UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

**UM Upper Chesapeake Medical Center**
500 Upper Chesapeake Dr.
Bel Air, MD 21014
Phone: 443-643-1730
Fax: 443-643-1729

**UM Harford Memorial Hospital**
501 South Union Ave.
Havre de Grace, MD 21078
Phone: 443-843-5350
Fax: 443-843-5215

**F. Steven Anderson**
Director, Volunteer Services
and Community Partnerships

Return to:
UM Upper Chesapeake Medical Center
Volunteer Services
500 Upper Chesapeake Drive
Bel Air, MD 21014

# APPLICATION FOR VOLUNTEER SERVICES

**PLEASE CHECK DESIRED LOCATION:**

☐ **UM UPPER CHESAPEAKE MEDICAL CENTER** (Bel Air)

☐ **UM HARFORD MEMORIAL HOSPITAL** (Havre de Grace)

☐ **SENATOR BOB HOOPER HOUSE** (Forest Hill)

☐ **KAUFMAN CANCER CENTER** (Bel Air)

**VOLUNTEER CLASSIFICATION:**

☐ **JUNIOR** (Age15 and completed the 9th grade – 17 years of age)

☐ **SENIOR (AGE 18 - OVER)**

☐ **CHAPLAINCY**

## PERSONAL INFORMATION

**NAME** _____
LAST FIRST MI

**ADDRESS** _____
STREET

_____
CITY STATE ZIP

**PHONE** _____
HOME WORK CELL

_____
DATE OF BIRTH GENDER EMAIL ADDRESS

## EDUCATIONAL/EXPERIENCE BACKGROUND

**ARE YOU CURRENTLY ATTENDING SCHOOL?** ☐ YES ☐ NO

**IF YES,** _____
NAME OF SCHOOL HIGHEST GRADE COMPLETED

**OCCUPATION OR PROFESSIONAL TRAINING (CURRENT OR PREVIOUS)** _____

**OTHER SKILLS NOT PREVIOUSLY ADDRESSED** _____

_____

**COMMUNITY AND ORGANIZATIONAL AFFILIATIONS** _____

**LIST PREVIOUS VOLUNTEER EXPERIENCE** _____

_____

**HAVE YOU EVER BEEN EMPLOYED BY OR VOLUNTEERED AT UPPER CHESAPEAKE HEALTH?**
☐ YES ☐ NO (this includes UCH, HMH, FGH, UCMC and Hospice/Homecare)

**HOW DID YOU LEARN ABOUT OUR PROGRAM?** _____

**HAVE YOU EVER BEEN CONVICTED OF OR CHARGED WITH A FELONY OR MISDEMEANOR OTHER THAN A MINOR TRAFFIC VIOLATION?** ☐ YES ☐ NO

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## HEALTH RECORD

- **PROVIDE A COPY OF YOUR MMR (MEASLES, MUMPS, RUBELLA) and VARICELLA (Chicken Pox) VACCINATIONS. CERTAIN PATIENT CONTACT VOLUNTEERS MAY ALSO BE REQUIRED TO BE VACCINATED AGAINST HEPITITUS-B.**

- **PROVIDE A COPY OF YOUR LAST TB SKIN TEST (PPD). YOU WILL BE REQUIRED TO PROVIDE PROOF OR RECEIVE A PPD IF YOU HAVE NOT HAD A TEST WITHIN THE YEAR.**

- **YOU WILL BE REQUIRED TO PROVIDE A COPY OF OR OBTAIN A FLU VACCINE DURING FLU SEASON.**

**DO YOU HAVE ANY PHYSICAL OR MENTAL LIMITATIONS THAT WOULD AFFECT YOUR PLACEMENT AS A VOLUNTEER?**

☐ **NO** ☐ **YES** **PLEASE EXPLAIN** _____

**PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:**

_____

**NAME** **RELATIONSHIP** **PHONE**

***I HEREBY CERTIFY THAT THE ANSWERS AND EXPLANATIONS TO ALL PRECEDING QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.***

_____ _____

**NAME** **DATE**

## PARENTAL CONSENT FOR JUNIOR VOLUNTEER (*REQUIRED*)

_____ has my approval to participate in the Upper Chesapeake Health Junior Volunteer Program. I understand that my child will be responsible for adhering to the rules and regulations set forth by the Volunteer Services Department. Non-conformance to set policies and procedures could result in termination from the program. My signature will give authorization to participate in this program, including orientation, in which fire and safety procedures and health issues, including AIDS education and infection control practices are discussed.

In addition, _____ has my consent for a PPD test for tuberculosis and a chest x-ray, (if indicated) to be done on an annual basis. Consent is also give for a titer to be drawn if proof of the recommended number of doses for the MMR and Varicella vaccines cannot be provided.

_____, also has my consent to receive a Seasonal Influenza Vaccine.

_____ _____ _____

**SIGNATURE** **RELATIONSHIP TO MINOR** **DATE**