

Dear Prospective Volunteer:

Thank you for your interest in volunteering. We offer rewarding volunteer experiences to consider at any of the Saint Luke's Health System facilities.

To become a volunteer, complete the checklist below.

- The Prospective Volunteer Profile.
- The Prospective Volunteer Health Statement.
- Ask your physician to complete and sign the Prospective Volunteer Physician Form. This form does not require an exam; it is documentation from your physician to recommend you to volunteer. The volunteer interview may be scheduled before the Physician Form is completed.
- Submit TB (tuberculosis) skin test documentation (valid within the last 12 months). If documentation is unavailable, the Saint Luke's Health System facility of choice will provide the test at no cost.
- The personal Background Check Report Disclosure form and the Background Check Report Release form.

[Note: some facilities will require other background checks]

To schedule an interview call the SLHS facility of choice. (the list of facilities is located on the second page of the Prospective Volunteer Profile) This will provide an opportunity to submit the completed forms, to discuss your volunteer interests, to investigate areas of service and to meet other volunteers.

Our goal is to match your interests and skills with the volunteer opportunity you choose. We appreciate your interest in Saint Luke's Health System volunteering.



saintlukeshealthsystem.org

PROSPECTIVE VOLUNTEER PROFILE

SOCIAL SECURITY #: ____/____/____ E-MAIL ADDRESS: _____
(Last six digits)

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____ CELL: (____) _____
[] Can call at work

BIRTHDATE: ____/____/____

PRESENT EMPLOYER, IF ANY:

BUSINESS EXPERIENCE:

VOLUNTEER EXPERIENCE/ORGANIZATIONAL MEMBERSHIPS: _____

HOW DID YOU LEARN ABOUT SLHS VOLUNTEER PROGRAM? _____

- Interest [] ER [] Info Desk [] Computer/Clerical [] Foreign/Sign Language
& [] Reception [] Errands/Escort [] Pt Visitation/companion [] Gift Shop [] Other
Skills: [] Newsletter [] Child Care [] Spiritual Wellness [] Support Group/Mentor

I WOULD BE AVAILABLE: S M T W TH F S [] Daytime [] Evenings

IN CASE OF EMERGENCY NOTIFY:

_____(NAME) _____(RELATIONSHIP) _____(DAY PHONE NUMBER)

_____(PHYSICIAN) _____(DAY PHONE NUMBER)

PERSONAL REFERENCES: Please list two (not relatives).

Name Street Address City State Zip Phone
Relationship _____

Name Street Address City State Zip Phone
Relationship _____

(Continue next page)

Have you been charged or convicted in criminal proceeding? YES NO (If yes, please explain)

I understand that I will receive no remuneration for the volunteer services I provide. I agree to maintain confidentiality concerning all guest information and adhere to the policies and procedures that have been established by Saint Luke's Health System. I understand all volunteers require TB Test documentation and a background check. I give permission to Saint Luke's Health System to contact my physician, personal references, and to conduct a personal background check. I understand SLHS facilities are tobacco free and acknowledge I can not smoke or use tobacco products of any kind on campus or on parking lots of the facilities. I hereby certify that the information contained in this profile is true and correct.

Signature _____ Date _____

NONDISCRIMINATION AND EQUAL OPPORTUNITY STATEMENT

It is the policy of Saint Luke's Health System not to discriminate in admissions or access to, or treatment or employment in its program and activities, or in the granting, maintaining, upgrading and withdrawal of physician staff privileges for any unlawful reason, such as race, color national origin, sex, age, or handicap in violation of Section 504 of the Rehabilitation Act and applicable regulations.
 Responsible employee: Administration Director of Civil Rights - 816/932-3820

<u>Saint Luke's Health System Facilities</u>		
<i>Saint Luke's East 100 NE Saint Luke's Blvd. Lee's Summit, MO 64086 (816) 347-4621</i>	<i>Cabot Westside Health Center 2121 Summit Kansas City, MO 64108 (816) 932-2183</i>	<i>Saint Luke's South 12300 Metcalf Avenue Overland Park, KS 66213 (913) 317-7405</i>
<i>Saint Luke's Northland 5830 NW Barry Road Kansas City, MO 64154 (816) 880-6083</i>	<i>Crittenton Children's Center 10918 Elm Avenue Kansas City, MO 64134 (816) 767-4124</i>	<i>SLHS Hospice 3100 Broadway, Suite 1000 Kansas City, MO 64111 (816) 756-1160</i>
<i>Saint Luke's Plaza 4401 Wornall Road Kansas City, MO 64111 (816) 932-2183</i>	<i>Cushing Memorial Hospital 711 Marshal Leavenworth, KS 66048 (913) 684-1112</i>	<i>Hedrick Medical Center 100 Central Chillicothe, MO 64601 (660) 646-1480</i>
<i>Saint Luke's Cancer Institute 4321 Washington, Suite 4000 Kansas City, MO 64111 (816) 932-2183</i>		

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[For department use only]

Interview Date/Time _____ By _____

Start Date/Time _____ Health Statement Background check sent Received

Manual Parking pass Orientation (Safety, HIPAA) References sent Received Uniform purchased (if applicable)

T.B. Test documentation Policies discussion

Assignment _____ / _____ / _____
 (Day) (Time) (Position)

REMARKS:

PROSPECTIVE VOLUNTEER HEALTH STATEMENT

(This section to be completed by Prospective Volunteer)

Prospective Volunteer, Name

Physician, Name

Check Facility:

- | | | |
|---|---|---|
| <input type="checkbox"/> Saint Luke's East | <input type="checkbox"/> Cabot Westside Health Center | <input type="checkbox"/> Saint Luke's Cancer Institute |
| <input type="checkbox"/> Saint Luke's North | <input type="checkbox"/> Crittenton Children's Center | <input type="checkbox"/> Saint Luke's Health System Hospice |
| <input type="checkbox"/> Saint Luke's Plaza | <input type="checkbox"/> Cushing Memorial | <input type="checkbox"/> Hedrick Medical Center |
| <input type="checkbox"/> Saint Luke's South | | |

Circle those that apply:

- | | |
|-----------------------------|-----------------|
| Allergies | Foot Problems |
| Hearing Problems | Arthritis |
| Heart Problems | Asthma |
| Hepatitis | Back Problems |
| High Blood Pressure | Diabetes |
| Tuberculosis | Fainting Spells |
| Other Infectious Conditions | Epilepsy |
| Mental Illness | |

Do you have any limitations, which would affect the type of volunteer position assigned? Yes No

If yes, please explain _____

List medications taken regularly: _____

Prospective Volunteer Physician Form

Prospective Volunteer, Name (print)

SS# (if required by physician)

Check Facility:

- Saint Luke's East Cabot Westside Health Center
 Saint Luke's North Crittenton Children's Center
 Saint Luke's Plaza Cushing Memorial
 Saint Luke's South

- Saint Luke's Cancer Institute
 Saint Luke's Health System Hospice
 Hedrick Medical Center

I authorize the release of the following information to Saint Luke's Health System Volunteer Services Department.

Prospective Volunteer's Signature

Date

(This section to be completed by Physician)

Please forward information requested in conjunction with volunteer service at a Saint Luke's Health System facility.

_____ I see no medical reason why this person should not volunteer.

_____ This person should volunteer with the following restrictions. _____
(use reverse side if more space is needed)

_____ This person should not be a volunteer in a healthcare facility.

A TB skin test, documented within the last 12 months, is required for all volunteers. (This test can be provided by Saint Luke's Health System of choice at no cost to the individual.)

_____ Date of negative TB skin test (if within the last 12 months)
or

_____ Date of chest x-ray that shows this person is free of active Tuberculosis (if within the last 12 months)
If x-ray is contraindicated, please comment on follow-up & whether this person will pose hazard to others.

Signature of Physician

Printed Name of Physician

Address/ City/State/Zip

____/____/____
Phone

____/____/____
Date

Return form to **Saint Luke's Health System**

P.O. Box 119000, Kansas City, MO 64111

Fax: (816)932-3888

INVESTIGATIVE CONSUMER REPORT DISCLOSURE

In connection with your profile to volunteer, an investigative consumer report and consumer reports, which may contain public record information, may be requested from USIS Commercial Services {"USIS"}. These reports include elder and child abuse.

You have the right to receive, upon your written request within a reasonable period of time, (not to exceed 30 days) a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to USIS, upon proper identification, to request the nature and substance of all information in its files on you at the time of your request, including the sources of information, and the recipients of any reports on you that USIS has previously furnished within the two-year period preceding your request. LSIS may be contacted by mail at P.O. Box 33181, Tulsa, Oklahoma, 74153, or by phone at (800) 381-0645.

A written summary of your rights under the Fair Credit Reporting Act (FCRA) as prepared by the Federal Trade Commission is available upon request from Human Resources.

Print Prospective Volunteer Full Name

Date

Prospective Volunteer Signature

[This form should be submitted with original signature, not duplicated or faxed]

