**VOLUNTEER RECRUITMENT FORM
*(Background check required)***

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Texts ☐ Yes ☐ No Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you under 18 years of age? ☐ Yes ☐ No

***\*\*If you are under the age of 18, please provide your guardian's information below:***

Guardian Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Guardian email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I grant permission to Cody Regional Health, Employee Health, to test my minor for TB (tuberculosis). I understand that it is my responsibility to have the test “read” within 48-72 hours by the Cody Regional Health Employee Health Nurse. I also understand that this test and results are confidential and kept on file in a secure volunteer medical record.

Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide your emergency contact information below:**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

Do you have any limitations related to health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last flu vaccine? ☐ This year ☐ Last Year ☐ More than three years ago ☐ None

Where did you receive your last flu vaccine? (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had TB? ☐ Yes ☐ No Does anyone in your family or home have TB? ☐ Yes ☐ No

When was your last TB test? \_\_\_\_\_\_\_\_\_\_\_\_ Results of your TB test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received your COVID-19 vaccination? ☐ Yes ☐ No

Where did you receive your COVID-19 vaccination? (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you ever had a latex allergy? ☐ Yes ☐ No

Other allergies (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent/Background**

Will you consent to the taking of photographs, and/or videotaping for Cody Regional Health’s use in marketing, advertising, or promotional materials? ☐ Yes, I consent ☐ No, I do not consent

Are you currently or have you ever been employed by Cody Regional Health? ☐ Yes ☐ No
\*If yes, please provide date\_\_\_\_\_\_\_\_\_\_ and reason for separation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever plead guilty to or been convicted of a misdemeanor or felony (except minor traffic violations)? *(\*A yes answer does not automatically disqualify you from volunteer status. The nature of the offense, date, and area you are applying for will be taken into consideration).* ☐ Yes ☐ No

* I hereby request status as a Non-Employee of Cody Regional Health.
* All information submitted by me in this application is true to the best of my knowledge and belief.
* I fully understand that any significant misrepresentation or omission constitutes cause for denial or revocation of my status as a volunteer.
* I certify that, to the best of my knowledge, I am free of infection and able to perform my duties as a volunteer.
* The information I have provided on this form is complete and accurate.
* If I develop a serious health issue or infection I will report these changes to the Employee Health Office.
* I acknowledge and understand that, as a volunteer, I am subject to Cody Regional Health policies and procedures as relevant to the scope of activities outlined above and approved within this document.
* I acknowledge that I can only perform activities that are listed within this document or are demonstrated in the competencies documentation that I have provided and that are retained with Cody Regional Health.
* I will act professionally and within the guidelines of Cody Regional Health Service Excellence Standards.
* I also understand that Cody Regional Health reserves the right to ask me to leave the facility at any time due to my behavior or organizational need.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Listed below are the volunteer service areas with a brief description.
Please check all areas that may be of interest to you.**

☐ Gift Shop – Assist customers with purchases and assist with inventory restocking.

☐ Office Help – Assist with filing, basic office duties.

☐ Pet Therapy – Visit patients and staff with your dog. Certification of animals through Alliance of Therapy Dogs, Inc. is required.

☐ Patient Care Cookie Baker (3rd Floor) - Make cookies and deliver them to patients and their family.

☐ Cancer Center – Assist with getting lunches from hospital and taking them over to nurses, patients, office help, and cookie bakers.

☐ Spirit Mountain Hospice – To volunteer for Spirit Mountain Hospice requires additional training. Hospice House volunteers (especially receptionists) are always needed. Another volunteer task is to serve in the homes of Hospice Patients.

☐ Human Resources/Flu Shot Clinic- Short term 3-6 months or by project basis, help with filing and making copies.

☐ Plant Operations – Flower bed gardening (seasonal), touching up wood furniture, outside cleanup, pressure washing, folding laundry, cleaning shop and break room, painting (see Volunteer Coordinator for additional tasks).

☐ LTCC – Includes: Bingo – Assisting residents with their bingo cards and helping with prizes; Manicures – Assist residents with manicures, polishing, filing, etc.; Music – Assist residents to and from activity; Reading newspapers, magazines, or books to residents and discussing the news with them; Work one-on-one with Alzheimer’s/Dementia residents; Ice Cream Social – Serving ice cream from room to room.

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours would you like to work each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about our volunteer program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What skills or training do you have that may be utilized in your volunteer assignments?