Dear Volunteer Applicant,

Thank you for your interest in our Adult Volunteer Program here at Lexington Medical Center. We are delighted that you are considering us as a place to volunteer your time for our patients, visitors and employees. We have an application process that is outlined below:

1. Complete Application (on-line or bring your application with you to the interview)
2. Call 791-2573 to schedule an interview
3. Attend Orientation (Invitation to attend a mandatory orientation will be mailed)
4. Complete free health assessment with Employee Health (by appointment only)

Steps 3 and 4 will be discussed in detail at the time of your interview. If you have any further questions, please do not hesitate to call 791-2573. I look forward to meeting you.

Thank you.

Ann Wingate, Director
Volunteer Services

LEXINGTON MEDICAL CENTER

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

Volunteer Department
ADULT VOLUNTEER PROGRAM APPLICATION

Date_____

SECTION I: GENERAL INFORMATION

Name_____
Last First Middle

Social Security Number_____ **Phone Number**_____ **Date of Birth**___/____

Cell Phone Number_____ **E-Mail Address** _____

Present Address_____
Number Street

_____
City State Zip

In Case of Emergency, Notify _____
Name Relationship

_____
Address

_____
Home Phone Business Phone Cell (Optional)

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_____
ADDRESS_____
CITY/STATE/ZIP_____
E-MAIL_____
RELATIONSHIP_____

2.
NAME_____
ADDRESS_____
CITY/STATE/ZIP_____
E-MAIL_____
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, schools 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

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.

Signature **Social Security #** **Driver's License #** **State**

Print name (last, first, middle initial) **Other names used (alias, maiden, nickname)**

Current address

City **State** **Zip Code** **County**

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

_____ _____
Street, City, State **County**

_____ _____
Street, City, State **County**

_____ _____
Street, City, State **County**

- 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 marital? 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.

_____
Signature Date

Date of Birth(month/day/year)_____

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