever had any of the following? Check Yes or No

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
High Blood Pressure	_____	_____	Neck/back/spine problems	_____	_____
Allergies	_____	_____	Fainting	_____	_____
Asthma	_____	_____	Eye Problems	_____	_____
Arthritis	_____	_____	Glaucoma	_____	_____
Cancer	_____	_____	Headaches	_____	_____
Chronic cough	_____	_____	Heart trouble	_____	_____
Epilepsy	_____	_____	Jaundice	_____	_____
Diabetes	_____	_____	Hepatitis	_____	_____
Ear trouble	_____	_____	Skin condition	_____	_____
Rheumatic fever	_____	_____	Tuberculosis	_____	_____
Thyroid problems	_____	_____	Mumps	_____	_____
Measles	_____	_____	Stomach/intestine problems	_____	_____
Chicken pox	_____	_____	Kidney/bladder problems	_____	_____
MMR Vaccine	_____	_____	Fit tested for TB mask	_____	_____



If you answered yes to any of the above, give details:

1. Have you ever been injured on the job? Yes No

Who was your employer and what was the approximate date of the injury?

A. Name and address of physician:

B. What part of your body was injured? _____

C. Did you receive worker's compensation benefits? Yes No

D. Did you receive any permanent disability? Yes No

E. Has a physician ever given you physical restrictions? Yes No

If yes, describe: _____

Have you ever had any problems with your back? Yes No

If so, give name of treating physician, approximate date, and any lifting limitations:



3. List any operations and/or serious medical illnesses that you have had, include dates:

4. Are you receiving any medical treatment at this time? Yes No

If yes, give reason: _____

5. List all medications you are taking and the reasons: _____

6. Have you ever been treated for nervous or mental illness? Yes No

If yes, explain: _____

I, the undersigned, do hereby certify that the answers to the above questions are true, and give permission for the medical examination. I authorize release of medical information to this facility, which may be necessary in determining my ability to meet the requirements of the job for which I am applying. I understand that giving false information about my health is grounds for dismissal from Hospital employment.

Signature

Date

