Greene County Medical Center
1000 W. Lincolnway
Jefferson, IA 50129

Volunteer/Auxiliary Application

Name _____ Date _____

Address _____ Phone No._____

City, Zip _____

E-Mail address _____

(Please check one)

____ I would like to become an ***ACTIVE*** member of the Greene County Medical Center Auxiliary. ($5.00 dues per year)

____ I would like to become an ***INACTIVE*** (Supporting) member of the Greene County Medical Center Auxiliary. ($10.00 dues per year)

As an Active Volunteer, I would be interested in the following (check all that apply):

___ Gift Shop 1 (Main Lobby) – 10 am to 3 pm

___ Fill Pop Machines

___ Sewing projects

___ Clerical (Typing, assembling packets, filing,)

___ Help with special events

___ Blood Drive

___ Serve on Fundraising Committee

___ Serve on Scholarship Committee

___ Other (please specify) _____

I would like to volunteer the following day of the week (Check which you prefer)

___ Monday ___ Tuesday ___ Wednesday ___ Thursday

___ Friday ___ Saturday ___ Sunday

How many hours on those days could you volunteer? (usually gift shop hours are all day unless you arrange to split the day with someone)

___ 1 hour ___ 2 hours
___ All Morning ___ All Afternoon ___ All day

If there is a specific duty you are **physically unable to perform** in the area you wish to volunteer, please list (for example, pushing patients in wheelchairs).

Other Volunteer Experience

_____
_____
_____

Employment Experience

_____
_____
_____

Interests, Skills, Hobbies, Etc.

_____
_____
_____

Reasons you wish to volunteer at Greene County Medical Center

_____
_____
_____

List the names of two people to contact in an emergency. At least one name should be local and the other to be a relative.

Name _____ Phone (H) _____ (W) _____

Name _____ Phone (H) _____ (W) _____

Your Physician: _____ Phone _____

Any emergency medical conditions we should be aware of in case of an emergency._____
_____

STATEMENT OF CONFIDENTIALITY

If I am accepted into the Auxiliary and volunteer program at Greene County Medical Center, I will be bound by the hospital policy regarding confidentiality. I understand that I am **NOT** to discuss or disclose information concerning a patient or resident to anyone inside or outside the hospital while volunteering at or for Greene County Medical Center. A patient's /resident's privacy **must be respected at all times**!

I understand I will have Auxiliary orientation about HIPPA, Safety, Infection Prevention and Auxiliary training prior to becoming an active member.

I give permission to be photographed in a group or individually while working as a GCMC Auxilian or attending auxiliary sponsored events.

_____ _____

Signature of Applicant Date

New Member Checklist

Checklist should be done in the following order and returned to the Foundation Director:

- ☐ Application returned to Foundation Director
- ☐ Background check approved by HR and returned to Foundation Director
- ☐ Foundation Director will call applicant to notify them of Background check completion
- ☐ Applicant schedules Employee Health appointment by calling Deb Wolterman, employee health nurse 386-0229, once complete contact Auxiliary President. (physical and vaccinations if needed)
- ☐ Orientation (HIPPA, Safety & Infection Prevention) scheduled by Foundation Director
- ☐ Confidentiality & Standards of Behavior forms signed
- ☐ Photo consent form signed
- ☐ I understand I am becoming an Active member of the Auxiliary. If I am not able to volunteer for 2 or more Auxiliary activities each year, I will be moved in Inactive status.
- ☐ I understand yearly training about HIPPA, safety and infection prevention and flu vaccination is required. Every four years a health physical is performed by the employee health nurse.
- ☐ Name badge/smock received from Auxiliary President. Gift Garden and other training from Auxiliary president and officers.

Revised 8-2022