EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

PLUS VOLUNTEER SERVICES

Dear PLUS Volunteer Applicant,

Thank you for your interest in joining Team PRMC and the PLUS Volunteers Program. We're excited to welcome you as a potential volunteer. Now that we have your completed application, we will begin the process to obtain clearance for you to attend a volunteer orientation class.

For our younger applicants who are 14 to 18 years of age, we will need you to submit some additional items for us to begin the clearance process. One is the SSA form-also known as the social security administration form-that was included in the application. We will also need a copy of your birth certificate and a copy of your social security card (front and back).

Everyone's background check will be submitted to the PRMC People Department within 24 hours of receiving your completed application. Your references will typically be sent out the next business day. The background check may take anywhere from one to two weeks to clear, so please be patient. Once approved, we'll send you a letter inviting you to attend volunteer orientation.

Once orientation is completed, the next step will be to schedule an interview, but only after we've received your references. Also, all of us at PRMC are required to obtain a yearly flu shot. As a volunteer, you will need to provide proof you have had on this year. If you haven't we'll be happy to provide one for you FREE when you visit for your interview.

We'll also need your immunization record if born after 1956 (two MMR's & two varicella are required) or we'll need proof that you are immune if born before 1956. See your primary physician and obtain a lab order for MMR titers and Varicella titers. Bloodwork will need to be done at your expense, and please bring those results of the titers and/or booster immunizations to your interview.

At the interview, we'll be interested in finding out where at PRMC you are interested in volunteering and the hours and days you are available. We offer opportunities at a number of locations and within quite a few clinical and non-clinical areas of the hospital. We'll provide a schedule, but it's always best if we know, in advance, what you would like to do and where.

Our PLUS Volunteer Program dates back to 1970, and has offered thousands of Delmarva residents the opportunity to become an integral part of our healthcare family. We have provided PRMC and their patients with over 1.8 million volunteer hours. We're so happy that you've chosen to become part of that rich tradition.

Thank you. We'll be in touch soon.

Joyce Lecates, Manager PLUS Volunteer Department

410-543-7284 joyce.lecates@peninsula.org

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

PLUS VOLUNTEER SERVICES

PLUS Volunteer Services Program Information Sheet

Office #410-543-7284 Fax: 410-677-6644

Office Hours: Monday – Friday 8AM -4PM

Joyce Lecates/Manager

PLEASE READ THIS SHEET **BEFORE** COMPLETING THE APPLICATION

Our expectation is that volunteers will contribute a minimum of 100 hours of service in a non-specific period of time, with the agreement of taking a scheduled volunteer assignment. If this does not meet your needs, we may not be the volunteer site for you.

- If you are volunteering because of Court Ordered Community Service, the PLUS Volunteer Services Department must be informed of this prior to your completing the application.
- Complete the first sheet which is the Application sheet.
- Complete the second sheet, listing the complete addresses and phone numbers of the two required references and sign releasing us to send reference requests.
- The third page is "Focus on You", to be completed and returned.
- The fourth is for the high school volunteer applicant to have their High School Guidance Counselor complete and return to the Volunteer Office.
- The fifth and final page is the Level 1 – Electronic Background Investigation Application; please complete the appropriate section in its entirety, including signature and date.

If you are under the age of 18, your parent or guardian ***must sign above your name of background check form.

*Volunteers born after 1956 must provide Immunization records. If these records cannot be provided, Lab work will be required at your expense.

- **An applicant will not be considered for class attendance until all paperwork is complete with PLUS Volunteer Services.**

Thank you for your interest in volunteering with us.

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

PLUS VOLUNTEER SERVICES

THE PENINSULA REGIONAL MEDICAL CENTER
Application for PLUS Volunteer Services

Date: _____ E-Mail address: _____

Name: _____ Spouse's Name_____

Address_____
(Include: city, state and zip code)

Home Phone Number: _____ Cell Phone Number: _____

Are you 14 or older? _____Birth: _____Month_____ Day_____

If 17 or under Parental/Guardian signature is required: _____

Notify in Emergency: _____ Tel. No.:_____

Education & Special Training: _____
(If presently in school, please indicate school and grade)

Previous Volunteer Experience: _____

Paid Work Experience: _____
(This includes babysitting, grass cutting etc.)

If presently employed, where: _____ Telephone Number: _____

Have You Ever Been Employed by Peninsula Regional? Yes No If yes, Dates: _____

Reason for leaving: _____

Have you previously volunteered with our PLUS Volunteer Program? Yes No

Reason(s) for Selecting Peninsula Regional: _____

Volunteer Office Use Only:

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

PLUS VOLUNTEER SERVICES

Please provide two names and complete mailing addresses of two individuals that will provide a reference for you.

REFERENCES CANNOT BE RELATED TO YOU AND SHOULD NOT LIVE IN THE SAME HOUSE. COMPLETE ADDRESSES ARE NEEDED TO PROCESS YOUR APPLICATION. WE MAIL THEM OUT AND PROVIDE A SELF-ADDRESSED ENVELOPE FOR THEM TO RETURN THE REFERENCE DIRECTLY TO US. THANK YOU

Name: _____

Address: _____

_____

_____

Name: _____

Address: _____

_____

_____

I hereby authorize the Volunteer Services Department of Peninsula Regional Medical Center to send reference requests to the above names and addresses.

Signature:_____

Date: _____

FOCUS ON YOU!

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.
PENINSULA REGIONAL MEDICAL CENTER
PLUS VOLUNTEER SERVICES

Your full name:	
Your preferred name:	
What do you enjoy doing in your free time?	
Why did you select us as your volunteer site?	
What special qualities do you bring to the Volunteer Program?	
How do you like being recognized for a job well done?	
Is there anything you DON'T want to do as a volunteer?	
What is your favorite type of cake?	

Plus Volunteer Services
100 E. Carroll Street
Salisbury, MD 21801
410-543-7284

High School students must have guidance counselor complete this form. All information is confidential.

Volunteer Applicant's Name: _____

Dear Guidance Counselor:

The above named is applying for a position as a volunteer at Peninsula Regional Medical Center. Please comment briefly on the following:

Scholastic Average:

Dependability:

Personality:

Punctuality:

Additional Comments:

Guidance Counselor's Printed Name: _____

Guidance Counselor's Signature: _____

School: _____

Office Number: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The Company or Employer indicated below may obtain information about you for employment purposes (including contract or volunteer services) from the following consumer reporting agency: Employment Background Investigations, Inc. (EBI), P.O. Box 629, Owings Mills, MD 21117, 1-800-324-7700. Thus, you may be the subject of a "consumer report" (investigative consumer reports in California) which may include, but not limited to, public record information, employment, education and license verification, etc. In addition, investigative consumer reports, as defined by the federal Fair Credit Reporting Act, may be obtained which are gathered from personal interviews with employers, and other current or past associates, which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report or consumer report. For complete details pertaining to EBI's privacy practices, including whether your personal information will be sent outside of the U.S. or its territories, EBI's Privacy Policy can be viewed at: http://www.ebiinc.com/privacy-policy.html.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, local, 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 (including, but not limited to, driving and/or motor vehicle records, transcripts, grades and attendance records, employment history, salary information and references, workers compensation documents, records or reports in Pennsylvania, Arizona and in all other states, drug and alcohol testing results) requested by EBI acting on behalf of Employer, and/or Employer itself. If and when applicable, I also hereby authorize any past employers regulated by the U.S. Department of Transportation (49 CFR Part 40 and/or 49 CFR Part 391), to provide (a) work history information, and (b) drug and alcohol testing records from the previous three years, to EBI acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

California, Minnesota and Oklahoma applicants or employees only: Please check the box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Corrections Law.

Company/Employer: ______________________________

Applicant Name: ______________________________

Parental Signature required if under 18 years of age: ______________________________

Applicant Signature: ______________________________ Date: ________________

TO BE COMPLETED BY APPLICANT

The Following Information Is True And Correct To The Best Of My Knowledge And Will Be Used For Background Screening Purposes Only.

Please Use an Ink Pen and Print Clearly. Use "UPPER CASE" Letters. One Letter Per Block.

Legal First Name				Middle Name			
Legal Last Name				Suffix			
Social Security No.	-	-		Date of Birth (mm/dd/yyyy)	-	-	
Current Address						Apt.	
City				State		Zip	
Main Contact Phone	-	-		Personal e-mail		Job Location (State)	
Driver's License No.				DL State		Gender (M/F)	M F
Other Names Used: Indicate if used while in school.							
Y	N	Last Name (1)		First Name			
Y	N	Last Name (2)		First Name			
Y	N	Last Name (3)		First Name			
Y	N	Last Name (4)		First Name			

PENINSULA REGIONAL
MEDICAL CENTER
Part of Peninsula Regional Health System

Child's Name:_____ DOB:_____

PARENTAL CONSENT AND AUTHORIZATION FOR MEDICAL CARE AND RELEASE OF HEALTH RECORDS

I, the parent(s)/ legal guardian, hereby request and consent that during my child's employment/service with Peninsula Regional Medical Center; a licensed medical practitioner may provide general medical care as it relates to employment/service requirements, day-to-day illness and/or injuries(non-major in nature) which, in his/her opinion, is necessary to protect the physical health of the above-named child. Medical treatments may include, but are not limited to, examinations, immunizations including MMR, Varicella, Flu, Tetanus, Hepatitis B, Tuberculin skin test(yearly), Respiratory fit test(yearly), urine drug test(pre-employment, random and for cause), and blood work including HIV tests (if an exposure occurs).

This consent includes the release of health or social information to persons or agencies directly concerned with public health or community welfare and to private institutions professionally engaged in carrying out a treatment plan for my child. Additionally, this consent includes authorization to obtain all records pertaining to medical history, services rendered or treatment given by other medical providers.

I understand that in the event of all illness or injury an attempt will be made to contact me.

This consent will remain effective unless evoked in writing by the parent(s)/ legal guardian.

I acknowledge that I have read this consent and understand its contents.

Signature_____Date_____

Relationship_____Phone#_____

Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:

I want this information released because I am conducting the following business transaction:

EMPLOYMENT PURPOSES

Reason (s) for using CBSV: (Please select all that apply)

- ☐ Mortgage Service
- ☐ Banking Service
- ☒ Background Check
- ☐ License Requirement
- ☐ Credit Check
- ☐ Other

with the following company ("the Company"):

Company Name: Peninsula Regional Medical Center

Company Address: 100 East Carroll St. Salisbury, MD 21801

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified.

The name and address of the Company's Agent is:

Equifax Verification Services, 11432 Lackland Road, St. Louis MO 63146
(888)749-4411

I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to $5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Relationship (if not the individual to whom the SSN was issued): _____

Contact information of individual signing authorization:

Address _____

City/State/Zip _____

Phone Number _____

Form **SSA-89** (06-2013)

Privacy Act Statement

SSA is authorized to collect the information on this form under Sections 205 and 1106 of the Social Security Act and the Privacy Act of 1974 (5 U.S.C. § 552a). We need this information to provide the verification of your name and SSN to the Company and/or the Company's Agent named on this form. Giving us this information is voluntary. However, we cannot honor your request to release this information without your consent. SSA may also use the information we collect on this form for such purposes authorized by law, including to ensure the Company and/or Company's Agent's appropriate use of the SSN verification service.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to complete the form. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401*. ***Send to this address only comments relating to our time estimate, not the completed form***.

TEAR OFF

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf