Unity Health Auxiliary - Searcy

Application to Serve as a Volunteer

Please complete your application fully. *Please print clearly.*

Application Date_____ Are you at least 18 years of age? Y or N

First Name_____ MI_____ Last Name_____

Mailing Address _____

Physical Address_____

City_____ State _____ Zip Code _____

Home Phone (_____) _____ Cell (_____) _____ Text Y or N

Email_____@_____

Emergency Contact_____ (relationship) _____

Phone (____) _____ Cell_____

Emergency Contact_____ (relationship) _____

Phone (____) _____ Cell_____

Physician Name _____ Phone_____

Have you received a Covid-19 vaccination? Y or N ___Shot #1 ___Shot #2

Education: (please mark all that apply.) ___ High School

___ Technical school Area of Study _____

___ Junior College Area of Study _____

___ College Area of Study _____

Special training or skills: _____

Military: _____

Current Employer: _____ Position:_____

Previous Employer: _____ Type of work _____

Have you ever been convicted of a criminal offense other than a minor traffic violation? If yes, please explain:

_____

_____

Are you able to perform the duties of a volunteer with or without reasonable accommodations? Please explain. _____

_____

Have you volunteered elsewhere? If yes, name of organization: _____

Volunteer duties performed: _____

REFERENCES: (must be completed)

Name	How do these people know you?	Phone number
1._____/	_____/	(____) _____
2._____/	_____/	(____) _____
3._____/	_____/	(____) _____

AVENUES OF SERVICE: (Please check all that interest you)_Volunteer shifts are 3 and 4 hours each.

_____ Cafeteria _____ Cancer Center _____ Clerical _____ Chaplain on-call

_____ Gift Shop, Sales _____ Gift Shop, Other _____ Information Desk _____ Sewing

_____Materials Mgmt. _____ Messenger _____ Surgery Waiting Desk

Location preference: ____North Campus (3214 East Race) or ____South Campus (1200 Main) or ____ Either

How did you hear about the UH Volunteer Program? _____

Why do you want to volunteer? _____

What service would you most like to do? _____ Least?

_____

Days available to volunteer? S M T W Th F Sa Times of day available? _____

MEMBERSHIP DUES & JACKETS

Membership dues for the UH Auxiliary are:

Active: $0.00 per year | Inactive: $10.00 per year | Life Time: $100.00 | Temporary/Student $0

Dues are paid to the auxiliary treasurer in January of each year.

The Auxiliary provides the first uniform upon orientation. Additional uniforms may be purchased for $30 each. For security reasons, uniforms should be returned upon resignation.

Thank you for your interest in the Unity Health Volunteer program. You will be contacted once your application is reviewed and processed. Unity Health reserves the right to terminate a volunteer and/or volunteer position as deemed necessary.

I understand as a volunteer, photos of me may be used in publications and social media. Any volunteer who does not want their photos published should abstain from being photographed. _____ (initial)

Applicant's Signature: _____ Date: _____

Mail or Email to:

Jamie Laughlin, Director of Volunteer Services

3214 East Race Avenue | Searcy, AR 72143 | 501-380-1055 | jlaughlin@unity-health.org

- My services are donated to Unity Health. I do not expect compensation, future employment or other benefits to be granted to me for my voluntary services.
- I will complete my duties in a professional manner, conducting myself with dignity, courtesy and consideration of others.
- I will be punctual, arriving and leaving for my assigned shifts so that the work of the Volunteers is not disrupted.
- I will uphold the standards and mission of Unity Health. "To improve the quality of health and well being for the communities we serve through compassionate care."
- I understand that I must undergo periodic TB testing as a condition of my continued volunteer status.
- I understand that my services are voluntary. I will not accept any payment or gift offered me for that service by a patient, family member or member of the public.
- I understand that I must comply with the mandatory training as established by Unity Health.
- I will attempt to resolve any problems I may experience, first with my Coordinator and then with the Director of Volunteer Services.
- I will not attempt to sell goods or services, request donations, solicit signatures, distribute petitions or publications of any kind on Unity Health property without the express written authorization of the Director of Volunteer Services.
- I understand that I may resign from the volunteer program at any time.
- I understand that I may be terminated from the Unity Health Volunteer program.

Behavior which may result in termination includes but is not limited to:

  - Failure to comply with Unity Health rules or policy.
  - Breach of Confidentiality.
  - Absences without prior notification.
  - Unsatisfactory attitude, work or appearance.
  - Theft of Unity Health property.
  - Any other circumstances which would make my continued service undesirable to Unity Health.

- Upon resignation or termination, I will return all Unity Health properties including badge and uniforms.

I agree with these conditions. Signature: _____ Date: _____

Statement of Confidentiality

As a Unity Health Volunteer, I understand and agree with the following:

- I understand that all information which I may obtain directly or indirectly concerning current or former patients, physicians, employees or others who have or have had any relationship with Unity Health **is absolutely confidential**.
- I understand that as a Unity Health Volunteer, others will take my remarks concerning Unity Health, its patients, policies, employees and operations as inside information and absolute truth.
- I will not disclose, discuss, confirm or deny any confidential information with anyone except as specifically instructed in the course of duty.
- I understand that a breach of confidentiality is a legal offense and that Unity Health, the Volunteer program and I personally may be sued because of such a breach on my part.
- I understand that if I breach confidentiality, I will be terminated from the Unity Health Volunteer Program.

I have read the above conditions. I understand them and understand that I am bound by them as a Unity Health Volunteer.

Name: _____

Signature: _____ Date: _____

_____ I would like to be mailed a copy of these Statements of Confidentiality and Commitment.