



ADULT VOLUNTEER APPLICATION (4 PAGES)

MAIL TO: Volunteer Services, P.O. Box 26666, Albuquerque, NM 87125
 Volunteer Office Tel: 505-841-1501 FAX TO: 505-841-1858 EMAIL TO: bdahle@phs.org

(This application will be kept confidential.)

Name: _____	Date: _____
Uniform: Men's or Women's Shirt Size _____ Preference: Pink Smock, Teal Smock, Red Polo	

Volunteer Locations:
 Please circle your location of interest

Downtown (PH)

Rust (RMC)

Kaseman (PKH)

Cooper (COOP)

Healthplex/Aquatics (HPX)

Northside (PN)

Hospice (HOS)

PMG's (Outpatient Clinics)
 PMG-Montgomery
 PMG-San Mateo
 PMG-Isleta
 PMG-Los Lunas
 PMG-Atrisco
 PMG-4100 High Resort—Rio Rancho
 PMG-4005 High Resort—Rio Rancho
 PMG-Southern—Rio Rancho

No Preference*

*Choosing this option may delay placement

Service Areas-Rank the top 3 in the order of preference.
 These are some of the high need areas, if you are interested in another area please list your interest below.

_____ Information Desk (PH,PKH,RMC)
 _____ Ambassadors/Patient Transport (PH,RMC)
 _____ Gift Shop (PH, PKH, RMC, COOP, PN)
 _____ Progressive Care (RMC)
 _____ Surgical Services (PH,PKH,RMC)
 _____ Outpatient Services only (PMG, HOS)
 _____ Eye Clinic (PN)
 _____ Pain and Spine (PKH)
 _____ Behavioral Health (PKH)
 _____ Rehab (HPX,PKH,PH)
 _____ Cardiac Care (PH,RMC)
 _____ Radiology (PH,PKH,RMC)
 _____ Infusion (PH,PKH,RMC)
 _____ Pediatrics (PH)
 _____ Patient Activities (PKH)
 _____ Administrative (PH,PKH,RMC)
 _____ Emergency Room (PH,PKH,RMC)
 _____ Fall Prevention (PH,PKH,RMC)
 _____ Pet Therapy (PH,PKH,RMC)
 _____ Healing through Music (RMC)
 _____ Sewing groups (Various Locations)
 _____ Cancer Resource Center (PKH,RMC)
 _____ Adult Patient Care (PH,RMC)
 _____ Patient Family Advisory Committee (PKH,PH, RMC)

Other:

***Please note that this is not a promise of a department opening, this is a tool to facilitate matching your interests and department needs.**

FOR OFFICE USE ONLY

Interview date _____

Orientation date _____

Uniform Color and Size _____

Notes _____

We ask for a **MINIMUM** commitment of **144 hours** over a 9 month period. (Approx. *one 4 hour shift per week*)

What days and times are you available to volunteer?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
After-noon							
Evening							



Purpose To provide services that enable Presbyterian to achieve and enhance its goal of delivering quality and affordable and timely healthcare to its patients and members.

Vision

Dear Presbyterian Volunteers: Thank you for sharing your time and embracing and caring for me and my family while I was a patient at Presbyterian. I was very grateful for the compassionate expression of comfort, outreach and support. The time we spent with you was peaceful and calming. You were a ray of sunshine during a very stressful and difficult time and made a difference during my stay.

Values

We will live the CARES behaviors and honor our values by expressing a willingness to serve and support Presbyterian's patients, members and employees; creating an environment that emphasizes sincerity and sensitivity toward our customers' needs and expectations; contributing to Presbyterian's mission of service to the community; and striving to positively impact the whole being through excellence, innovation, Trust and teamwork.

Strategy

To be an active, caring, supporting and integral role in the healing process as PHS transforms into "One Presbyterian". To encourage innovation and the use of best practices in the recruitment, retention and recognition of volunteers as the healthcare environment changes.

CUSTOMERS

Approved by the Volunteer Services Board of Directors
March 18, 2014

Volunteer Signature _____

Date: _____

Presbyterian Volunteer Services reserves the right to refuse any applicant.

Personal Contact Information

Social Security # _____

Last Name: _____ First: _____ MI: _____

DOB: _____ Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Cell Phone: _____ (Optional) Home: _____ Work: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

General Information

Hobbies, interests, or skills: _____

How did you learn about our program?

Any previous or current work experience? If so, where?

Any previous Volunteer experience? If so, where?

Why are you interested in Volunteering for Presbyterian Healthcare Services? (Please be specific, we use this to match you with the appropriate department)

Do you have BLS (Basic Life Support)/CPR certification? _____

If so, please include a copy with application.

Medical Information

The Presbyterian Healthcare Services Volunteer Program is available to all, without regard to race, color, national origin, disability, gender, political affiliation or religion.

Are you currently being treated for any medical conditions that Volunteer Services should know about? Yes No

If so, please list them: 1. _____ 2. _____ 3. _____

Are you currently taking any medications that Volunteer Services should know about? Yes No

If so, please list them: 1. _____ 2. _____ 3. _____

Volunteer Statement and Background Check Authorization

I, _____, certify that all of the information provided in this volunteer application is true and correct to the best of my knowledge. I authorize PHS to conduct any and all inquiries necessary to determine my acceptability as a volunteer, including a thorough background check. I understand that this background check may include verification of personal and/or employment references, military information, or police record inquiries. The following will help to facilitate this process.

Have you every been convicted or have plead guilty, no contest, (nolo contendere), or received deferred adjudication for any criminal offense, including both misdemeanors and felonies? Answering "yes" will NOT automatically bar you from volunteering. If yes, please indicate the requested information below. If you need additional space, please continue on a separate sheet of paper.

Date	Charge	City/State:	Disposition:

Signature: X _____ Date: _____

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURES (above and below)

PHS Volunteer Agreement

I have reviewed and understand all of the information provided by the Presbyterian Healthcare System regarding the Volunteer Program and my responsibilities as a volunteer.

As a volunteer, I understand and acknowledge that my service as a PHS volunteer is completely voluntary and I will perform my role without any promise, expectation, or receipt of compensation. I further understand and acknowledge that I may decline to perform any task I do not feel comfortable performing, and/or to terminate my volunteer service at any time without penalty.

I understand that all Presbyterian Healthcare System medical records and patient records shall be treated as confidential information. I further understand that as a Presbyterian Healthcare System volunteer I am bound by Federal, State and Local laws and regulations regarding medical records and governmental records.

Printed Name: _____ Signature: X _____ Date: _____

FOR OFFICE USE ONLY:

- Criminal Background Check _____
- Criminal Background Check _____
- Follow-up/App Forwarded _____
- Personal Interview _____
- Orientation Scheduled/Date _____

Volunteer Position Schedule

Day: _____
Time/Shift: _____
Assignment: _____
Department Manager: _____

In addition to filling out this application in order to start you must:

- Pass criminal background checks.
- Schedule a brief interview with a Volunteer Program Manager.
- Receive an invitation to attend the General Volunteer Orientation.
- Submit proof of a negative TB Skin Test within the last year.
- Complete a Department/Area specific orientation.
- Be issued a security badge.

PLEASE BE SURE YOU HAVE COMPLETED THE APPLICATION IN ITS ENTIRETY.

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