Family Health West
PO Box 130 Fruita CO 81521

VolunTeen Application

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____
(Must be at least 12 years of age. If applicant is under the age of 18, a completed Parental Consent form is required.)

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE # _____ CELL PHONE # _____

PARENT / GUARDIAN _____ RELATIONSHIP _____ HOME PHONE # _____ CELL PHONE # _____

EMERGENCY CONTACT _____ EMERGENCY CONTACT # _____

Do you have any physical or medical limitations?_____

Have you ever been employed by Family Health West? ❑ yes ❑ no Area: _____

Please select areas of interest

Frequency: ❑ weekly ❑ bi-weekly ❑ every other week ❑ monthly

Time per Frequency: ❑ 1 hr ❑ 2 hrs ❑ 3 hrs

Day of Week: ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday ❑ Sunday

Time of Day: ❑ morning ❑ afternoon ❑ afternoon after school ❑ evening

Prefer Working: ❑ individually ❑ in a group ❑ as a group – Name of Group _____

Area Preferred: ❑ Hospital ❑ Nursing Home ❑ Assisted Living ❑ Office

Prefer to Help With: ❑ Parties/Outings/Activities ❑ Decorations ❑ Bulletin Board Updates ❑ Games (table, Wii, physical) ❑ Reading (magazine, newspaper) ❑ Friendly visits ❑ Gardening / Watering Plants ❑ Sing/Dance/Play Musical Instrument ❑ Deliver Ice Water Room-to-Room ❑ Sew / Mend ❑ Organize Media ❑ Arts / Crafts

Please list your special skills, talents, and interests: _____
_____
_____

Please list two character references (please do not use relatives):

Name _____ Name_____
Address_____ Address _____
_____ _____
Phone #_____ Phone #_____

SIGNATURE _____ DATE _____

Applicant will be called by a Volunteer Coordinator to be scheduled for an interview

Family Health West
PO Box 130 Fruita CO 81521

Parental Consent

PURPOSE:
All prospective volunteers are subject to the terms and conditions listed below. All prospective volunteers under the age of 18 must have parental consent prior to the terms and conditions being executed.

PROSPECTIVE VOLUNTEER:

_____ _____
Last Name First Name

TERMS AND CONDITIONS:
Please initial each item listed below to indicate that you consent to the term and / or condition for the above-named volunteer applicant.

_____ 1. Consent is given for the above-named applicant to be interviewed by a Volunteer Coordinator.

_____ 2. Consent is given for a CBI check (criminal background check).

If accepted into the Jr. Volunteer Program:

_____ 3. Consent is given for TB testing (tuberculosis screening), drug screen, and flu shot (Seasonal).

_____ 4. Consent is given to attend Orientation, i.e., OSHA and HIPAA in-services and placement orientation.

_____ 5. Consent is given to volunteer according to assignment, job description, guidelines and policies.

PARENTAL CONSENT:
I herby give permission for the above-named applicant to volunteer at Family Health West and give permission for him/her to comply with each term and/or condition that I have initialed above. I understand that he/she cannot begin his/her assignment until the results of these tests have been confirmed.

_____ _____
Signature (BEFORE SIGNING SEE NOTE BELOW) Date

_____ _____
Relationship to Prospective Volunteer Witness

→ THIS FORM MUST BE **SIGNED IN THE PRESENCE OF AND WITNESSED BY** A FAMILY HEALTH WEST VOLUNTEER COORDINATOR, DIRECTOR, FRONT OFFICE RECEPTIONIST, OR HUMAN RESOURCES SPECIALIST.

Family Health West

CONSENT FORM FOR BACKGROUND CHECK

Applicant, please complete the following:

The following information is required by law enforcement agencies and other entities for positive identification when checking records. It is confidential and will not be used for other purposes.

Print Full Name (last, first, middle): _____

Print other names used: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State of Issue: _____

Race: Asian ❑ Black ❑ Hispanic ❑ White ❑ Other ❑ Sex: Male ❑ Female ❑

List address(es) for the past five years

Include city, state, zip code, and how long you lived there. List current address first.

1. _____
2. _____
3. _____
4. _____
5. _____

By checking the box below, I hereby authorize Family Health West to contact me and my listed references and use the information entered on this form for the Volunteer Application process and file/information storing.

I understand that a condition of volunteering at Family Health West is a screening test for tuberculosis. Upon completion of the volunteer interview and initial volunteer on boarding process, it is the responsibility of the volunteer or the parent of the volunteen to contact the Access Clinic at 970-858-2190 to schedule their TB test, the follow up visit, the second TB test and the second follow up visit. If the results of this test are positive, I understand that a chest x-ray will be done. Family Health West agrees to do the screen and/or x-ray free of charge.

I acknowledge that I will also be required to complete a drug screening prior to volunteer service. Family Health West is determined to eliminate the use of illegal drugs, alcohol and controlled substances. This program is designed solely for the benefit of volunteers and employees, to provide reasonable safety while on duty, and to protect them and patients / residents from offending individuals. Additionally, this program meets Family Health West's commitment to the community it serves.

I also authorize Family Health West to perform a Criminal Background Check. In connection with this request, I authorize all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, county, state, and federal courts, military services and persons, CBI, and FBI, to release information they may have about me to the person or their agent or company with which this form has been filed. This releases the aforesaid parties from any liability and responsibility for collecting the above information. This authorization, in original form or copy form, shall be valid for this and any future reports or updates that may be requested.

I authorize the procurement of my Colorado Worker's Compensation files or any other states' Worker's Compensation files. I also authorize a consumer credit report to be run. I understand these files may contain negative information about my background, mode of living, character and personal reputation. This authorization, in original form or copy form, shall be valid for this and any future reports or updates that may be requested.

_____ _____

Volunteers Parent/ Legal Guardians Signature Date

Volunteer Coordinator Requesting: _____ Ext._____

Family Health West

VOLUNTEER TUBERCULOSIS SCREENING

I understand that a condition of volunteering at Family Health West is a screening test for tuberculosis. It is the responsibility of the volunteer or the parent of the volunteen to contact the Access Clinic at 970-858-2190 to schedule their TB test, the follow up visit, the second TB test and the second follow up visit.

If the results of this test are positive, I understand that a chest x-ray will be done.

Family Health West agrees to do the screen and/or x-ray free of charge.

Name of Volunteer (please print)	Date	Signature

Signature of Parent/Legal Guardian

C-214 1211