



Community Hospital of San Bernardino

A member of CHW

Volunteer Services Adult/ Auxiliary Application/ Membership Package





Becoming a Volunteer or Auxiliary Member

There are four steps to the volunteer intake process:

1. the Application process
2. the Interview
3. the Screening process and,
4. the Orientation

The Application Process:

You may pick up an Adult, Junior, or Auxiliary application at the front desk in the hospital lobby. Once completed you should return your application to the front desk. After your application has been reviewed, you will be contacted in approximately one or two weeks to schedule an interview.

The Interview:

Volunteer candidates will be invited to interview with the Manager of Volunteer Services. This interview helps the Manager to understand your needs and desires as a volunteer and helps us to best match your interests, skills and talents with the current needs of the hospital. You may also be asked to volunteer with the Manager or Director of a specific department. At this time volunteers are asked to make a minimum commitment of 100 hours of volunteer service.

The Screening Process:

All adult volunteers (age 18 plus) are required to have a background check. All volunteers, adults and juniors, are required to complete the TB screening process. Once the background screening is complete you will be contacted by the Manager of Volunteer Services to begin your first TB screening. The TB screening is a two part process. The first screening must be completed before the volunteer can attend orientation. The second follow-up screening is completed approximately two weeks after the first screening.

The Orientation:

Once the screening process is complete you will be contacted by the Manager of Volunteer Services and asked to attend a scheduled orientation. Orientation will cover topics such as Fire and Facility Safety, Infection Control, Privacy Policy, Volunteer Responsibilities, Dress Code Policy, and Standards of Behavior. This information is important in the hospital environment and is required for all healthcare workers, including volunteers. Additional paperwork will be given to you at this time to comply with these policies. Once you have been placed on a volunteer assignment you will be given additional orientation by your department supervisor relating to your specific role as a volunteer within that department.

Once your orientation is complete your start date will be scheduled.

Adult Volunteer Program

Dear Interested Adult:

Thank you for your interest in the Volunteer Program at Community Hospital of San Bernardino.

The purpose of the Volunteer Program is to provide non-clinical customer service to our patients, visitors and staff. The Volunteer Program offers the opportunity to perform community service and provides an introduction to a variety of career choices in healthcare.

To be eligible for the Volunteer Program, you must:

- ☞ Have a High School Diploma or equivalent
- ☞ Submit this completed application packet with all the requested attachments
- ☞ Consent to a background check completed by HireRight, Inc.
- ☞ Copy of Drivers License or small photo of yourself
- ☞ Attend an interview session (by appointment)
- ☞ Complete R.S.V.P. Safety and Infection Control packet
- ☞ Purchase and maintain volunteer uniform. Volunteer shirts are available for purchase in the Volunteer Center upon acceptance to the program
- ☞ Consent to and clear the TB test administered by CHSB Employee Health Services
- ☞ Attend Orientation (by appointment)
- ☞ Commit to volunteer a minimum of 100 hours a calendar year
- ☞ Commit to abide by the policies and procedures of Volunteer Services, including ethical guidelines for conduct and protecting patient confidentiality at all times
- ☞ Maintain a positive attitude and support the mission and values of Community Hospital of San Bernardino

Upon receipt of your completed application and background check you will be contacted to schedule an interview. Upon acceptance into the volunteer program you will be required to complete the TB tests, then invited to attend the next scheduled orientation. At the orientation you will learn about the Volunteer Program, the policies and procedures for Volunteers, and potential Volunteer assignments will be discussed.

For more information please contact Carrie Schmidt, Manager Volunteer Services, at 909.806.1260. Again, thank you for your interest in joining the Volunteer Program at CHSB. Volunteers touch lives and lift spirits every day in our hospital. We appreciate your interest in joining our team.



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**ADULT VOLUNTEER PROGRAM
APPLICATION CHECKLIST**

Dear Interested Adult,

Thank you for your interest in the Volunteer Program of Community Hospital of San Bernardino.

To complete the first step of the application process, please return the following documents, signed and dated as appropriate:

- Volunteer Application
- Consent to Background Check (completed by HireRight, Inc. in coordination with Human Resources)
- Disclosure of Authorization Form
- Ethics Guidelines Agreement
- Authorization for Consent to Treatment

Once these documents have been submitted and approved, you will be contacted to schedule an interview for consideration into the volunteer program at the hospital. Upon acceptance you will then be required to complete the TB screening and the remainder of the volunteer application process.

Thank you once again for your interest in volunteering at Community Hospital of San Bernardino.

Carrie Schmidt
Manager, Volunteer Services
Community Hospital of San Bernardino
909.806.1260
clschmidt@chw.edu



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Community Hospital of San Bernardino Auxiliary Information and Application for Membership

Auxiliary Purpose:

- To promote and advance the welfare of the Community Hospital of San Bernardino.
- To assist patients, visitors and hospital personnel.
- To develop good public relations within our facility and the community.
- To aid in the purchase of needed equipment.

Requirement:

- Annual membership dues
 - ~ Active dues = \$5.00
 - ~ Sustaining dues = \$25.00
- Interview with Director of Volunteer Services
- Complete required application packet with requested attachments, as described in the Adult Volunteer Program Introduction letter
- Complete TB testing series
- Purchase, wear and maintain volunteer uniform
- Attend Orientation
- Volunteer a minimum of (8) hours per month
- Attend monthly meetings, unless excused by the Membership Chairman (Meetings are held 1st Monday of each month in the Henderson Auditorium at 10:00 a.m., except July & August)
- Sign in and out when you volunteer
- Participate in safety, infection control and patient privacy training annually



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Volunteer Services Adult/ Auxiliary Application/ Membership Forms



ADULT VOLUNTEER APPLICATION

- Adult Volunteer**
 Auxiliary Member

LAST NAME: _____ FIRST NAME: _____ MI: _____ SUFFIX: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ STATE: _____ EMAIL ADDRESS: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME NUMBER: _____ CELL NUMBER: _____ EMERGENCY NUMBER: _____

SPOUSES NAME: _____ NEAREST RELATIVE NAME: _____

PHONE NUMBER: _____ PHONE NUMBER: _____

CHSB EMPLOYEE? NO YES
 CHSB EMPLOYEE? NO YES

IF YES, STATE DEPARTMENT: _____ IF YES, STATE DEPARTMENT: _____

ARE YOU CURRENTLY EMPLOYED? NO YES
 ARE YOU CURRENTLY ENROLLED IN COLLEGE? NO YES

IF YES, SPECIFY WHERE: _____ IF YES, SPECIFY WHERE: _____

AVAILABILITY: (PLEASE CHECK ALL THAT APPLY) TIME(S) AVAILABLE:

SU M TU W TH F SA _____ A P _____ A P

SU M TU W TH F SA _____ A P _____ A P

WHAT IS YOUR PRIMARY LANGUAGE? _____ LIST OTHER LANGUAGE(S) YOU SPEAK FLUENTLY: _____

LIST ANY VOLUNTEER EXPERIENCE: _____

PLEASE STATE THE REASON(S) YOU WANT TO VOLUNTEER AT CHSB: _____

FOR COMMUNITY SERVICE HOURS? _____ HOURS NEEDED: _____ DATE TO BE COMPLETED BY: _____

NO YES

**ADULT VOLUNTEER/ AUXILIARY MEMBER
APPLICATION SIGNATURE PAGE**

As a member of the Community Hospital of San Bernardino Auxiliary/ Adult Volunteer, I will do my best to be a cheerful volunteer and to fulfill my obligations to Volunteer Services. I will uphold the values of Community Hospital of San Bernardino Mission and Confidentiality statements.

I will remember my volunteer work is very important to the many people of our community and the departments we serve. I will handle problems within the scope of my assignment or contact the Manager of Volunteer Services for direction.

Signature

Date of Application

Signature of Approval by Manager Volunteer Services

Date Signed by Manager Volunteer Services

Date Submitted for Board Approval (Auxiliary Membership only)

Signature of Approval by CHSB Auxiliary President

Date Signed by Auxiliary President

IMPORTANT INFORMATION

HireRight, Inc. will be verifying the information you provided to Catholic Healthcare West and Community Hospital of San Bernardino, during the pre-employment process and researching background information at our request. Our objective is to complete this process quickly.

- You may receive an email from your Recruiter requesting that you complete the on-line background check submittal process.
- A representative from HireRight, Inc. may contact you by email or phone requesting additional information to complete the background check.

Please respond promptly to help ensure that your information is processed as quickly as possible. Any delays which occur in obtaining information from you will delay the hire process.

Thank you,

Human Resources
Community Hospital of San Bernardino

Form No. 3

DISCLOSURE AND AUTHORIZATION FORM

Catholic Healthcare West may request background information about you from a consumer reporting agency in connection with your employment application and for employment purposes. This information may be obtained in the form of consumer reports and/or investigative consumer reports. These reports may be obtained at any time after receipt of your authorization and, if you are hired by the Company, throughout your employment.

HireRight, Inc., or another consumer reporting agency, will obtain the reports for the Company. HireRight, Inc. is located at 5151 California, Irvine, CA 92617, and can be contacted at 800-400-2761. The reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: social security number verifications; credit reports; criminal records checks; public court records checks; driving records checks; educational records checks; employment verifications; personal and professional references checks; licensing and certification records checks; drug testing results; etc. The information contained in the reports will be obtained from private and public record sources, including, as appropriate, personal interviews with sources, such as neighbors, friends and associates.

You may request more information about the nature and scope of any investigative consumer reports by contacting the Company. A summary of your rights under the Fair Credit Reporting Act is also being provided to you.

ADDITIONAL STATE LAW NOTICES

If you are a California, Maine, New York or Washington applicant, please also note:

CALIFORNIA: Under section 1786.22 of the California Civil Code, you may view the file maintained on you by HireRight during normal business hours. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at HireRight's offices in person, during normal business hours and on reasonable notice, or by mail. You may also receive a summary of the file by telephone, upon submitting proper identification. HireRight has trained personnel available to explain your file to you, including any coded information. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification.

NEW YORK: You have the right, upon request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

MAINE: You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

WASHINGTON STATE: If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from us a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

DISCLOSURE AND AUTHORIZATION FORM (CONT.)

AUTHORIZATION

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to the release of consumer reports and investigative consumer reports prepared by a consumer reporting agency, such as HireRight, Inc., to the Company and its designated representatives and agents. I understand that if the Company hires me, my consent will apply, and the Company may obtain reports, throughout my employment.

I also understand that information contained in my job application or otherwise disclosed by me before or during my employment, if any, may be used for the purpose of obtaining consumer reports and/or investigative consumer reports.

By my signature below, I authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requested by the consumer reporting agency.

By my signature below, I certify the information I provided on this form is true and correct. I agree that this Disclosure and Authorization form in original, faxed, photocopied or electronic (including electronically signed) form, will be valid for any reports that may be requested by or on behalf of the Company.

California, Minnesota or Oklahoma applicants only – You will be provided with a free copy of any consumer reports or investigative consumer reports obtained on you if you check the box below.

I wish to receive a free copy of the report.

Applicant Last Name _____ First _____ Middle _____

Applicant Signature _____ **Date** _____

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

| TYPE OF BUSINESS: | CONTACT: |
|--|--|
| Consumer reporting agencies, creditors and others not listed below | Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 1-877-382-4357 |
| National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name) | Office of the Controller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743 |
| Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks) | Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693 |
| Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appear in federal institutions name) | Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929 |
| Federal credit unions (words “Federal Credit Union” appear in Institution’s name) | National Credit Union Administration 1775 Duke Street Alexandra, VA 22314 703-519-4600 |
| State-chartered banks that are not members of the Federal Reserve System | Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342 |
| Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission | Department of Transportation, Office of Financial Management Washington, DC 20590 202-366-1306 |
| Activities subject to the Packers and Stockyards Act, 1921 | Department of Agriculture Office of Deputy Administrator – GIPSA Washington, DC 20250 202-720-7051 |

ETHICS GUIDELINES AGREEMENT

AUXILIARY MEMBER

ADULT VOLUNTEER

If accepted as a hospital volunteer, I agree that:

1. I will 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.
2. I am volunteering my services and there is no pay involved in the assignment.
3. I understand it is a crime to solicit business for attorneys. I will not solicit any business for attorneys or insurance companies on hospital property, or act as a runner or carrier for an attorney in the solicitation of business. I will report all known occurrences of solicitation for attorneys to the hospital Volunteer Manager.
4. I will not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions or religious material on hospital premises, unless I receive the express authorization of the hospital Volunteer Manager to engage in these activities.
5. I will, if requested, submit to examinations, which may include chest x-rays, skin tests, approved laboratory tests, and/ or immunizations that may be necessary as part of my volunteer service. If requested, I hereby authorize my doctor(s) to furnish the hospital information concerning my health. I also authorize the person(s) making x-ray films to report the results to the hospital
6. I shall be on time and conscientious, conduct myself with dignity, courtesy and consideration of others, endeavor to work as a professional and will speak and act in this manner at all times. I will keep a quiet voice.
7. I will attempt to resolve any problems related to my volunteer activities with my immediate department supervisor, and if unsuccessful, attempt to resolve any such problems in the matter with the Manager of Volunteer Services.
8. I will make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
9. I will at all times uphold the philosophy and standards of the hospital.
10. I understand that the Volunteer Service Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude work or experience; or (d) any other circumstances which, in the judgment of the department director or hospital, would make my continued services as a volunteer contrary to the best interest of the hospital.

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

Volunteer Signature

Date

Manager Volunteer Services Signature

Date

AUTHORIZATION FOR CONSENT TO TREATMENT

I, _____ do hereby authorize Community Hospital of San Bernardino's Emergency Department and Medical Staff as agent(s) for above-named to consent to any x-ray examination, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

I hereby authorize any hospital, which has provided treatment to the above-named pursuant to the provision of Section 25.8 of the Civil Code of California to surrender physical custody of such person to my above named agent(s) under the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

These authorizations shall remain effective until said above-named is no longer in the Volunteer Program at Community Hospital of San Bernardino.

Volunteer's Name (Please **PRINT**)

Volunteer's Signature (Please **SIGN**)

Home Address (Please **PRINT**)

City, State, Zip (Please **PRINT**)

Home Telephone Number

Work or Alternate Phone Number

Volunteer's Date of Birth

Volunteer's Social Security Number

Physician's Name (Please **PRINT**)

Physician's Phone Number

Today's Date



Community Hospital of San Bernardino

A member of CHW

AUXILIARY MEMBER/ VOLUNTEER EMERGENCY CONTACT INFORMATION

Dear Auxiliary Member/ Volunteer,

In order to ensure that we have the most recent and accurate emergency contact information on file, we are requesting that the following information be completed and returned along with your application package to the Manager of Volunteer Services.

Thank you.

Name: _____ Phone Number: _____

Address: _____ City/ Zip Code: _____

Mailing Address, if different from above:

Date of Birth: _____

Marital status, spouses name and anniversary completed if applicable:

Marital Status: _____ Spouses Name: _____

Anniversary: _____

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____ Phone Number: _____

Relationship: _____ Alternate Number: _____

Name: _____ Phone Number: _____

Relationship: _____ Alternate Number: _____

Physician's Name: _____ Phone Number: _____



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