Acceptance as a volunteer is contingent upon completing all checklist items by the listed due dates. NO EXCEPTIONS.

<table>
<thead>
<tr>
<th>CHECKLIST ITEMS</th>
<th>IMPORTANT DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Complete this entire packet</td>
<td></td>
</tr>
<tr>
<td>☐ Please bring to your scheduled interview:</td>
<td></td>
</tr>
<tr>
<td>1. This entire packet</td>
<td></td>
</tr>
<tr>
<td>2. Valid form of ID, e.g., driver’s license, state ID, passport, school ID (if a minor without other form of government-issued identification)</td>
<td></td>
</tr>
<tr>
<td>☐ Tuberculosis (TB) skin test #1 – Please bring a copy of immunization records if you have them</td>
<td>1st part – TB Test #1 Placed</td>
</tr>
<tr>
<td>Schedule an appointment with Employee Health by calling 847.437.5500, ext. 4431. Employee Health is located on the ground floor of the West Tower. See map on the final page.</td>
<td>2nd part – Test #1 Read (2–3 days AFTER 1st part) Note: Employee Health will tell you when to come back</td>
</tr>
<tr>
<td>Hours are generally 8–11:30 am and 1–4 pm</td>
<td></td>
</tr>
<tr>
<td>☐ TB skin test #2</td>
<td>1st part – TB Test #1 Placed</td>
</tr>
<tr>
<td>NOTE: YOU MUST COMPLETE BOTH TB TESTS</td>
<td>2nd part – Test #1 Read (2–3 days AFTER 1st part) Note: Employee Health will tell you when to come back</td>
</tr>
<tr>
<td>Hours are generally 8–11:30 am and 1–4 pm</td>
<td></td>
</tr>
<tr>
<td>☐ Complete Orientation</td>
<td>Set up with Amanda B.</td>
</tr>
<tr>
<td>☐ Have ID picture taken</td>
<td>Before start date</td>
</tr>
<tr>
<td>☐ Receive ID badge</td>
<td></td>
</tr>
<tr>
<td>☐ First day as an official hospice volunteer!</td>
<td></td>
</tr>
<tr>
<td>Call Amanda B. or Heather N. for volunteer assignment</td>
<td></td>
</tr>
</tbody>
</table>

Assigned Department: ____________________________________________

Shift Times: ____________________________________________  Shift Day: ____________________________

Tentative Start Date*: _______________________________

*Pending clearance of background check, if applicable
Volunteer Expectations

The success of the Hospice Volunteer Program depends on active participation from all volunteers, working towards furthering the mission and values of AMITA Health. Since communication, cooperation and responsibility are key concepts to ensure that things run effectively and efficiently, clear expectations are needed. Listed below are the essential expectations of every volunteer, regardless of position. In order to be eligible to volunteer at AMITA Health Alexian Brothers Hospice Care, I agree to the following statements:

- I understand that volunteer services are performed without compensation.
- I understand that if I have recently experienced a loss prior to volunteering, I must wait 6–12 months, then attend an interview with the Volunteer Department.
- I will attend an interview and orientation as part of the application process.
- I will have my picture taken for an ID badge, which I will receive at the security desk. Furthermore, I will wear my badge at lapel level at all times whenever I am on-duty.
- I will submit to all health testing and an annual flu shot as required by AMITA Health policy.
- I will submit to a criminal background check.
- I will review my orientation handout and ask for clarification on any items that I do not understand.
- I will attend any required volunteer training sessions, as directed by the volunteer coordinator or assignment.
- I will attend a volunteer renewal session every year in order to comply with the requirements of The Joint Commission.
- I will comply with all confidentiality and patient privacy standards/guidelines as a volunteer.
- I will actively participate and provide availability on a regular basis, as outlined, specified by my specific department need and/or patient and family need.
- I will serve as an integral member of the hospice interdisciplinary group amid various settings: residence, home care, respite, inpatient, bereavement and administrative/office duties.
- I will be supportive of the hospice concept, comfortable with each patient’s faith traditions and willing to serve and care for others in a volunteer capacity.
- I will notify the volunteer coordinator at the beginning and end of my shift each time I volunteer, unless assigned to AMITA Health Alexian Brothers Hospice Residence.
- I will volunteer at my specific department and/or assignment at the times assigned by the volunteer coordinator. If I need to change my day/time/assignment, I will speak with the volunteer coordinator before changing assignments.
- I will maintain open communication with the volunteer coordinator and my assignment’s family/caregiver. I will speak with the volunteer coordinator if I have any concerns and/or questions.
- I will treat all patients, visitors, volunteers and associates with dignity, respect and courtesy.
- I will maintain a positive attitude and mature relationship with all volunteers, associates, visitors and patients.
- I will maintain professionalism at all times, whether I am serving the patient and family/caregiver or interacting with associates or other volunteers.
- I confirm that I understand and abide by all AMITA Health Alexian Brothers Hospice Care policies and regulations.
# Volunteer Application

## SECTION 1: PERSONAL HISTORY

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address:</th>
<th>City:</th>
<th>State:</th>
<th>ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone Number:</td>
<td>Mobile:</td>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td>Date of Birth (Must be at least 16 years of age)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact/Relationship:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Two References (Non-Family Related)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: _______________________</td>
</tr>
<tr>
<td>Name: _______________________</td>
</tr>
</tbody>
</table>

## SECTION 2: TIME PREFERENCE

**Availability:** Please circle day and shift preferences:

- M         T         W         TH         F          SAT         SUN
- Mornings (8 am–12 pm)                      Afternoon (12 pm–4 pm)                      Evenings (4 pm–8 pm)

## SECTION 3: PERSONAL INTEREST/INSPIRATION

In which of the following would you like to play a role? Please checkmark:

- [ ] Residence – Staff Support/Front Desk/Patient Support & Companionship/Ice Water Trays/Baking
- [ ] Companionship – Playing Cards/Reading/Music/Watching TV/Talking/Patient Home Visits/Respite
- [ ] Patient/Family Support – Grocery Shopping/Light Cooking/Light Cleaning
- [ ] Vigil Support or Bereavement Calls & Mailings or Administrative – Hospice Clerical Tasks/Charting

Volunteers “Inspire By Example.” Why are you inspired to work with AMITA Health Alexian Brothers Hospice Care?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________


Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098
## SECTION 4: PREVIOUS VOLUNTEER/WORK EXPERIENCE

<table>
<thead>
<tr>
<th>Volunteer Work Experience:</th>
<th>Position:</th>
<th>Organization:</th>
</tr>
</thead>
</table>

Explanation of Duties:

<table>
<thead>
<tr>
<th>Personal Interests/Hobbies:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupation/Work Experience:</th>
<th>Position:</th>
<th>Organization:</th>
</tr>
</thead>
</table>

Explanation of Duties:

## SECTION 5: EDUCATION/SKILLS

Occupation/Work Experience:  

<table>
<thead>
<tr>
<th>Skills (Circle all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typing</td>
</tr>
</tbody>
</table>

## SECTION 6: CLEARANCE INFORMATION

Have you ever been convicted of any criminal offense other than a minor traffic violation?

☐ Yes      If yes, please explain: _______________________________________________________________

☐ No

Are you volunteering to satisfy court requirements?

☐ Yes      If yes, please attach a copy of your court order, number of hours required and contact person’s name, email and phone number

☐ No

Please read this section carefully:

I affirm that the information I provided on this application is accurate and complete. I understand that any false statements or significant omissions on this application or interview, whenever discovered, may result in termination of my volunteer service. I authorize AMITA Health Alexian Brothers Hospice Care to investigate my statements without my further consent. I understand that my affiliation with AMITA Health Alexian Brothers Hospice Care is contingent upon satisfactory references, a pre-volunteer medical and drug screening, and submitting to a criminal background check.

Signature: ____________________________  Date: ____________________

For more than 800 years, the Alexian Brothers have cared for the sick, the aged and the dying. AMITA Health Alexian Brothers Hospice Care continues that tradition of care and compassion — enhanced by new therapies for pain and symptom of relief and advancements in the understanding of grief. AMITA Health is committed to promoting the physical, mental, spiritual and social well-being of all individuals served through its healthcare ministry.

Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098
Volunteer Applicant Testing Consent Form

I consent to the mandatory tuberculosis (TB) testing. In addition, I consent to a chest X-ray if positive reaction occurs. Furthermore, I understand that immunity to varicella (chickenpox), mumps, rubella (German measles) and rubeola (measles) is a mandatory requirement for all volunteers at AMITA Health Alexian Brothers Hospice Care, and if the results of my laboratory tests indicate that I am non-immune to any or all, I consent to be vaccinated against the disease(s) to which I am not immune.

Lastly, I understand that I must comply with the annual influenza requirement by either obtaining a vaccination (free of charge if done at AMITA Health Alexian Brothers Medical Center Elk Grove Village) or providing appropriate proof of medical contraindication.

I am aware that if I decline any part of the health testing, I will not be eligible to serve as a volunteer.

Applicant Name (PRINT): ______________________________________________________

Applicant Signature: ________________________________ Date: ______________

*Parent/Guardian signature required if applicant is under 18 years of age.

*Parent/Guardian Name (PRINT): ________________________________________________

*Parent/Guardian Signature: ________________________________ Date: ______________

NOTE: You must complete this form prior to having any testing done at AMITA Health Alexian Brothers Medical Center Elk Grove Village.

Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098
Employee Health Services
HEPATITIS B Vaccine Declination

I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me by Employee Health Services.

Volunteer Signature  Date

Volunteer Coordinator Signature  Date
Volunteer Tuberculosis (TB)
Testing Order Form

| LOCATION | Employee Health Office  
|-----------|--------------------|
|           | (AMITA Health Alexian Brothers Medical Center Elk Grove Village,  
|           | 800 Biesterfield Rd., Ground Floor by Employee Entrance) |

| PHONE     | 847.437.5500, ext. 4431 – Please call ahead to confirm that the  
|           | employee health nurse is available. |

| HOURS     | Mon–Fri: 8 am–4 pm; closed 11:30 am–1 pm for lunch |

| FEE       | • Testing done by Employee Health at AMITA Health Elk Grove  
|           | Village: NO FEE  
|           | • Testing done at an occupational health site: YOU PAY |

BRING THE FOLLOWING TO YOUR 1ST VISIT

- Volunteer TB testing order form (this form)
- Volunteer applicant testing Consent form
- Immunization records (if you have them)
  Give these forms to the associate administering your test at Employee Health.

| NOTE      | • You must complete two (2) TB skin tests  
|           | • Each test requires two (2) visits  
|           | • This is four (4) total visits to Employee Health  
|           | • Results only valid if read by an Employee Health associate |

FILL IN ALL INFORMATION BELOW BEFORE 1ST TEST:

Name (PRINT): ________________________________________________________________

Address: __________________________________________ City: ___________________ ZIP: ____________

Phone: __________________________________________ Date of Birth: ________________  
| | (MM/DD/YYYY) |

Gender: ☐ Male    ☐ Female

Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098
Employee Health Laboratory and Radiology Order Form

Pre-Employment/Volunteer Screening. Go to Employee Health

SEROLOGY
☐ RUBELLA IGG (RUBELLA Immunity)
☐ RUBEOLA IGG (RUBEOLA Immunity)
☐ VARICELLA IGG (VARICELLA Immunity)
☐ MUMPS IGG (MUMPS Immunity)

CHEMISTRY
☐ HEP BS AB (HEPATITIS B SURFACE AB)
☐ HEP BS AG (HEPATITIS B SURFACE AG)

RADIOLOGY
☐ CHEST X-RAY PA & LATERAL

OTHER
☐

POST-EXPOSURE TESTING. DO NOT GO TO REGISTRATION.
1. Go directly to the outpatient lab
2. Registration will be done by the lab

Original date of exposure: ______________________________

☐ Hep C ☐ CBC
☐ Antibody ALT ☐ BMP
☐ HIV 1 & 2 ☐ Liver functions

COLLECTION DATE: ________________________________ TIME: __________________

PHLEBOTOMIST: PLEASE SEND RESULTS TO EMPLOYEE HEALTH SERVICES

Patient Name: ___________________________________ DOB:_____________________

Employee ID #: __________________________________ Male Female

Date Ordered: ____________________________________

Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098

Give this page to Employee Health
Authorization For Release Of Consumer Information
(VOLUNTEER BACKGROUND CHECK AUTHORIZATION)

TO BE COMPLETED BY VOLUNTEER APPLICANT (PLEASE PRINT LEGIBLY OR TYPE)

Name: _________________________________________________________________________

Last Name                                                 First Name                                            Middle Name

Social Security # [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Date of Birth

M     M     D     D     Y     Y     Y     Y

Driver's License: ___________________________________________ State: _________________

Address: _______________________________________________________________________

Street Address

City                                                                                           State                                            ZIP Code

Volunteer Applicant Signature: ______________________________________________________

Applicant Authorization

1. Without reservation, I authorize this employer or any party or agency contacted by this employer to obtain or furnish information concerning my criminal, motor vehicle or other history. I understand that inquiries may be made to various federal and state agencies, employers, references, acquaintances and others seeking information as to my personal characteristics, general reputation and mode of living.

2. Under provisions of the Fair Credit Reporting Act, certain information, when used for employment purposes, is considered to be a consumer report. This information includes, but is not limited to, public record information (criminal history, civil litigation, etc.), driving records, education records and employment records. If an adverse employment decision is made due, in whole or part, to information received as a result of these inquiries, I will be provided with a copy of the consumer report and a summary of my rights under the Fair Credit Reporting Act.

*This information is requested by VERIFY solely for the purpose of ensuring accurate retrieval of records.

TO BE COMPLETED BY EMPLOYER (PLEASE PRINT LEGIBLY OR TYPE):

COMPANY/ORGANIZATION: AMITA Health Alexian Brothers Hospice Care
1515 E. Lake St., Ste. 206, Hanover Park, IL 60133
847.652.5098, FAX: 630.233.5101

Contact the volunteer coordinator: Amanda.Bailey@AMITAhealth.org or 847.652.5098
A. **Volunteer Center** - Ground Floor, Medical Offices B
B. **ID Picture** - Security Desk, ER Waiting Room, 1st Floor
C. **TB Test** - Employee Health, Ground Floor
D. **Lab Test** - Patient Registration, Ground Floor
E. **Lab Test** - Outpatient Lab, Ground Floor