



Name (print): _____

Telephone _____ Date of Birth _____

E-mail Address: _____

Address _____ City _____ Zip _____

College/University _____ Year _____

Major: _____

Emergency Contact _____ Telephone _____
 Relationship _____

Day(s) Available (Please circle day or days you wish to volunteer or complete your internship)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Time available (Three hour assignment minimum) _____

Most volunteer service is on weekdays with 9:00 a.m. - Noon or 1:00 p.m. – 4:00 p.m. shifts.

Areas of Interest:

- _____ Administrative
- _____ Behavioral Health
- _____ Emergency Department
- _____ Finance / Accounting
- _____ Gastroenterology
- _____ Legal
- _____ Nursing Unit
- _____ Physical Therapy (A.M. only)
- _____ Occupational Therapy (A.M. only)
- _____ Other

For Office Use Only

Dept. Contact: _____ Contact Telephone: _____ Orientation Date: _____ Start Date: _____ Completion Date: _____
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Complete the Application & Consent and Disclosure form then call to schedule an appointment for an orientation.

Interested Interns & Students call Judy Villani, Director of Volunteer Services, for an interview, placement, orientation and training, 278-4440 or e-mail judy.villani@nfmcc.org.

If accepted as a Medical Center volunteer, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel, and not seek to obtain confidential information from a patient. After completing my orientation, I will abide by HIPAA regulations (Health Insurance Portability and Accountability Act).
2. My services are donated to the Medical Center without contemplation of compensation or future employment and given with humanitarian, religious, or charitable reasons.
3. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign political petitions on Medical Center premises unless I receive the express authorization of the **Director of Volunteer Services** to engage in these activities.
4. I shall submit to examinations which may include skin tests, appropriate laboratory tests and/or immunizations. An annual TB skin test (PPD) is required, and if the test is positive, I will have my physician take a chest x-ray. I hereby authorize person(s) making tests or x-ray films to report the results to the Medical Center. I understand that there is no cost to volunteers for the annual PPD test.
5. I shall be punctual and conscientious; conduct myself with dignity, courtesy, and consideration of others and endeavor to make my work professional in quality.
6. I shall attempt to resolve any problems related to my volunteer activities with my supervisor and if unsuccessful attempt to resolve such problems with the **Director of Volunteer Services**.
7. I shall make my best effort to fulfill my commitment to the Medical Center by completing all assignments I accept.
8. I shall at all times uphold the philosophy, policies, and standards of Niagara Falls Memorial Medical Center.
9. I understand that the use of cell phones, pagers and other electronic devices are prohibited within Memorial facilities. Also, all devices must be completely turned off within the buildings, except for the main entrance of Memorial.
10. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
 - A) Failure to comply with Medical Center policies, rules, and regulations.
 - B) Absences without prior notification.
 - C) Unsatisfactory attitude, work, or appearance.
 - D) Any other circumstances which in the judgment of the Director of Volunteer Services would make my continued service as a volunteer contrary to the best interests of the Medical Center.

I have read each of the above conditions and agree to be bound by them.

Signature _____

Date _____