NORTHWEST MEDICAL CENTER
2801 North State Road 7
Margate, FL 33063
Phone: (954) 978-4050 Fax: (954) 984-6351

VOLUNTEER APPLICATION

Date: _____

Personal Information (please type or print)

Name: (Last, First) _____ Nickname: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Other Phone: _____

Email Address: _____

Seasonal Resident? ____Yes ____ No

Seasonal Address: _____

City: _____ State: _____ Zip code: _____

Person to contact in case of an emergency:

Name: _____ Relationship: _____

Phone: _____

Time Availability (circle all that apply)

8:00am – 12:00pm 12:00pm – 4:00pm 4:00pm-8:00pm

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

List Area's of Interest:_____

_____

Please list any physical limitations: _____

Are you able to push a wheelchair? ____ Yes ____ No

Can you keep a commitment to volunteer a minimum of 100 hours? ____ Yes ____ No

Do you have any special skills (i.e. typing/computer, technical, medical, etc.): _____

_____

Have you ever been convicted of a felony or any other criminal offenses? ___ Yes ___ No

If yes, please explain (A criminal record does not necessarily disqualify you from Volunteering) _____

_____

_____

In completing this application, I understand that an investigation report may be made by a consumer reporting agency and/or law enforcement agency to include information as to my character, general reputation, personal characteristics, and mode of living, whichever may be applicable. If such an investigative report is made, I will have the right to make a written request for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. I hereby certify that the information contained in this application is true and correct.

I understand that in case of an accident, the Hospital will bill all insurance providers as applicable and I hereby release Northwest Medical Center for liability due to injury and/or illness as a result of my volunteer service at the Hospital.

Signature of Applicant _____ Date _____

Parental Consent: If you are a minor under the age of 18, please have a parent or legal guardian sign.
Note to parent/legal guardian (s): Your signature indicates that your son/daughter is in good health and has your permission to volunteer at NWMC. It also authorizes us to perform the necessary tests to obtain medical information required with this application. Your signature authorizes emergency medical care while your son/daughter is on duty at the hospital.

Signature of Parent or Guardian _____ Date _____

Student Volunteers Only

School presently attending _____ Grade _____

School Counselor _____ Phone _____

Signature of School Advisor_____Date _____

FOR OFFICE USE ONLY

Date Received _____ Interview Date and Time _____

Position Assigned and Schedule _____ Start Date _____

Background check _____ Orientation Date _____

Comments _____

CONFIDENTIALITY AGREEMENT

I realize, that as a Volunteer, I will have access to information about patients and their medical treatment that is private and confidential in nature. As a volunteer, I share in the responsibility of observing the Code of Ethics, which included protecting the right of patient to keep private information private.

I understand that all information concerning patients, employees, fellow volunteers, and other Northwest Medical Center business of a confidential nature must not be discussed with persons not concerned with such information and certainly no one, including the news media, outside of our facility. This includes discussing information about our patients in areas where those not concerned may overhear the conversation (such as elevators, the cafeteria, hallways, etc.). I also understand that even disclosing to an outsider is a breach of the patient's right to confidentiality.

In certain instances, the Hospital is required to reveal basic information about a patient to the news media, but I understand that this is done only through our Marketing Department or the Administration of the Hospital.

I understand that failure to meet this obligation could result in legal action taken, not only against Northwest Medical Center, but also me, should I breach this confidentiality.

_____
Print Name

_____ _____
Sign Name Date

_____ _____
Parent or Guardian (if under 18) Date

VOLUNTEER CONTRACT

To perform my duties as a NWMC volunteer to the best of my ability, I will:

- Consider my volunteer assignment as a commitment; fill it regularly, expect for illness or vacation.
- Commit to volunteering a minimum of 100 hours.
- Contact my assigned department & the volunteer when I am unable to volunteer. I realize that if I should be absent two times in a row without notifying my immediate supervisor, I may be terminated from the program.
- Consider as confidential, all information concerning any patient, nurse, doctor or employee of Northwest Medical Center.
- Take any problem, criticism or suggestion directly to my immediate supervisor.
- Endeavor to make my work professional in all ways; conduct myself with dignity, courtesy and consideration of others.
- Follow established dress code policies detailed during orientation.
- Follow all the rules and regulations of NWMC.
- Always wear my NWMC ID badge and volunteer uniform while on duty.

Signature: _____ Date: _____

If under 18
Parent or Guardian Signature: _____ Date: _____