



2720 Sunset Boulevard
West Columbia, SC 29169
803-791-2000

Dear Applicant,

Thank you so much for your interest in volunteering at Lexington Medical Center. We are delighted that you are considering us as a place to contribute your volunteer time.

Enclosed is an application, which will need to be completed and **brought with you** on your initial interview. **To set a time and date for the initial interview please call the Volunteer Office at 791-2573.**

During the interview, we will get acquainted and discuss areas of service interest. Efforts are made to match both the interests of the volunteer applicant and the needs of the Medical Center. Service opportunities are also based on the availability of open volunteer positions and not all areas may have openings.

As a part of our two phase application process, we require the following:

Phase One

- **Interview – Call Volunteer Office(791-2573) to make an appointment**
- Two personal references (please provide names and address, we will mail ref. Letters)
- A health reference from your doctor (please provide Drs. Name, we will mail ref letter)
- Background check

Upon successful completion of Phase One, we will then invite you to attend Volunteer Orientation. After orientation you will meet with the Employee Health Nurse for the following:

Phase Two

- TB (done at orientation), and health assessment

If it is mutually agreeable that you join our program after completing Phases One & Two of the application process we will then arrange for you to have your ID badge made and you may purchase your uniform from the hospital at that time.

If you have any questions, please don't hesitate to call our office (791-2573). Thank you again for your interest in our volunteer program.

Sincerely,

Ann Bethea, Director
Volunteer Services Department



2720 Sunset Blvd. West Columbia, SC 29169
803-791-2573

**Volunteer Department
MATURE COLLEGE STUDENT
VOLUNTEER PROGRAM APPLICATION**

Lexington Medical Center is an equal Opportunity Employer and pledges to provide equal opportunities without regard to race, color, religion, age, sex, national origin, disability or veteran's status. Lexington Medical Center provides a smoke-free work environment.

Date _____

SECTION I: GENERAL INFORMATION

Name _____
Last First Middle

Social Security Number _____ Phone Number _____ Birthdate ____/____

Cell Phone Number _____ E-Mail Address (Optional) _____

Present Address _____
Number Street

City State Zip

In Case of Emergency, Notify _____
Name Relationship

Address

Home Phone Business Phone Cell Phone

Volunteer Position Preference _____ Availability: Morning _____ Afternoon _____ Evening _____

Will you volunteer weekends? _____ Yes _____ No

Have you been convicted of anything other than minor traffic violations? _____ Yes, _____ No. If yes,

(Please explain) _____
(Conviction of a crime is not an automatic bar to volunteering other circumstances will be considered)

Please list any special skills, experience, hobbies and/or interests _____

SECTION II Education

SCHOOL NAME AND LOCATION	DATES ATTENDED	GRADUATED	DEGREE/DIPLOMA
High School -			
College -			
Special training, professional or technical School -			

SECTION III: EMPLOYMENT/VOLUNTEER HISTORY

Please list any professional and/or volunteer experience _____

If currently employed, please complete the following:

Name and address of Company	Dates From/To	Job Title
_____	_____	_____

Duties _____

If presently employed, may your employer be contacted at this time for a reference? Yes _____ No _____

SECTION IV: Please list reasons for wanting to volunteer: _____

SECTION V: REFERENCES

REFERENCES (PLEASE LIST TWO PEOPLE WHO YOU AUTHORIZE US TO CONTACT FOR A REFERENCE(PLEASE NO RELATIVES)

1. NAME _____	2. NAME _____
ADDRESS _____	ADDRESS _____
CITY/STATE/ZIP _____	CITY/STATE/ZIP _____
PHONE _____	PHONE _____
RELATIONSHIP _____	RELATIONSHIP _____

PHYSICIAN

Personal Physician _____ Phone Number _____

Physician's Address _____
Number Street Suite Number

City State Zip

I certify that the information I have given on this application is true and complete and agree that any false information including that given at the time of physical examination is cause for dismissal. The company, school and person named above may give information regarding me and I release them from all liability for doing so. I understand that any offer by the Volunteer Services Department is conditional on satisfactory replies from references, background check, health reference and physical examination, which includes blood and/or urine tests to detect the presence of illegal drugs or alcohol. This is not a contract for the Volunteer Services Department and Lexington Medical Center has the right to separate you from the volunteer program at any time as you have the right to leave at any time. If qualified for volunteer service, I agree to abide by the rules and regulations of Lexington Medical Center, that policies and procedures of the Volunteer Service Department and the department to which I am assigned. I will respect the confidentiality of patient information and abide by all HIPAA guidelines

Signature _____

Date _____

Print Patient (Volunteer) Full Name _____

Date of Birth _____

AUTHORIZATION FOR RELEASE OF Personal Health Information (PHI)

I authorize _____
Name of physician or physician practice
to release personal health information as listed below and is related to my application for volunteer service at Lexington Health Services District.

Signature of Volunteer Candidate _____

Date _____

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To be Completed by Clinical Staff

**Request for Personal Health Information and Release Form**

**Dear Physician:**

Your patient has applied for hospital volunteer service with Lexington Medical Center. In order to volunteer the individual must be in good physical and mental health and free of infectious diseases.

Please answer the questions below and return this letter in the **enclosed stamped, self-addressed envelope** at your earliest convenience. The Information will be regarded as confidential and maintained in the volunteer's health record in Employee Health. This information will be discussed as part of their occupational health nursing assessment/screening process and provided to regulating agencies upon request.

1. \_\_\_\_ Yes \_\_\_\_ No To the best of your knowledge, is this applicant in sufficiently good physical and emotional health and free of infectious diseases to perform hospital volunteer duties with Lexington Medical Center?
2. \_\_\_\_ Yes \_\_\_\_ No This applicant may be assigned to work directly with patient(s).

Comments: \_\_\_\_\_  
\_\_\_\_\_

**Please complete if information is already available. TB testing and titers and vaccinations may be performed in Employee Health at no cost to the patient/volunteer if information is not already available.**

|                                  | Vaccination Dates                                                 | Titer Date IF AVAILABLE | Titer Results (CIRCLE) | Documented Disease Date |
|----------------------------------|-------------------------------------------------------------------|-------------------------|------------------------|-------------------------|
| MMR or individual vaccines below | <input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 _____ |                         |                        |                         |
| Measles                          | <input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 _____ |                         | POS NEG INDET          |                         |
| Mumps                            | <input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 _____ |                         | POS NEG INDET          |                         |
| Rubella                          | <input type="checkbox"/> 1 _____                                  |                         | POS NEG INDET          |                         |
| Varicella                        | <input type="checkbox"/> 1 _____ <input type="checkbox"/> 2 _____ |                         |                        |                         |

Signature of Physician \_\_\_\_\_

Print MD name \_\_\_\_\_

Date \_\_\_\_\_

Employee Health Medical Director is Alice Barker, MD, Occupational Health  
**Return completed form to:**  
LMC Employee Health Clinic  
2720 Sunset Blvd.  
West Columbia, S.C. 29169

**Notice/Authorization for Release of Information for Volunteer Purposes  
Investigative Consumer Report**

**This form will not be accepted if altered, illegible, or incomplete.**

In connection with my application for volunteering with Lexington Medical Center, I authorize Lexington Medical Center-Volunteer Services, Background America, Inc., or its agents to procure a consumer report, SLED report and/or investigative consumer report about my background, character or reputation, including, but not limited to, information as to my employment, education, consumer credit history, driving record, social security number verification, criminal record and/or other public records history as is applicable to volunteering. I authorize all persons to fully disclose information relevant to this investigation. I further authorize that a photocopy of this authorization may be considered as an original. I understand that all offers of volunteering are contingent upon the results of this background investigation.

**I have read and understand this statement and I authorize, any person, agency or other entity contacted by Lexington Medical Center, Background America, Inc., or its agents, to furnish the above-mentioned information.**

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|                  |                          |                           |              |
|------------------|--------------------------|---------------------------|--------------|
| <b>Signature</b> | <b>Social Security #</b> | <b>Driver's License #</b> | <b>State</b> |
|------------------|--------------------------|---------------------------|--------------|

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|                                                 |                                                   |
|-------------------------------------------------|---------------------------------------------------|
| <b>Print name (last, first, middle initial)</b> | <b>Other names used (alias, maiden, nickname)</b> |
|-------------------------------------------------|---------------------------------------------------|

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**Current address**

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|             |              |                 |               |
|-------------|--------------|-----------------|---------------|
| <b>City</b> | <b>State</b> | <b>Zip Code</b> | <b>County</b> |
|-------------|--------------|-----------------|---------------|

**Previous addresses (for the past seven years):**                      **Dates lived here:**

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|                     |               |  |
|---------------------|---------------|--|
| Street, City, State | <b>County</b> |  |
|---------------------|---------------|--|

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|                     |               |  |
|---------------------|---------------|--|
| Street, City, State | <b>County</b> |  |
|---------------------|---------------|--|

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|                     |               |  |
|---------------------|---------------|--|
| Street, City, State | <b>County</b> |  |
|---------------------|---------------|--|

- Have you ever been convicted of, or plead guilty or no contest to any crime (anything other than a minor traffic violation)? YES\_\_\_NO\_\_\_ If yes. What? \_\_\_\_\_
- Have you ever been convicted in a military court martial? YES\_\_\_NO\_\_\_
- Are you currently under any investigation or pending charge? YES\_\_\_NO\_\_\_
- Have you ever been sanctioned, disciplined, debarred and/or excluded by a duly authorized regulatory agency? YES\_\_\_NO\_\_\_
- Is your license/certification currently in a probationary status, restricted or limited in any way? YES\_\_\_NO\_\_\_

I certify that the information contained on this form is true and correct and I understand that my application or volunteering will be terminated based on any false, omitted or fraudulent information. Further, I understand that this Authorization/Release form shall remain in effect for the duration of my volunteering with Lexington Medical Center.

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Signature

Date

Date of Birth(month/day/year)\_\_\_\_\_