Thank you for your interest in volunteering at Memorial Healthcare System. The Memorial Healthcare System is recognized as one of the outstanding Healthcare Systems in the country. The volunteers are a dynamic group who everyday live the Mission and Vision of our Healthcare System. Attached you will find our SPECIFIC volunteer application for working with one of our Patient and Family Advisory Councils.

Please read it carefully and follow directions.
There are items below intended for Teen Volunteers only.

WHAT IS EXPECTED OF A
Memorial Healthcare System
Patient and Family Advisory Council Member

- A desire to meet the needs of our community, patients, families, visitors, physicians, and employees.
- A one year commitment.
- Please be prepared to give us a copy of your driver's license.
- A mandatory Patient and Family Advisory Council orientation.
- Teen volunteer, Youth Advisory Council instructions and guidelines are on next page.
- A completion of a Tuberculosis Screening (PFAC Mentor/Family Support Network).

PLEASE CALL Michelle Barone, Director of PFCC at 954-265-0191 or 954-265-3000 TO SCHEDULE AN INTERVIEW. **PLEASE DO NOT MAIL IN YOUR APPLICATION** – BRING IT WITH YOU WHEN YOU ARRIVE FOR YOUR INTERVIEW.

Appointment:_____ Orientation:_____ Badge:_____ Copy of Drivers License:_____	Affidavits:_____ Index Card:_____ Data Entered:_____	**TEENAGERS ONLY** Proof of Age:_____ Transcript:_____ Letter of Recommendation:_____

OFFICIAL USE ONLY

Memorial Healthcare System

PFCC PFAC ADVISOR APPLICATION

PLEASE PRINT

CIRCLE ONE: **ADULT** **COLLEGE** **STUDENT** **TEENAGER**

DATE:_____

NAME:_____
Last First M.I.

ADDRESS:_____
Street Address Apartment Number

_____
City State Zip

EMAIL ADDRESS:_____

PRIMARY PHONE #:_____ **SECONDARY PHONE #:**_____

DATE OF BIRTH: _____ **SEX:** **FEMALE** **MALE**

SOCIAL SECURITY #: _____ **DRIVER'S LICENSE #:**_____

PREVIOUS / CURRENT OCCUPATION:_____

PERSONAL OR WORK REFERENCE:_____
Name Phone #

SIGNATURE:_____

Prospective volunteers will be subjected to a background check. Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, sex, marital status or disability.

DEPARTMENT:_____ **DAYS:**_____ **HOURS:**_____

OFFICIAL USE ONLY

PLEASE SELECT THE AREA YOU FEEL YOU WOULD BEST BE ABLE TO SERVE WITHIN THE PFAC COUNCILS OF MEMORIAL HOSPITAL SYSTEM

REGIONAL **JDCH / YOUTH** **SOUTH** **PEMBROKE** **WEST** **MIRAMAR**

SPECIAL NEEDS **PRIMARY CARE**

Committees

Cancer Center	Maternity	Patient Relations	Pharmacy
Diabetes Center	Women's Imaging	PFCC Education	Coffee Cart Host
Sickle Cell	Outpatient	Dietary	Discharge
New Born ICU	Family Support	Hospitality	

Do you speak or write any foreign language? YES NO
(If yes, please indicate which language(s):_____

PREVIOUS VOLUNTEER EXPERIENCE:_____

_____

_____

_____

WHICH FACILITY ARE YOU INTERESTED IN BECOMING A MEMBER OF THE MEMORIAL PFAC ADVISOR PROGRAM AND WHY?

_____

_____

_____

_____

_____

_____

_____

How did you learn about our PFAC program?

Newspaper	_____	**Newsletter**	_____
From a friend	_____	**School**	_____
Volunteer Recruitment Event	_____	**Web site**	_____
Ad in program or bulletin	_____		

INFORMATION FOR BACKGROUND CHECK PURPOSES

for 18 years and older only

Have you ever been convicted of a felony?	Yes_____ No_____
Have you ever pled Nolo Contendre (no contest) to a felony?	Yes_____ No ____
Have you ever pled guilty to a felony?	Yes_____ No_____
Have you ever been found guilty of a felony?	Yes_____ No_____
Have you had an adjudication withheld for a felony?	Yes_____ No_____
Have a nol pros for a felony?	Yes_____ No_____
Are you presently charged with a felony?	Yes_____ No_____

Have you ever had to serve probation in any pre-trial intervention as a result of a criminal charge?

Yes_____ No_____

NOTE: A yes response does not necessarily disqualify an applicant from acceptance as a volunteer.

PLEASE LIST ANYCITY/STATE WHERE YOU HAVE RESIDED, PLEASE INCLUDE MONTH AND YEAR.
WE ARE REQUIRED TO GO BACK TEN YEARS

PREVIOUS ADDRESS:_____
City State Zip Month/Year

PREVIOUS ADDRESS:_____
City State Zip Month/Year

PREVIOUS ADDRESS:_____
City State Zip Month/Year

PREVIOUS ADDRESS:_____
City State Zip Month/Year

Due to the high cost of background checks if you fail to complete the six-month minimum commitment and minimum 100 service hours re-instatement may not be considered. Please ask for clarification if this is not clear to you.

I acknowledge that I have read and understand the commitment I am making.

Signature: _____

Date:_____

TEENAGE VOLUNTEERS ONLY

INFORMATION FOR PARENTS

1. All teenagers must be interviewed and approved by the President of the Youth Advisory Council (YAC) and the Manager of the YAC.
2. All teenagers must submit a complete application at the time of the scheduled interview.
3. YAC Shirts are available; please ask about them at your first meeting.
4. Ask how the Auxiliary assists its teen volunteers who serve 500 or more hours.
5. Service hours will be awarded at the completion of their six-month commitment. Service hour letters must be requested within a month of leaving the Volunteer Services Department.

PARENTAL CONSENT FORM FOR JOE DIMAGGIO CHILDRENS HOSPITAL YOUTH ADVISORY COUNCIL

Date:_____

My daughter/son has my consent to become a Teenage Volunteer for Memorial. In addition, I do hereby give my consent to have him/**her tested for Tuberculosis (PPD) as part of standard pre-employment/volunteer, physical assessment process.** I have read and understand the above requirements. In addition, I have gone over the cover sheet with my teenager and he/she meets the requirements requested.

Parent's Signature:_____

_____

Address **City** **State** **Zip**

Home Phone:_____ Work Phone:_____

NOTICE TO APPLICANT OR EMPLOYEE OF INTENT TO

OBTAIN AN INVESTIGATIVE CONSUMER REPORT

Dear Applicant or Employee:

In connection with your application or employment, Memorial Healthcare System would like to procure certain background information concerning you which is contained in an investigative consumer report. An investigative consumer report may contain information regarding your: creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, and/or criminal background. This information may be gathered from personal interviews with your neighbors, friends, and/or associates, e.g., former employers.

Before we may procure an investigative consumer report, you must authorize such procurement in writing. You have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report. However, if you are an applicant, we will not consider you further for employment if you so decline. If you are an employee, we may consider employment action if you decline.

Below you will find a release which will allow us to obtain an investigative consumer report concerning the foregoing questions. Please read the release carefully before signing it and indicating your choice regarding disclosure.

RELEASE TO PROCURE AN INVESTIGATIVE CONSUMER REPORT

I have read the "Notice to Applicant or Employee" provided. I understand that I have the right to decline authorization for Memorial Healthcare System to procure an investigative consumer report concerning me.

I understand that the investigative consumer report may contain information concerning my: creditworthiness, credit standing, general reputation, personal characteristics, mode of living, and/or criminal background. I also understand that this information may be gathered from personal interviews with my neighbors, friends, and/or associates, e.g., former employers.

As disclosed above, I understand the nature and scope of the investigation that is going to be made into my background.

Understanding these rights,

_____ I authorize Memorial Healthcare System to procure an investigative Consumer Report concerning me.

_____ I do not authorize Memorial Healthcare System to procure an investigative Consumer Report concerning me.

NAME (Print Please): _____

FORMER NAMES: _____

Signature: _____

Date: _____