Dear Volunteer Applicant,

Thank you for your interest in our Volunteer Program. More than 500 volunteers contribute more than 65,000 hours of service annually to our hospital. Still, we have many areas in need of volunteer assistance and we do hope you will decide to join our hospital family.

Our volunteers are carefully screened and asked for a specific commitment. Please review the prerequisites and Volunteer Agreement before completing the enclosed application to ensure you can meet the criteria for a Suburban Hospital Volunteer. If you have any questions, please call us at 301-896-3092.

**Prerequisites**
- Must be at least 15 years old.
- Sign the Volunteer Agreement.
- Attend an onsite, 2-hour screening interview, orientation, and pre-placement meeting.
- Attend a second interview with a department manager in your area of interest.
- Pass a mandatory drug screening test.
- Receive/produce a tuberculin screening test and flu vaccination at orientation and annually thereafter.

**To complete this application:**
- Please print or type all the information except your signature.
- Sign the Volunteer Agreement. A parent or guardian signature is required if you are under 18 or enrolled in high school.
- Complete all sections of the application.
- Please mail completed application and signed Volunteer Agreement to the Volunteer Services Office at the address above or scan and email to vboyer1@jh.edu.

A member of the Volunteer Services staff will schedule your initial interview and orientation. Your placement will be finalized after the second interview.

Many thanks for your interest. We look forward to hearing from you soon.

Sincerely,

Pamela M. Fogan, CAVS
Director, Volunteer Services
pfogan1@jh.edu

**Please note:** Should you be accepted for placement, a background check will be required for those persons age 19 and older.
NAME  Last ____________________________ First ____________________________ MI ______

FIRST NAME FOR ID BADGE, if different from above ____________________________________

TITLE  Mr.  Mrs.  Miss  Ms  E-MAIL Address _________________________________________

STREET ADDRESS _______________________________________________________________

CITY ____________________________ STATE ________ ZIP _____________________________

PHONE  Home ( ) ______________________ Work ( ) _________________________________

School ( ) ________________________ Cell ( ) ______________________________________

BIRTH DATE ____________   PREFERRED WORK AREA (Circle)  Patients  Public  Office

Undecided  Specific Area _______

AVAILABILITY
Number of days per week  1  2  3  4  5   DAY  HOURS  (Please specify earliest hour to
Hours per day  4  6   start and latest hour to stop)

Start Date ___________________________

How long do you plan to volunteer?

______ 100 Hours

_____ One Year

_____ More than one year

_____ Summer

WORK EXPERIENCE (Paid or volunteer; list current or most recent job first.)

Current Status (Circle one)  Retired  Unemployed  Employed  Student

1. Job Title ______________________________________________________ Dates _________

Company Name _____________________________________________________________

Supervisor ________________________________________ Phone __________________

Duties _________________________________________________________________

Reason for Leaving ________________________________________________________

2. Job Title ______________________________________________________ Dates _________

Company Name _____________________________________________________________

Supervisor ________________________________________ Phone __________________

Duties _________________________________________________________________

Reason for Leaving ________________________________________________________

3. Other Jobs (List job titles only.)

______________________________________________________________

LANGUAGE SPOKEN  English  French  Spanish  Farsi  Amharic  Other: __________
SKILLS/HOBBIES (Please list)

____________________________________________________________________

WHY DO YOU WANT TO VOLUNTEER? (Check all that apply.)

___ Retired
___ Experience
___ School Requirement
___ Give Back to Community
Other (Please specify) ____________________________________________

EDUCATION Career Goal _________________________________________

Currently enrolled? Yes  No  Last Grade Completed: 9  10  11  12  College Fr So Jr Sr

Name of High School ____________________________  Graduated: Yes  No

Name of College ____________________________  Graduated: Yes  No

Degree/Major(s) _____________________________________________

Other Training or License ____________________________________________________________________________

HOW DID YOU FIND OUT ABOUT VOLUNTEERING AT SUBURBAN HOSPITAL?

___ Employee (Name: __________________ )  Patient
___ Newspaper (Name: __________________ )  Montgomery County Volunteer Center
___ Volunteer (Name: __________________ )  Other (Specify)

HAVE YOU EVER VOLUNTEERED AT SUBURBAN BEFORE?

Yes  No

Year(s) _______________ Name (if different) ____________________________

Area(s) ____________________________________________________

WILL YOU PARK YOUR VEHICLE AT THE HOSPITAL?

Yes  No

License Plate Number  Vehicle #1 ____________________________  Vehicle #2 ____________________________

EMERGENCY CONTACT

Name ____________________________  Relation ____________________________

Home Phone ( ) ____________________________  Work ( )

HEALTH SURVEY

Date of last TB Skin Test ______ Reaction: ___ Negative (no reaction) ___ Positive (swollen, red)

Check those that apply to you and elaborate, if needed.

___ Back Problems ____________________________  Epilepsy ____________________________  
___ Diabetic ____________________________  Mental Health Concerns ____________________________
___ Hearing Impaired ____________________________  Other (Specify) ____________________________
___ Tuberculosis (TB) ____________________________  Other ____________________________

Signature of Applicant ____________________________  Date ____________________________
Volunteer Agreement

If I am accepted as a volunteer, I agree to:
1. Keep all information regarding patients/clients and hospital business confidential.
2. Give permission for the Volunteer Services staff to discuss my work history and performance with those I have listed as supervisors and references with my potential Suburban Hospital supervisor(s).
3. Sign in and out each day I volunteer according to the protocol defined by Volunteer Services for my particular area.
4. Volunteer at least one 4-hour day per week—the same day(s) every week.
5. Be punctual and regular in attendance.
6. Notify my supervisor(s) in advance if I cannot work as scheduled. If listed as a part of my job responsibilities, I will get a substitute.
7. Wear the hospital I.D. badge while on duty.
8. Purchase a volunteer jacket or shirt and wear it whenever on duty.
9. Always adhere to the volunteer dress code
10. Pass a mandatory drug screening test and randomly conducted tests.
11. Receive/produce a tuberculin screening test and flu vaccination initially at orientation and annually thereafter.
12. Not expect compensation or employment as a result of my volunteer work.
13. No smoking. This is a smoke-free campus.
14. Provide my own transportation to and from the volunteer work area at my expense.
15. Abide by all hospital policies and procedures.
16. Perform duties as defined by the position description or my supervisor
17. Notify my supervisor and the Director of Volunteer Services of my plans to resign at least two weeks in advance.
18. At the time of resignation, return my ID badge to Volunteer Services.

I certify that:
1. I am at least 15 years old.
2. I am not volunteering as a court requirement or as an attorney referral.

Signature of Applicant __________________________ Date ________________

PARENT/GUARDIAN OF THOSE APPLICANTS WHO ARE 15-18 YEARS OLD
1. This applicant has my permission to volunteer at Suburban Hospital.
2. I have read the above Volunteer Agreement.
3. I will support this applicant in fulfilling the Volunteer Agreement.
4. I give permission for this applicant to receive a TB Skin Test (PPD) and/or chest x-ray as required by Suburban Hospital’s Occupational Health Guidelines and the Maryland State Health Department regulations for hospital workers. I release Suburban Hospital of any responsibility if the applicant should have any adverse reaction as a result of the skin test.

Parent/Guardian (Print) ___________________________ Relationship ________________

Signature ________________________________ Date ________________