AUXILIARY VOLUNTEER APPLICATION / INFORMATION

(PLEASE PRINT CLEARLY)

NAME (First)_____**(Middle)**_____**(Last)**_____

ALIAS/OTHER NAMES KNOWN BY * _____

CURRENT ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (Home) (_____)_____-_____ (Cell) (_____)_____-_____ (Other) (_____)_____-_____

EMAIL _____

BIRTH DATE * _____/_____/_____ **GENDER *** ☐ **Male** ☐ **Female** ☐ **Other** **SSN** _____-_____-_____

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EMERGENCY CONTACT NAME (First)_____**(Last)**_____

RELATION _____

PHONE (Home) (_____)_____-_____ (Cell) (_____)_____-_____ (Other) (_____)_____-_____

EMAIL _____

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PREFERRED VOLUNTEER AREA(S) _____

FOR PEDIATRICS, CUDDLER (NICU) PROGRAMS,
YOU MUST PROVIDE THE FOLLOWING INFORMATION FOR A SECONDARY BACKGROUND CHECK

PLACE OF BIRTH (State or Country) _____ **HAIR COLOR** _____

RACE _____ **EYE COLOR** _____ **HEIGHT** _____ **WEIGHT** _____

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Have you ever been convicted of any felony or misdemeanor charges? ☐ Yes ☐ No (If yes, please briefly explain the type of offense, date, location of occurence and disposition)

_____

_____

California, Oklahoma or Minnesota Applicants:

I would like to receive a copy of any report by Broward Health.obtained relating to me. ☐ Yes ☐ No

Applicant Signature _____ **Date** _____/_____/_____

** Federal law prohibits discrimination in employment on the basis of age, race, creed, religion, sex, or national origin. Many states also prohibit some or all of the above types of discrimination and discrimination based on martial status. This information will be used for purposes of identification only. Without this information, we may be unable to distinguish you from another person in the event we discover adverse information during our background investigation.*

Please also read and sign on the reverse side of this form.

Disclosure and Authorization
for Release of Information and Procurement of a Background Report

DISCLOSURE

In reference to the Fair Credit Reporting Act, Section 604 (b) and 606 (a), a consumer report may be obtained on you for employment purposes at anytime during the employment application process, or, if you are hired, during your tenure as a Volunteer. It may be an investigative consumer report that includes information as to your consumer or employment character, reputation, and characteristics. You have a right to request disclosure of the nature and scope of the investigative consumer report, which may involve interviews with any sources having information of the above.

AUTHORIZATION

I consent to have an investigative consumer report made as to my credit history, motor vehicle driving record, social security information, criminal record, civil record, education and employment history and other pertinent information for employment purposes, including initial hiring decisions, promotions, reassignments, and/or retention. I hereby authorize North Broward Hospital District dba Broward Health to obtain a background report containing the foregoing information from Accurate Background, Inc. (and/or any of their licensed agents) located at 6 Orchard, Suite 200, Lake Forest, CA 92630, (800) 784-3911. I am aware that the background report I consent to have prepared, may include information obtained from a variety of sources, including but not limited to Federal, State, County government agencies, national credit reporting agencies, and others. I am aware that if I choose, I may obtain a complete disclosure of the nature and scope of any report prepared about me if I make a written request to Broward Health within a reasonable time after I execute this authorization.

I also authorize and request every person, firm, company, corporation, governmental agency, court, law enforcement office, credit agency, educational institution, workers compensation agency, and any other entity having control or possession of any information pertaining to me or my background to furnish same to any requesting party and release them from liability and responsibility in doing so. By this Authorization for Release of Information and for the Procurement of a Background Report, I hereby forever release, discharge, exonerate, hold harmless and indemnify Accurate Background, Inc., its client (North Broward Hospital District dba Broward Health), affiliates, Volunteers, representatives, agents, subcontractors, clients and any other person, entity, organization or institution furnishing information to them from any and all liabilities of every nature and kind, including but not limited to claims for libel, slander, invasion of privacy, related tort claims, misuse of information obtained from Accurate Background, Inc., and any other claim or cause of action arising out of the furnishing, inspection or copying of any documents, files, records, and other information, or the investigation made by or on behalf of Accurate Background, Inc., unless such release is determined to violate the public policy of the state or federal district in which this contract is executed, and in that event this release will be permitted to the maximum extent allowed by the governing law. I understand that this Disclosure and Authorization form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by Broward Health or Accurate Background, Inc and its affiliates.

I also understand that if hired, my consent will apply throughout my employment, unless I revoke or cancel my consent by sending a signed letter or statement to Broward Health at any time, stating that I revoke my consent and no longer allow Broward Health to obtain consumer or investigative consumer reports about me.

I acknowledge that I am being given a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act" prepared pursuant to 15 U.S.C. Section 1681-1681u. If I am a resident of California at the time of applying for employment, a summary of the provisions of California Civil Code section 1786.22 is also being provided to me with this form.

IMPORTANT! IS IT SATISFACTORY TO CONTACT PRESENT OR FORMER EMPLOYER? YES ☐ NO ☐

_____ _____/_____/_____

APPLICANT'S SIGNATURE **DATE**

Volunteer Medical Clearance

To be completed by applicant

Name: _____Date of Birth: _____ Last 4 digits of SS#: _____

Address: _____ City: _____ Zip: _____

Phone: (____) _____

I understand that providing documentation of the health information below is a condition of being permitted to volunteer at a Broward Health Facility. I authorize, my physician, _____, to provide such documentation and to provide any vaccines and/or TB skin tests necessary to complete my orientation requirements.

Applicant Signature_____ Date:_____

If Applicant is under 18 years of age, parent or legal guardian signature is required.

Parent/Guardian Signature_____ Print Name:_____

To be completed by Physician: _____ (Printed Name)
Due to infection control policies, volunteer applicants for the BHMC Auxiliary must provide documentation of compliance for the following (copies may be attached to this form).

- Chicken Pox. Has the applicant had chicken pox? Yes___ No___
- If yes, date of disease_____ OR date of positive titer _____(attach lab report)
- If no, provide documentation of vaccination (2 doses of varicella) _____date of first dose, Date of second dose_____
- TB tests - recent skin tests within 6 months. Chest X-ray required for a positive history of positive skin tests.
- If the applicant had a TB skin test within the past 12 months, another skin test is required no more than 30 days prior to volunteering.
- Date of TST _____Date read_____ Results (in mm)_____ (attach result)
- IF applicant has had a positive skin test, what was the date? _____ He/She will need a Chest X-ray within 6 months. IF there was a significant reaction, was a chest X-ray taken? Y ___ N ___. Date of X-ray _____ (attach results). Was INH provided for treatment? Y ___ N ___, If Yes, Dates of Treatment_____.

Is applicant able to ambulate more than 1500 feet independently? Y ___ N ___
If no, can the applicant ambulate with assistive devices? Y ___ N ___
Specify device and/or any restrictions; _____

Certification: The applicant to my knowledge does not have any medical or cognitive condition what would affect their ability to perform volunteer duties within a hospital or office setting. The above information has been provided by me, the undersigned.

Signature of Practioner_____Title_____Date_____

Printed Name of Practitioner_____

Address_____City_____Zip_____

Phone: _____