HALE MAKUA HEALTH SERVICES

COMPASSION COMMITMENT COMMUNITY

# Volunteer Application

Name:_____ Today's Date:_____

Address:_____ Date of Birth: _____

_____ Contact Phone: _____

Your Occupation: _____ Email Address:_____

Person to notify in case of emergency:

Name: _____ Relationship: _____

Phone: _____ Address: _____

_____

What languages do you speak other than English? _____

Where have you volunteered before? _____

What volunteer work would you like to do at Hale Makua Health Services?

_____

_____

When are you available to volunteer (Please list days and times)?

_____

_____

Please list 2 reference (not family members):

Name: _____ Name: _____

Phone:_____ Phone:_____

How do you know them? _____ How do you know them? _____

**Maintaining Confidential and Proprietary (Private) Information**

While performing volunteer services, you may learn confidential information about residents, clients, employees, other individuals or about Hale Makua Health Services. Any information about their activities, circumstances or conditions is strictly confidential. It must not be discussed with non-staff, or anyone not connected with Hale Makua Health Services. It must not be discussed with Hale Makua Health Services employees or volunteers who do not require this information to perform service.

Please be very careful about discussions relating to a resident's or client's care or other work-related matters. This confidential information should only be shared by those who need to know in order to provide care and must be protected so that others cannot hear or see the information. Your disclosure, or failure to protect others from access to this confidential information is a violation of privacy rights- of a resident, client, employee, or our company.

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# CONSENT TO CRIMINAL CONVICTION RECORD INQUIRY

Name (Print):_____

Other names used_____

Date of birth_____

Social Security Number_____

I hereby authorize Hale Makua Health Services to conduct an inquiry into my criminal conviction record, including state and federal checks. I further authorize any state, its cities and counties, the federal government and any government agency to release the results of the checks to Hale Makua Health Services or its agent. I understand that the purpose of this check is to determine whether I have a conviction record that bears a rational relationship to the duties and responsibilities of the position that Hale Makua Health Services has offered to me. I understand and acknowledge that my conditional offer of a volunteer position may be withdrawn if the results of the inquiry indicate that my conviction record bears a rational relationship to the duties and responsibilities of the position.

List below any/all convictions or exclusions from participation in the federal health care programs:

_____

_____

_____

I understand and acknowledge that the information disclosed to Hale Makua Health Services shall remain confidential and that Hale Makua Health Services will not disclose the information to any other employer or third party except to affiliated companies or as required by law.

Your signature_____ Today's date_____

Attached are 2 documents from the Hale Makua Health Services Management Manual:
Volunteer Services – Philosophy- 20-01
Volunteer Services – Volunteer Agreement- 20-03

Please read them and sign where indicated.