



Greetings:

Thank you for your interest in volunteering at Community Medical Center.

Enclosed you will find:

- Volunteer Opportunity list
- an Application
- a Parental/Guardian Consent Form (if applicable)
- a Volunteer Agreement Form
- a Confidentiality Statement
- a Volunteer Checklist for Immunizations (Please provide a photocopy of your immunization card or indicate your date of birth if prior to January 1, 1957. CMC will provide the Tuberculosis screening requirement)
- 3 Letters of Personal Reference (complete the top portion and give the letters and envelopes to friends/co-workers)
- Background Check Authorization


If you have any questions regarding the materials in this packet please contact me for clarification. Otherwise, when the forms are complete, call me to arrange a meeting time. At that time we will review the volunteer opportunities that best fit with your schedule.

Thanks again for your interest and I hope to hear from you soon.

Sincerely,

Jennifer Martin  
Volunteer Coordinator  
327-4258

## VOLUNTEER SERVICES

 <b>COMMUNITY MEDICAL CENTER</b> 2827 Fort Missoula Road • Missoula, MT 59804 (406) 728-4100		Areas of interest:	
		<b>Instructions</b> – Print in ink or type all answers. Read carefully and fill in items completely. Return completed application directly to Community Medical Center.	
Name (Last, First, Middle)		Social Security No.	Home Phone
Mailing Address	City	County	State      Zip Code      Office Phone
Are you under 18? Yes      No	Date of Birth	Are you interested in information pertaining to CMC Auxiliary?    Yes      No	
PROFESSIONALS: Are you Registered/Licensed/or Certified in this state? Yes      No	Year first Registered/Licensed/or Certified	Registered/Licensed/Certified As	Last date renewed From                      To                      Registration/License/ or Certification No.
Is there anything you would like us to consider prior to volunteering?			
<b>QUALIFICATIONS</b>			
Please list any education, training and/or specialized experience which you feel would help you perform the job(s) for which you are applying, such as schools; colleges, degrees; licenses; vocation technical or military experience or training; hobbies, etc.			
<b>NAME AND ADDRESS OF SCHOOL OTHER PROVIDER OR PROGRAM</b>		<b>IDENTIFY YOUR MAJOR OR MINOR; DESCRIBE THE SPECIALIZED TRAINING OR EXPERIENCE, ETC.</b>	
		Did you graduate? Yes      No Degree _____	
		Did you graduate? Yes      No Degree _____	
		Did you graduate? Yes      No Degree _____	
Special skills or experiences pertinent to this application			
Is volunteer work a requirement for school credit?      Yes      No      How many hours? _____			
How did you become interested in Community Medical Center's Volunteer Program?			
<b>VERIFICATION AND SIGNATURE</b>			
1. I authorize the investigation of all matters which the Medical Center deems relevant to my qualifications for volunteering, including all statements made in this application and in any attachments or supporting documents. I authorize Community Medical Center to request and receive such information, and I release from all liability any persons (such as former supervisors or employers) supplying it. I also release the Medical Center from all liability which might result from making the investigation.			
2. I certify that the facts and information in this application and in any attachments or supporting documents are true and complete to the best of my knowledge. I understand that any falsification, misrepresentation or omission, as well as any misleading statements, generally will result in denial of volunteering or immediate termination, regardless of when and how discovered.			
3. I understand that I may be required to submit to pre- or post- employment physical or other professional examinations, medical inquiries, and/or testing. I agree to such examinations, inquiries and/or testing at the Medical Center's expense. I authorize release of the results to the Medical Center and their use to evaluate my suitability for volunteering. I also release the Medical Center from all liability arising out of or connected with any examinations, inquiries and/or testing.			
I certify that I have read each of the above statements and that I have also reviewed all of the information I have provided in this application and in any supporting documents.			
SIGNATURE: _____		DATE: _____	

**UNSIGNED APPLICATIONS WILL NOT BE ACCEPTED**

Days & Times Available: _____ _____	<b>PERSONAL REFERENCES:</b> - List names and addresses of three personal references _____ _____ _____
Date you will be available for volunteering:	

**CRIMINAL RECORD:** Conviction of a crime is not an automatic bar from volunteering. Factors such as the nature and the gravity of the crime, the length of time since the conviction and/or completion of any sentence, and the nature of the job for which you have applied will be considered.

Have you ever been CONVICTED, pled GUILTY or NO CONTEST, or forfeited bond or bail for any crime other than traffic violations? Yes No  
If yes, give details: \_\_\_\_\_

**DRIVING RECORD:** *If the position applied for involves driving.*

Have you ever been CONVICTED, pled GUILTY or NO CONTEST, or FORFEITED BAIL for any traffic violation in the past 3 years? Yes No  
If yes, give details: \_\_\_\_\_

#### VOLUNTEER/WORK HISTORY

Are you willing to have your present or most recent employer contacted regarding your qualifications? Yes No

Have you ever been employed by Community Medical Center? Yes No

Begin with your present or last work and list in reverse order every position you have held. Complete fully, especially description of duties, giving tasks performed, responsibilities and number of people you supervised.

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time ____yrs. ____mos.	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties _____ _____				

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time ____yrs. ____mos.	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties _____ _____				

Name of firm:		Street Address, City, State, Zip Code		
Date started	Date separated	Total time ____yrs. ____mos.	Hours per week	Position held
Immediate Supervisor and Title			Reason for leaving	
Description of duties _____ _____				

NOTE: It is the policy of this institution to check the personal references of persons selected for volunteering.

8313-4B



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www.communitymed.org

## CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES

This will authorize \_\_\_\_\_, a minor, to participate in such volunteer activities as may be prescribed by the Medical Center's Director of Volunteer Services or the designated representative. I understand that my daughter's or son's services are donated to the Medical Center without thought of compensation or future employment, and is given for humanitarian or charitable reasons.

We release the Medical Center and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the Medical Center, while participating in such volunteer activities.

\_\_\_\_\_  
Signature of parents/guardian

\_\_\_\_\_  
Date



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**IF ACCEPTED AS A 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 or about a patient.
2. My services are donated to the Medical Center without thought of compensation or future employment, and given with humanitarian or charitable reasons.
3. I understand that it is a crime to solicit business for attorneys or insurance companies.
4. I shall not sell or attempt to sell goods or services, request contributions, or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Volunteer Specialist to engage in these activities.
5. I shall submit to examinations, which may include chest X-rays, skin test, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer services. I also authorize the person(s) making tests of X-ray film to report the results to the hospital.
6. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
7. I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and, if unsuccessful, attempt to resolve any such problems with the Volunteer Specialist.
8. I shall make my best effort to fulfill my commitment to the Medical Center by completing all assignments that I accept.
9. I shall at all times uphold the mission and standards of the Medical Center.
10. I understand that Volunteer Services 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; or (d) any other circumstances which, in the judgment of the department director, 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 I agree to be bound by them.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer's Parent/Guardian Signature Date  
(For Volunteer Under Age 18)





**COMMUNITY MEDICAL CENTER**  
Missoula, Montana

**CONFIDENTIALITY STATEMENT**

Inappropriate access, discussion, or release of patient's condition, nursing or medical care, or any personal information about a patient (including financial status) is considered to be a violation of privacy.

Every employee who has direct or indirect access to data pertaining to the admission, care and disposition of any and all patients treated at Community Medical Center is to access that information based on a "business need to know" basis only and to maintain that information with the strictest confidentiality. Any unauthorized releasing or casual discussion of such information is considered to be a violation of the patient's privacy. Not only is health care information confidential but all personal, practice, business, and other corporation information is confidential and may constitute a trade secret as well. Any release of information emanating from Community Medical Center is not allowed. Any breach of patient confidentiality is considered gross misconduct and subject to immediate dismissal.

This also applies to any and all information obtained through the computer system regarding clinical information and / or financial data.

Exchange of confidential information with patients, visitors, or other employees inside or outside Community Medical Center is unethical and may harm the patient and subject the Medical Center to liability. Everything that happens within Community Medical Center must be treated as confidential and should not be discussed with anyone except on a "need to know" basis.

This also applies to any and all information obtained through the computer system regarding diagnostic test information and financial data.

To be completed by all employees, volunteers, and students.

I, \_\_\_\_\_, have read the above Community  
(Print Name)

Medical Center policy pertaining to confidentiality. I agree to safeguard the privacy and confidentiality of **all** information that I have access to in the course of my work and to use proper procedures when required to release such information to others. I understand that failure to do so may result in disciplinary action, up to and including termination of employment.

\_\_\_\_\_  
Employee, Volunteer, or Student

\_\_\_\_\_  
Date



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## VOLUNTEER CHECKLIST

NAME: \_\_\_\_\_

Please print

The following have been completed:

Measles requirement: (ONE of the following)

- a) Born on or before January 1, 1957
- b) Written proof of receiving TWO measles vaccinations (dates of)
- c) Proof of positive serology titer

\_\_\_\_\_ Measles requirement      Date: \_\_\_\_\_

Rubella requirement: (ONE of the following)

- a) Born on or before January 1, 1957
- b) Written proof of receiving a rubella vaccination (date of)
- c) Proof of positive serology titer

\_\_\_\_\_ Rubella requirement      Date: \_\_\_\_\_

Tuberculosis screening requirement: (Proof of ONE of the following)

- a) Skin test performed
- b) Negative chest x-ray within the last year

\_\_\_\_\_ Tuberculosis requirement      Date: \_\_\_\_\_

\_\_\_\_\_  
(Verified by)

\_\_\_\_\_  
(Date)



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I, \_\_\_\_\_, have applied to be a volunteer at Community Medical Center. I would appreciate a personal reference from you on my behalf. Please complete the following and return it in the enclosed envelope to the Volunteer Services Program at Community Medical Center. Thank you.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

Name \_\_\_\_\_

Relationship to the applicant \_\_\_\_\_

Years acquainted with the applicant \_\_\_\_\_

Would you recommend that we accept this applicant as a volunteer?  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

Name \_\_\_\_\_

Relationship to the applicant \_\_\_\_\_

Years acquainted with the applicant \_\_\_\_\_

Would you recommend that we accept this applicant as a volunteer?  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

Name \_\_\_\_\_

Relationship to the applicant \_\_\_\_\_

Years acquainted with the applicant \_\_\_\_\_

Would you recommend that we accept this applicant as a volunteer?  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_