



**Venice Regional
Bayfront Health**

HOSPITAL VOLUNTEERS OF VENICE

**Application
for
Membership**

540 The Rialto
Venice, FL 34285-2900

(941) 483-7050

PLEASE PRINT

Name & Location	Last Name		First Name		Title	Middle Name	Application Date - -	
	Local Address (Number & Street)					Home Phone #		Volunteer #
	City, State & Zip					Badge Name		Social Security # - -
Miscellaneous	Northern Address (needed if you are not a FL Resident) OR If you have not lived in Sarasota County for the past 5 yrs)					Birthday		Seasonal Phone #
	E-mail address					Are you a Florida Resident? Y N		If yes, has it been 5 years? Y
	Date Available for Work	Circle or Check The Days You Are Available S M T W T F S				Circle or Check The Time You Are Available 8am – Noon Noon – 4pm 4pm – 8pm		
	Circle or Check The Months That You Are Available ALL Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec							
Emergency	Person to Notify in Case of Accident or Emergency Name					Relationship		
	Address					Home Phone		
	City, State & Zip					Work Phone		
	Personal Physician					Phone #		
	Do you have previous volunteer experience: ___Yes ___ No If yes explain _____							
	Would you be willing to work on special events such as Jewelry Sales, Uniform sales, Book fair. Yes _____ No _____							

Work Experience or Interest (check all that apply)

Accounting/Bookkeeping____ Leadership _____ Foreign Language _____
 Arts & Crafts _____ Merchandising _____ Teaching _____
 Carpentry _____ Musical _____ Photography _____
 Cashiering _____ Nursing _____ Public Relations _____
 Computer/Word Proc _____ Clerical/Office _____ Other _____
 Signature _____ Date _____
 Interviewer _____ Date _____
 Placement _____

For Office Use Only

As Healthcare regulatory agencies require – please complete the following:

NAME: _____ Social Security # _____ - _____ - _____ DATE: _____

In the last ten years have you ever been convicted of a felony or first-degree misdemeanor?
Any drug-related offense or any crime related to the care of a patient?

NO _____ YES _____

If yes:

Date? _____ Where? _____

What charges?

Have you ever pled nolo contendere or pled guilty to a felony charge or first-degree misdemeanor?
Or been found guilty of a lesser offense than originally charged as part of a plea bargain?

NO _____ YES _____

If yes:

Date? _____ Where? _____

What Charges?

Have you ever had adjudication of guilt withheld for any felony or first-degree misdemeanor?

NO _____ YES _____

If yes:

Date? _____ Where? _____

What charges?

Is there a criminal charge pending against you?

NO _____ YES _____

If yes:

Date? _____ Where? _____

What Charges?

Conviction is not an absolute bar to volunteering but will be considered in relation to job requirements. The nature, severity and date of offense(s) in relation to the position volunteering for are considered.

Have you ever been convicted of a criminal offense related to healthcare or listed or disbarred, excluded or otherwise ineligible for participation in a federal healthcare program, including Medicare?

If Yes: Date _____

Please explain:

APPLICANT'S AGREEMENT

To help establish my eligibility to volunteer, I hereby authorize Venice Regional Medical Center, its subsidiaries and affiliates to conduct a background check (which may include finger printing) and to request and receive appropriate report (s) which may include information as to my character, general reputation, personal characteristics and mode of living and credit. The request of an applicant's social security number is to verify identity, employment history and eligibility under immigration laws.

I authorize any former employer, or medical provider to release information and documentation which is deemed relevant to my application to volunteer.

I understand that any offer to volunteer is conditioned on the satisfactory completion of all relevant aspects of my background check.

If accepted as a volunteer, I agree to observe any and all policies, practices, and rules of the organization, which may be amended from time to time. Violation of any such policy, practice or rule may subject me to disciplinary sanctions including dismissal.

If accepted, I hereby consent to any required security investigation. Refusal to cooperate with or submit to any lawful security investigation may be grounds for dismissal.

I understand that any volunteer relationship with the organization, its subsidiaries or affiliates is an at-will relationship, meaning that the relationship can be terminated at any time for any reason by either myself or the organization, as stated in the Healthcare Volunteers of Venice Bylaws.

I certify that the information provided in this application is correct to the best of my knowledge. I understand that if any statements made by me, either in this application or otherwise, are found to be false or misleading in any way, either because of the nature of the statements themselves or because of omitted information which makes any such statements false or misleading, my application may be excluded from further consideration or, if accepted, I may be subject to dismissal.

APPLICANT'S SIGNATURE _____

DATE _____

It is the policy of Venice Regional Medical Center, its subsidiaries and affiliates, that equal employment opportunity be available to all without regard to race, color, religion, national origin, sex, age, disability or marital status.