



Volunteer Services Application Packet

Because Getting It Right Matters.

Volunteer Services Program

Thank you for your interest in volunteering at **Shiawassee County Medical Care Facility!** We are seeking volunteers who will carry out our facility's vision and mission. Please note we are required by law to complete a screening process and run a background check on all volunteers.

WHAT IS A VOLUNTEER?

A **Shiawassee County Medical Care Facility** volunteer is a member of a team of individuals who serve without salary under staff supervision and direction. Volunteers are placed in nonprofessional areas and are essential in helping us deliver compassionate care to our residents.

VOLUNTEER EXPECTATIONS

All volunteers attend a special orientation session and receive personal training within the department to which they are assigned. In addition, each volunteer receives an identification badge to wear while volunteering.

GOALS FOR EACH VOLUNTEER

- Assist staff members with non-professional aspects of their work.
- Enhance the resident care experience by providing a personal touch in a highly technical environment.

VOLUNTEER TERMINATION

All volunteers deemed unsuitable for continued volunteer service will be terminated and prohibited from further volunteer activity at the facility. Volunteers may be terminated for but not limited to the following:


- Breach of Confidentiality
- Disregard for facility and Volunteer Program policies.
- Inability to work well with others.
- Any concern the facility may have for the safety and comfort of our residents and their families.

In addition to the application and forms provided, **Shiawassee County Medical Care Facility** requires vaccination records for all caregivers and volunteers. If you have received T-dap, MMR, Hep B, varicella (chicken Pox), and/or a current season flu shot, please submit these records with your application. Employee Health will evaluate your records and determine the next steps. We will contact you for an interview and run a background check. When the volunteer criteria has been met, we will schedule you for

Volunteer Orientation and Employee Health screening. Please bring your photo ID to your appointments with Employee Health. If you have, any questions please call (989) 743-3491.

Volunteer Services Program Packet

The following Steps must be completed for every new volunteer:

Required:	
STEP ONE: Complete Volunteer Application Form	<input type="checkbox"/>
<ul style="list-style-type: none"> • Signed Confidentiality Statement 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Volunteer Availability Statement 	<input type="checkbox"/>
STEP TWO: Volunteer interview Process	<input type="checkbox"/>
STEP THREE: Background Check Process	<input type="checkbox"/>
<ul style="list-style-type: none"> • One Reference Check 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Criminal Background Check (according to the State of Michigan requirements.) 	<input type="checkbox"/>
STEP FOUR: Volunteer Orientation	<input type="checkbox"/>
<ul style="list-style-type: none"> • Attend Volunteer orientation session 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Copy of Driver's License 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Identification Badge 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Facility Tour and Department Orientation 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Completion of vaccine requirements 	<input type="checkbox"/>

VOLUNTEER SERVICES PROGRAM APPLICATION

PERSONAL INFORMATION

Name:

_____ (Last) _____ (First) _____ (Middle)

Street Address:

_____ (City) _____ (State) _____ (Zip Code)

Home Phone: () _____ OK to contact?

Cell Phone: () _____ OK to contact?

Date of Birth: _____ Email Address: _____

Do you have a family member employed at **Shiawassee County Medical Care Facility**?
 Yes No

If you answered yes, please list name of family member:

Have you ever volunteered or been employed with **Shiawassee County Medical Care Facility** or any other contracted agency affiliated with **Shiawassee County Medical Care Facility**? Yes No

Present Occupation/Employer:

Position/Years of Service:

Special Training/ Certification:

Previous volunteer experience with any other organizations? Yes No

If yes, where? _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency whom should we notify?

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

VOLUNTEER SHIFT AVAILABILITY & ASSIGNMENT PREFERENCE

Please tell us which days and times you are available to provide assistance.

First Choice

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Morning Afternoon Evening Overnight

Second Choice

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Morning Afternoon Evening Overnight

Third Choice

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Morning Afternoon Evening Overnight

Please list any current scheduling obligations:

How many Hours would you like to serve? _____

HEALTH CONSIDERATIONS

Are there any known health concerns or physical limitations that need to be accommodated to help you volunteer? _____

HOBBIES, TALENTS, OR SKILLS

Tell us a little about yourself. What hobbies, talents, or skills do you have that will assist you in a volunteering position?

Art Music Reading Nutrition/Cooking Ceramics Gardening
Nature Knitting/Crochet Quilting Aerobics Religious Services Support

Foreign Languages spoken: _____

AREAS OF INTEREST FOR VOLUNTEERING

Please tell us which areas you are interested in volunteering:

- Assisting with nursing staff as a unit helper on our nursing home floor.
- Help accompany residents to and from the facility to the community.
- Engaging our residents in conversation by leading individual and group sessions.
- Providing entertainment to our residents by assisting our Activities Department.
- Arts and Crafts Therapy
- Music Therapy
- Spending the day with a resident and simply keeping them company.
- Assisting with rehabilitation services.
- Religious services support and pastoral visits.
- Clerical support such as answering telephones, data entry, filing and taking messages.
- Gardening
- Library services.
- Safety monitoring and surveillance
- Other

PERSONAL OR PROFESSIONAL REFERENCES

Please provide names and email addresses of three people who are not family members or significant others. References can be personal or professional in nature. I authorize my reference to release any information they may have concerning my volunteering.

1. Name _____ Phone: _____

Home Address:

Email Address _____ Relationship _____

2. Name _____ Phone: _____

Home Address:

Email Address _____ Relationship _____

3. Name _____ Phone: _____

Home Address:

Email Address _____ Relationship _____

VOLUNTEER HEALTH REQUIREMENTS

Shiawassee County Medical Care Facility requires all volunteers to have proof of immunity to the following:

- ❖ Varicella (Chicken Pox): Varicella vaccine is given to those that have been identified as non-immune to chickenpox.
- ❖ MMR (Measles, Mumps, and Rubella): MMR vaccine is given to those identified as non-immune to measles, mumps and rubella.
- ❖ T-dap (Tetanus, Diphtheria and Pertussis Whooping Cough): T-dap vaccine is available for those who aren't current.
- ❖ Tuberculosis Testing: T-spot blood draw and monitoring for positive tests required.
- ❖ Annual flu vaccination: Volunteers may refuse the flu vaccination yearly by completing a refusal of vaccination form and agreeing to wear a mask per policy during influenza season.
- ❖ Hepatitis B vaccination: Step 1, 2, and 3.