

STAMFORD HOSPITAL

30 West Broad Street

P.O. Box 9317

Stamford Connecticut, 06904-9317

VOLUNTEER APPLICATION

It is the policy of Stamford Health System and its affiliates to accept the best-qualified personnel for volunteer positions based upon individual skills and the needs of the Stamford Health System and its affiliates without unlawful regard to race, color, religion, gender, sexual orientation, marital status, national origin, ancestry, age or physical or mental disability. You may request any needed accommodation to participate in the application process.

PLEASE PRINT AND COMPLETE FORM IN DETAIL. PLEASE BE SPECIFIC, AND FILL IN ALL APPROPRIATE BLANKS. ALL INFORMATION GIVEN WILL BE HELD IN STRICT CONFIDENCE.

PERSONAL INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	
STREET ADDRESS			
CITY		STATE	ZIP CODE
PHONE NUMBER () ()	BUSINESS NUMBER () ()	CELL NUMBER () ()	
EMAIL ADDRESS		Fax # () ()	

GENERAL INFORMATION
PLEASE LIST ANY SPECIAL SKILLS OR TALENTS
PLEASE LIST FOREIGN LANGUAGES YOU SPEAK FLUENTLY

VOLUNTEER OR WORK EXPERIENCE	
ORGANIZATION NAME AND ADDRESS	
DATES WORKED	POSITION DESCRIPTION
ORGANIZATION NAME AND ADDRESS	
DATES WORKED	POSITION DESCRIPTION

EDUCATION		
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JUNIOR HIGH SCHOOL	YEAR COMPLETED
HIGH SCHOOL	YEAR COMPLETED
COLLEGE	YEAR COMPLETED
MAJOR	GRADUATE SCHOOL

HOW DID YOU HEAR ABOUT US?	(Circle any that apply)
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WALKIN	WEBSITE	BROCHURE	FAMILY/FRIEND	COURT SYSTEM
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WHICH DAYS/TIMES ARE YOU AVAILABLE TO VOLUNTEER? (Circle days and specify hours.)									
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S	M	T	W	R	F	S	MORNING	AFTERNOON	EVENING
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WOULD YOU BE WILLING TO MAKE A TIME COMMITMENT OF THREE HOURS PER WEEK, AND ONE YEAR OF SERVICE?
 _____YES _____NO

REFERENCES (NOT A FAMILY MEMBER)

NAME	PHONE #	ADDRESS
NAME	PHONE #	ADDRESS

PATIENT AND HOSPITAL CONFIDENTIALITY: In performing volunteer services throughout the hospital you may see or hear information regarding patients, be it diagnosis, financial or that an individual you know or a well-known personality is a patient in the Hospital. In performing your duties you may also learn information concerning the services performed by the Hospital for its patients. Divulging confidential information is cause for dismissal and is punishable by law..

Your signature indicates your acknowledgement and understanding of Patient and Hospital Confidentiality.

Volunteer Signature _____ Date _____

OFFICE USE ONLY:

Date of interview: ____/____/____ Orientation Date(s) ____/____/____/____ Self Tests _____

Follow-up necessary: _____

Placement _____

My signature below indicates that I understand and agree with all of the following statements:

- Nothing contained in this volunteer application shall be deemed to create an employment contract between Stamford Health System or any of its affiliates and myself for either employment or for the providing of any benefit. The granting of an interview shall likewise not create such a contract.
- No promises regarding my volunteering or inducements to volunteer have been made or offered to me and I understand and agree that no such promises are binding upon Stamford Health System or any of its affiliates unless made in writing and signed by the chief executive officer of Stamford Health System or its affiliates.
- If I am selected as a volunteer, I understand and agree that I have the right to terminate the volunteer relationship at any time and for any reason and the Stamford Health System and its affiliates have a similar right.
- After receiving a conditional offer to participate in a volunteer program, I may be asked to submit to a physical examination that includes a drug test. Any offer to participate in a volunteer program is contingent upon my satisfactory completion of the physical examination, satisfactory references verification, and receipt of a negative drug test result. Such drug test shall be conducted in conformity with the Connecticut drug testing statute (Conn. Gen. Stat. 31-51t to 51aa).
- I hereby give Stamford Health System and its affiliates to which I am applying for a volunteer position, and their agents, permission to undertake verification of the information I have provided, to investigate me regarding any criminal records and to investigate my previous employment, educational background and references, and I release them from any liability and responsibility from doing so. Pursuant to section 31-128f of the Connecticut General Statutes, I also hereby release all parties supplying references and other personally identifiable information from any liability or damage whatsoever arising therefrom.
- My volunteer application is not complete until I have read and signed the Substance Abuse Testing and Background Verification Disclosure sheets provided to me.
- The information supplied by me on this volunteer application is true and complete to the best of my knowledge. I understand that the discovery of any misrepresentation or omission of facts in the volunteer application may result in revoking my volunteer status.

Volunteer Applicant Signature

Date