



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** ____-____-____

EMERGENCY CONTACT NAME (First) _____ (Last) _____

RELATION _____

PHONE (Home) (____)____-____ (Cell) (____)____-____ (Other) (____)____-____

EMAIL _____

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 _____

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 occurrence 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 marital 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

Broward Health
Enter Regional Logo Here

VOLUNTEER APPLICATION

Date _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age - Under 18 years _____ Over 18 years _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Bus. Phone: _____

Email Address: _____ Shirt Size: _____

Language Skills: _____ Computer Skills: _____

Special Skills: _____

Emergency Contact:

Name: _____ Relation: _____

Emergency Contact Phone Number: _____

Availability - Please indicate hours and time

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
AM							
PM							
EVE							

How were you referred to the Volunteer program? _____

If employee referral, list the Employee name: _____

Volunteering for the CUDDLER PROGRAM? Y N BHMC BHCS

I agree to abide by all policies and procedures of the Volunteer Department and those of Broward Health.
I agree to complete all required orientation and training as needed.

Signature _____ Date: _____

Broward Health
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 _____ Print Name: _____

To be completed by Provider _____ (Printed Name)

Due to infection control policies, volunteer applicants for (enter Medical Center), must provide documentation of compliance for the following (copies may be attached to this form).

- Chicken Pox. Has the applicant had chicken pox? No ___ Yes ___
- If yes, date of disease _____ OR date of positive titer _____ attach lab report
- If no, provide documentation of vaccination (2 doses of varicella) _____ 1st dose date _____ 2nd dose date.
- TDAP for Pediatric Volunteers only: Date: _____
- MMR (measles, Mumps and Rubella)
Date of 2 MMR vaccines (both must be AFTER 1st birthday.
Dates _____ (first vaccine) _____ second vaccine OR
Date of positive titer _____ (Measles – attach lab report)
Date of positive titer _____ (Mumps – attach lab report)
Date of positive titer _____ (Rubella – attach lab report)
- See attached TB Skin tests, Quantiferon Gold Test or recent Chest X-Ray completed by Broward Health.
- 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. _____
- If applicant has had a positive skin test or positive Quantiferon Gold Test, please advise if latent TB treatment is recommended.
Yes, Indicate Medication _____
No
- Covid 19 Vaccination Y N If yes, Date of Vaccination _____ (copies may be attached to this form)
- Is the 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 Provider _____ Title _____ Date _____

Printed Name of Provider _____ Phone _____

Location of Practice: _____ City _____ Zip _____