



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 references (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 is a document from the Hale Makua Health Services Management Manual: Volunteer Services - Volunteer Agreement- 20-03

Please read and sign where indicated.