

# Volunteer Services

## Adult Application

Volunteer Services  
555 North Duke Street • P.O. Box 3555  
Lancaster, PA 17604-3555  
Phone (717) 544-5005 • Fax (717) 544-5966  
[www.LGHealth.org](http://www.LGHealth.org)

Today's Date \_\_\_\_\_

TITLE <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other (please specify)					GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
LAST NAME		FIRST NAME		MI	PREFERRED NAME	
MAILING ADDRESS						APT. NO.
CITY		STATE	ZIP	EMAIL ADDRESS		
HOME PHONE			CELL PHONE		WORK PHONE	
PREFERRED METHOD OF COMMUNICATION <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Other (please specify)						
<b>PERSONAL INFORMATION</b>						
How did you learn about volunteering at LG Health?						
Have you previously been employed by or volunteered for any of the LG Health entities? <input type="checkbox"/> YES <input type="checkbox"/> NO				If yes, when and for which entity?		
Do you have any relatives who work or volunteer for LG Health/Penn Medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO				If yes, name/department:		
Were you referred to volunteer with LG Health/Penn Medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO				If yes, by whom?		
Have you volunteered in a health care setting before? <input type="checkbox"/> YES <input type="checkbox"/> NO				If so, where?		
Do you speak and understand English? <input type="checkbox"/> YES <input type="checkbox"/> NO				If no, what is your primary language?		
Are you a year-round resident? <input type="checkbox"/> YES <input type="checkbox"/> NO				If not, what months are you available to volunteer?		
Are there any special accommodations we will need to provide for you to volunteer?						
Have you ever been convicted of a felony or misdemeanor?* <input type="checkbox"/> YES <input type="checkbox"/> NO if yes, please explain: <i>*Conviction of a crime will not necessarily disqualify you from volunteering.</i>						
Vehicle License Plate Number						
BIRTHDATE						
Lancaster General requires a minimum of 100 hours of services per year. (with assignment exceptions) Are you willing to make this commitment? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain.						
<b>PREVIOUS VOLUNTEER EXPERIENCE</b>						
Name of Agency				Dates of Volunteer Experience		
Duties/Responsibilities:						
<b>PREVIOUS VOLUNTEER EXPERIENCE</b>						
Name of Agency				Dates of Volunteer Experience		
Duties/Responsibilities:						
<b>EDUCATION</b>						
Level of Education <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Post-Graduate Degree:				Name of College or Graduate School		
Major	Graduation Date	Extracurricular Activities:			Are you volunteering to complete a class or extracurricular requirement? <input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>EMPLOYMENT INFORMATION</b>			
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Stay-at-Home Parent <input type="checkbox"/> College Student			
Current/Most Recent/Retired From Employer:			DATES From: _____ To: _____
Address		City	State      Zip
Position/Title		Job Responsibilities:	
<b>EMERGENCY CONTACT INFORMATION</b>			
Name		Relationship	Phone #
PERSONAL REFERENCES – Two references are required. Please provide complete names and addresses of references that will be completing a reference form for you. References should not be related to you or live at the same address.			
Name		Relationship	Phone
Address		City	State      Zip
Name		Relationship	Phone
Address		City	State      Zip
<b>MEDICAL INFORMATION</b>			
Family Doctor's Name		Phone	
Are you able to provide record of proof of 2 MMR's (Rubella, Rubeola and Mumps) and proof of 2 varicella (chicken pox) vaccinations if born after 1957? * <input type="checkbox"/> YES <input type="checkbox"/> NO      *If you are unable to provide proof, we will test you for immunization at our expense.			
Do you use nicotine products? <input type="checkbox"/> YES <input type="checkbox"/> NO		Do you agree to have a mandatory flu shot vaccination during each flu season? <input type="checkbox"/> YES <input type="checkbox"/> NO Note: It is mandatory to complete a 2-step tuberculosis test, nicotine, and drug screening after volunteer orientation If you fail these tests you will be unable to volunteer at LGH.	
COVID-19 Vaccine is mandatory. Please submit a copy of you Covid-19 vaccination record card along with this application.			
<b>ADDITIONAL SKILLS AND EXPERIENCES (check all that apply)</b>			
Administrative/Office: <input type="checkbox"/> Accounting <input type="checkbox"/> Answering Phones <input type="checkbox"/> Bookkeeping <input type="checkbox"/> Filing <input type="checkbox"/> Receptionist			
Medical: <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Technician			
Computer: <input type="checkbox"/> Data Entry <input type="checkbox"/> Data Analysis <input type="checkbox"/> Microsoft Access <input type="checkbox"/> Microsoft Excel <input type="checkbox"/> Microsoft PowerPoint <input type="checkbox"/> Microsoft Word			
Miscellaneous: <input type="checkbox"/> Music <input type="checkbox"/> Pet Therapy <input type="checkbox"/> Reiki <input type="checkbox"/> Cuddler <input type="checkbox"/> Other (please specify): Do you currently hold any certification or licensure? If yes, please describe:			
<b>INTERESTS (check all that apply)</b>		<b>PHYSICAL LIMITATIONS</b>	
<input type="checkbox"/> Direct patient contact <input type="checkbox"/> Greeter <input type="checkbox"/> No patient contact <input type="checkbox"/> Office/Clerical <input type="checkbox"/> Transporter		<input type="checkbox"/> Unable to walk distances <input type="checkbox"/> Unable to push wheelchairs	
<b>AVAILABILITY</b>			
Date available to begin:		Total hours per week desired: <input type="checkbox"/> 2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 4+	
Preferred day(s) and time(s) to volunteer: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU			<input type="checkbox"/> MORNINGS <input type="checkbox"/> AFTERNOONS <input type="checkbox"/> EVENINGS
Preferred location: <input type="checkbox"/> Downtown Hospital <input type="checkbox"/> Women & Babies Hospital <input type="checkbox"/> Suburban Outpatient Pavilion <input type="checkbox"/> Ann B. Barshinger Cancer Institute <input type="checkbox"/> Other (please specify):			
What do you hope to gain from volunteering?			

## RELEASE OF INFORMATION, CONFIDENTIALITY STATEMENT AND CONSENT OF PHOTO(S)

Upon submission of this application, I certify that all statements are true and correct to the best of my knowledge and belief. Any misrepresentation or omissions on this application may be sufficient cause for rejection of the application or dismissal. If accepted to volunteer, I hereby agree to abide by the rules and policies of Lancaster General Health. In connection with my application for volunteering for Lancaster General Health, I understand that investigative background inquiries will be done, including criminal, driving, and other reports. These reports may include information reflecting upon my character, work habits, performance, and experience. Further, I understand that information from various federal, state, or local agencies, which maintain records concerning my past activities relating to my driving, criminal, civil, and other experiences, may be required.

In order to enable Lancaster General Health to fulfill its obligation to provide a safe environment for patients, employees, and volunteers, I consent to the collection of blood and/or urine samples to test for the presence of alcohol, drugs, and nicotine. I understand that if the results of such testing are confirmed positive, I will not be eligible to volunteer. I understand that at any time during my volunteer assignment, I may be tested again. If the results of such testing are confirmed positive or I refuse to cooperate fully with a testing procedure, I may be subject to discipline, including termination. I furthermore authorize the release of any and all medical information obtained during the testing procedures as required.

I acknowledge and agree to abide by LGH's "Tobacco-Free Environment" policy that smoking or any tobacco use is strictly prohibited on LG Health grounds.

I also understand that patient information is strictly confidential. All hospital personnel (paid or unpaid) have an obligation to maintain patient confidentiality. Information concerning patients must never be discussed by volunteers or shared with other people inside or outside LGH. Any violation of a patient's privacy will result in the immediate dismissal of the volunteer.

I hereby consent to have photograph(s), including still photo, art or illustration, motion picture, or video pictures and/or recordings taken of me by Lancaster General Health and any of its entities. I consent to the use of the photographs and /or recordings for such purposes as promotion and publicity of LG Health and its entities. I waive all claims for compensation for use of the photographs and hereby release all members of the LGH System, its employees, and its medical and dental staff from any claim or liability arising from the taking or use of photographs and/or recordings.

**Signature of Applicant** \_\_\_\_\_

**Date** \_\_\_\_\_

The typical timeframe for an applicant to start volunteering is anywhere from 6-8 weeks, depending on capacity of orientation sessions, additional training needed, criminal background results, meeting health screening requirements, etc.

### FOR OFFICE USE ONLY

**Application Received:**

**Orientation Date:**

**Date Started:**

**Date Active:**

**Assignment/Association:**

**Day/Time:**

**Location:**

- Covid -19 Handout
- Covid -19 Acknowledgement
- Covid -19 Vaccine Record Card

- Uniform Received     Paid     N/A
- Megan's Law
- Background Check
- Child Abuse/ Fingerprint
- Position Description
- Department Orientation  
Date Received \_\_\_\_\_
- Computer Access
- Sign-In Sheet
- Department Schedule  
(Schedule/Assignment)

- Drug and Nicotine Complete
- 2 step TB Complete
- Immunizations Complete
- Flu shot (during flu season Oct-Apr)

- If applicable titers/booster needed for:**
- Chicken Pox
  - Measles     Mumps     Rubeolla/Rubeolla
  - Booster Complete
  - All Medicals and Immunization Complete