COMMUNITY MEDICAL CENTER
From day one.

2827 Fort Missoula Road ▪ Missoula, MT 59804
(406) 728-4100 ▪ www.communitymed.org

Greetings:

Thank you for your interest in volunteering at Community Medical Center.

Enclosed you will find:

- Application
- Parental/Guardian Consent Form (if applicable)
- Volunteer Agreement Form
- Background Check Authorization
- Confidentiality Statement
- Immunization Checklist (Please provide a photocopy of your immunization card. CMC will provide the TB test, boosters and other screenings, if necessary).
- 3 Letters of Reference (Complete the top portion and attach the reference or give the form to other professionals and ask them to complete for you).

If you have any questions regarding the materials in this packet, please email jmartin@communitymed.org, or call me at 327-4258 for clarification. Otherwise, when the forms are complete, please mail or drop off to Volunteer Services, 2827 Fort Missoula Road, Missoula, MT 59804.

Sincerely,

Jennifer Martin
Volunteer Coordinator
327-4258

VOLUNTEER SERVICES

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Areas of interest:

Instructions – Print in ink or type all answers. Read carefully and fill in items completely. Return completed application directly to Community Medical Center.

Name (Last, First, Middle)	Email Address	Social Security No.	Home Phone

Mailing Address	City	County	State	Zip Code	Cell Phone

Are you under 18? Yes ☐ No ☐	Date of Birth	Are you interested in information pertaining to CMC Auxiliary? Yes ☐ No ☐

PROFESSIONALS: Are you Registered/Licensed/or Certified in this state? Yes ☐ No ☐	Year first Registered/ Licensed/or Certified	Registered/Licensed/ Certified As	Last date renewed		Registration/ License/ or Certification No.
			From	To	

Is there anything you would like us to consider prior to volunteering?

QUALIFICATIONS

Please list any education, training and/or specialized experience which you feel would help you perform the job(s) for which you are applying, such as schools; colleges, degrees; licenses; vocation technical or military experience or training; hobbies, etc.

NAME AND ADDRESS OF SCHOOL OTHER PROVIDER OR PROGRAM		IDENTIFY YOUR MAJOR OR MINOR; DESCRIBE THE SPECIALIZED TRAINING OR EXPERIENCE, ETC.
	Did you graduate? Yes ☐ No ☐ Degree_____	
	Did you graduate? Yes ☐ No ☐ Degree_____	
	Did you graduate? Yes ☐ No ☐ Degree_____	

Special skills or experiences pertinent to this application

Is volunteer work a requirement for school credit? Yes ☐ No ☐ How many hours?_____

How did you become interested in Community Medical Center's Volunteer Program?

VERIFICATION AND SIGNATURE

1. I authorize the investigation of all matters which the Medical Center deems relevant to my qualifications for volunteering, including all statements made in this application and in any attachments or supporting documents. I authorize Community Medical Center to request and receive such information, and I release from all liability any persons (such as former supervisors or employers) supplying it. I also release the Medical Center from all liability which might result from making the investigation.
2. I certify that the facts and information in this application and in any attachments or supporting documents are true and complete to the best of my knowledge. I understand that any falsification, misrepresentation or omission, as well as any misleading statements, generally will result in denial of volunteering or immediate termination, regardless of when and how discovered.
3. I understand that I may be required to submit to pre- or post- employment physical or other professional examinations, medical inquiries, and/or testing. I agree to such examinations, inquiries and/or testing at the Medical Center's expense. I authorize release of the results to the Medical Center and their use to evaluate my suitability for volunteering. I also release the Medical Center from all liability arising out of or connected with any examinations, inquiries and/or testing.

I certify that I have read each of the above statements and that I have also reviewed all of the information I have provided in this application and in any supporting documents.

SIGNATURE:_____ DATE:_____

UNSIGNED APPLICATIONS WILL NOT BE ACCEPTED

Days & Times Available:	**REFERENCES:** List names and contact information for your three references
_____	_____
_____	_____
	_____
Date you will be available for volunteering:	

CRIMINAL RECORD: Conviction of a crime is not an automatic bar from volunteering. Factors such as the nature and the gravity of the crime, the length of time since the conviction and/or completion of any sentence, and the nature of the job for which you have applied will be considered.

Have you ever been CONVICTED, pled GUILTY or NO CONTEST, or forfeited bond or bail for any crime other than traffic violations? Yes ☐ No ☐
If yes, give details:_____

DRIVING RECORD: *If the position applied for involves driving.*
Have you ever been CONVICTED, pled GUILTY or NO CONTEST, or FORFEITED BAIL for any traffic violation in the past 3 years? Yes ☐ No ☐
If yes, give details:_____

VOLUNTEER/WORK HISTORY

Are you willing to have your present or most recent employer contacted regarding your qualifications? Yes ☐ No ☐
Have you ever been employed by Community Medical Center? Yes ☐ No ☐

Begin with your present or last work and list in reverse order every position you have held. Complete fully, especially description of duties, giving tasks performed, responsibilities and number of people you supervised.

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time ____yrs. ____mos.	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties				

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties				

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time ____yrs. ____mos.	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties				

NOTE: It is the policy of this institution to check the personal references of persons selected for volunteering.

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CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES

This authorizes _____ to participate in volunteer activities prescribed by Community Medical Center's Employee Health and Volunteer Services. I understand that my daughter's or son's services are donated to Community Medical Center without thought of compensation or future employment. Her/his time is given for humanitarian or charitable reasons.

We release Community Medical Center and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the CMC, while participating in such volunteer activities.

_____
Signature of parents/guardian

_____
Date

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IF ACCEPTED AS A VOLUNTEER, I AGREE THAT:

1. I shall hold as *absolutely confidential* all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and *not seek* to obtain confidential information from a patient or about a patient.
2. My services are donated to the Medical Center without thought of compensation or future employment, and given with humanitarian or charitable reasons.
3. I understand that it is a crime to solicit business for attorneys or insurance companies.
4. I shall not sell or attempt to sell goods or services, request contributions, or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of Volunteer Services to engage in these activities.
5. I shall submit to examinations, which may include chest X-rays, skin test, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer services. I also authorize the person(s) making tests of X-ray film to report the results to the hospital.
6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
7. I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and, if unsuccessful, attempt to resolve any such problems with Volunteer Services.
8. I shall make my best effort to fulfill my commitment to the Medical Center by completing all assignments that I accept.
9. I shall at all times uphold the mission and standards of the Medical Center.
10. I understand that Volunteer Services reserves the right to terminate my volunteer status as a result of (a) failure to comply with Medical Center policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the department director, would make my continued service as a volunteer contrary to the best interests of the Medical Center.

I have read each of the above conditions and I agree to be bound by them.

_____ _____

Volunteer Signature Date

_____ _____

Volunteer's Parent/Guardian Signature (For Volunteer Under Age 18) Date

BACKGROUND CHECK FORM

NAME:_____
FIRST MIDDLE LAST

ADDRESS:_____
Street City State Zip Code

MAIDEN NAME OR OTHER NAMES USED: _____

DATE OF BIRTH_____ **SOC. SEC. #**_____

Have you ever been arrested or convicted for any criminal offense excluding minor traffic violations? If yes, explain:

Have you ever been accused, arrested, or convicted of abuse or sexually related crimes? If yes, explain:

Is there anything in your life-style or background that would call into question your ability? If yes, explain:

(PLEASE NOTE: answering "yes" to any of these questions does not automatically disqualify you. Please use the spaces provided to explain the circumstances.)

I hereby authorize Community Medical Center to make an independent investigation of my background and criminal or police records. I release Community Medical Center and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above sources. The information contained in this application is correct to the best of my knowledge. I understand that any omission of material fact may be grounds for rejection of this application. All information gathered will be kept strictly confidential.

SIGNATURE:_____

DATE:_____

COMMUNITY MEDICAL CENTER

Missoula, Montana

From day one.

CONFIDENTIALITY STATEMENT

Inappropriate access, discussion, or release of patient's condition, nursing or medical care, or any personal information about a patient (including financial status) is considered to be a violation of privacy.

Every employee who has direct or indirect access to data pertaining to the admission, care and disposition of any and all patients treated at Community Medical Center is to access that information based on a "business need to know" basis only and to maintain that information with the strictest confidentiality. Any unauthorized releasing or casual discussion of such information is considered to be a violation of the patient's privacy. Not only is health care information confidential but all personal, practice, business, and other corporation information is confidential and may constitute a trade secret as well. Any release of information emanating from Community Medical Center is not allowed. Any breach of patient confidentiality is considered gross misconduct and subject to immediate dismissal.

This also applies to any and all information obtained through the computer system regarding clinical information and / or financial data.

Exchange of confidential information with patients, visitors, or other employees inside or outside Community Medical Center is unethical and may harm the patient and subject the Medical Center to liability. Everything that happens within Community Medical Center must be treated as confidential and should not be discussed with anyone except on a "need to know" basis.

This also applies to any and all information obtained through the computer system regarding diagnostic test information and financial data.

To be completed by all employees, volunteers, and students.

I, _____, have read the above Community
(Print Name)
Medical Center policy pertaining to confidentiality. I agree to safeguard the privacy and confidentiality of **all** information that I have access to in the course of my work and to use proper procedures when required to release such information to others. I understand that failure to do so may result in disciplinary action, up to and including termination of employment.

_____ _____

Employee, Volunteer, or Student Date

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VOLUNTEER IMMUNIZATION CHECKLIST

NAME: _____
Please print

Please attach photocopies of the following immunizations:

1. Measles, Mumps, and Rubella (MMR)
   2 dates of MMR immunizations, one is given as a baby and the other before starting Kindergarten. Individuals born before January 1st, 1957 may not have this documentation.
2. Tuberculosis (TB)
   A negative chest x-ray within the last year or 2 TB skin tests performed 1-3 weeks after the initial within the previous year.
3. Tetanus, Diphtheria, and Pertussis (TDaP)
4. Varicella Titer (Chicken Pox)

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I, _____, have applied to be a volunteer at Community Medical Center. I would appreciate a personal reference from you on my behalf. Please complete the following and return it in the enclosed envelope to the Volunteer Services Program at Community Medical Center. Thank you.

Signature _____ Date _____

****

Name _____

Relationship to the applicant _____

Years acquainted with the applicant _____

Would you recommend that we accept this applicant as a volunteer? Yes ☐ No ☐

Remarks _____

_____

_____

_____

_____

_____

Signature _____ Date _____

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_____

_____

_____

_____

_____

Signature _____ Date _____

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Years acquainted with the applicant _____

Would you recommend that we accept this applicant as a volunteer? Yes ☐ No ☐

Remarks _____

_____

_____

_____

_____

_____

Signature _____ Date _____