Volunteer Service Application

Hillcrest Health Services 1820 Hillcrest Drive, Suite B Bellevue, NE 68005
www.hillcresthealth.com 402.934-2376

Name: _____

Group/Organization: _____ Date of Birth:_____

Address: _____City:_____State:_____ Zip:_____

Email: _____ Telephone: _____ Home/Work/Cell

Emergency Contact Name:_____ Phone Number:_____

Preferred method of communication (mark preference): ___email ___phone

How did you hear about this volunteer opportunity? _____
Has a civil or criminal complaint ever been filed against you that alleged sexual misconduct or abuse? **Yes No**
Have you ever been convicted of a crime (misdemeanor or felony) or minor traffic violations? **Yes No**
Have you ever been terminated from a volunteer service or employment due to misconduct towards a patient/client/customer/participant? **Yes No**
If **Yes** on any of the above, please explain_____
Are you 18 years of age or older (under 18 need to have consent) **Yes No**
Have you ever volunteered for Hillcrest Health Systems? **Yes No**
If yes, give details: _____

Time preference (mark availability): __ Morning __ Afternoon __ Evening

Day(s) of week preferred: _____

Length of time you wish to serve in one sitting (mark preference):
__ 1 Hour __ 2 Hours __ 3 Hours __ Longer Periods

Location:
__ Hillcrest Mable Rose __ Hillcrest Country Estates - Cottages __ Hillcrest Hospice Care __ Hillcrest Millard
__ Hillcrest Health & Rehab __Hillcrest Grand Lodge __Hillcrest Physical Therapy __Hillcrest Shadow Lake
__Hillcrest Firethorn

Are there any skills drawn from previous experiences you would care to use in volunteer work (hobbies, talents, work or volunteer experiences)? _____
_____

Confidentiality Agreement

Volunteers have access to confidential information. It is the volunteer's moral, professional and legal obligation to keep all information regarding customers, the organization, and team members confidential. All people have certain information that they would not wish to be shared with others. It is important for the dignity of those we care for, and work with, to respect the right of confidentiality. It is the responsibility of all volunteers to safeguard all confidential information.

As long as I am a volunteer with Hillcrest Health Services I agree to follow company, state, and federal confidentiality laws and regulations, as well as, all Hillcrest Health Services policies and procedures.

_____
Signature Date

Revised March 2018

Activities you are interested in? (Please check your preferences)

Community Volunteer Programming

__ Group that is already formed
__ Happy Hours
__ Leading/assisting with crafts
__ 1:1 companionship care
__ BINGO
__ Assist with Holiday Parties
__ Outings
__ Office Support/Clerical
__ Polish Nails
__Bible Study
__Musical talents
__Other

Hospice Volunteer Programming

__ One on one visits with Hillcrest Hospice Care patient's
__ Veteran to Veteran Care
__ No One Dies Alone Program
__ Administrative Support

Questions for Hospice Volunteers only

__ Have you ever had a family member or friend a patient of hospice? If so, who and how long has it been that they were a patient? _____

__ Have you lost a loved one in the last year? If so, do you believe this will have a positive or negative effect on your volunteer service? _____

_____

Level IV: Internship/Practicum

School/College/Universtiy:_____

Student Requirements for internship/practicum: _____

_____

In signing your name below, you are indicating that all the information you provided is true, correct, and complete.

_____

Print Name Signature Date

Parental/Guardian Consent for Minor

Your son/daughter has expressed an interest in participating in Hillcrest Health Service Volunteer Program, and they are under 18 years of age. Since volunteering requires a commitment of time, training, and transportation, we are requesting your written permission for your son/daughter to participate.

Please sign and date this consent form, allowing your son/daughter to participate in volunteer opportunities and that you accept responsibility for their transportation.

I give permission for my son/daughter to perform volunteer service within Hillcrest Health Services. I have discussed this commitment with them and support their efforts.

Son/Daughter's Name (please print):_____

Son/Daughter's Date of Birth:_____

Name of Parent/Guardian (please print):_____

Signature of Parent/Guardian:_____

Date:_____