Want to Volunteer at Atrium Health Lincoln?

Atrium Health Lincoln provides a high level of professionalism and medical technology combined with the essential element of the human touch, which all aid in improving overall health. Our volunteers are of great service to the hospital in providing that additional compassionate, healing and high-touch presence at work in a high-tech environment. Volunteers assist in alleviating the natural fears and apprehension of a patient or family member by performing courteous and beneficial services. They help reduce the isolation and stress associated with hospitalization by delivering mail or flowers to the patient, filling a water pitcher, escorting a family member to the appropriate area, communicating to family members and friends while they are waiting for surgery and recovery of their loved ones, or simply working in the gift shop.

No matter how small the service may seem, volunteers continue to prove themselves as an integral part of the healing process.

How to Become an Adult Volunteer

To become an adult volunteer, one must be 18 years of age or older, commit to one year or more, and complete application process:

1. Submit a completed application
2. Include two non-family references (forms included in application)
3. Authorize us to conduct a criminal background check
4. Provide documentation of two measles, mumps, rubella and chickenpox immunizations
5. Receive two TB skin tests
6. Appear for a personal interview with volunteer coordinator
7. Attend an all-day (8am to 3pm) new teammate orientation (held first Tuesday of each month).

Acceptance of volunteers is contingent upon meeting the above requirements and the needs of the hospital. Completing an application does not guarantee acceptance into the volunteer program.

The following departments have volunteer opportunities; placement depends on available spots open at current time:

- Administration
- Cafeteria Attendant
- Clerical Assistance
- Emergency Department
- Floater – various departments as needed
- Guest Services/Greeters and Escorts
- Gift Shop
- Housekeeping/EVS
- Infusion Center/Levine Cancer
- Materials Management
- Meal Prep Patient Rooms
- Outpatient Registration
- Pain Center in Denver
- Patient Care Units (Medical, Telemetry)
- Radiology
- Rehab in Denver, or Gaston Street
- Shuttle Driver (golf cart)
- Special projects – call as needed

For more information about volunteer opportunities, please call 980-212-1962.

Atrium Health

Dear Volunteer Applicant:

Thank you for your interest in the Volunteer Services program at Atrium Health Lincoln. Joining the dedicated team of adult and teen volunteers can be a richly rewarding experience for you. Through volunteering at Atrium Health Lincoln, you will find challenging and enjoyable activities that will be satisfying to you while you perform valuable service to others. Atrium Health requests a commitment of a minimum of 50 hours within six-months and at least one full year of service.

In keeping with the excellent care tradition of Atrium Health, we are committed to creating and maintaining excellence in all that we do. As part of the volunteer services process, Atrium Health conducts a background check for all potential volunteers.

Please complete the attached application and background form and return them to:

Atrium Health Lincoln
Volunteer Services Department
Attn: Jackie Gardella
P.O. Box 677
Lincolnton, NC 28093

Once we have processed your application and conducted an interview with you, you will be required to meet with an Employee Health Nurse for a health assessment. Please complete the attached Health History form and **bring it with you to your scheduled interview (do not submit this with your application);** along with a copy of your vaccination record indicating you have received your Measles, Mumps, Rubella and Varicella (Chicken Pox) vaccinations.

We look forward to helping you pursue your interest in volunteering at Atrium Health Lincoln.

Sincerely,

Jackie Gardella
Volunteer Services
(980) 212-1962

Atrium Health

Volunteer Application Form

Name_____
(Last) (First) (Middle initial)

Address_____
(Street) (City) (State) (Zip Code)

Phones (H) _____ (C) _____ (W) _____

Email Address_____ **Birthdate: month_____ day_____ (recognition only)**
Volunteers must be 18 years or older to be considered for the adult volunteer program. Do you meet this requirement?
_____yes_____no

I have completed: ___ High School___ Some College ___ College ___ Graduate School

Previous Volunteer Experience: _____

How did you hear about the volunteer program? _____

Are you seeking paid employment with Atrium Health? _____

Please give us any other information you feel would be pertinent to your application (hobbies, interests, skills, training, etc.)
_____

Areas of interest to volunteer in: ____ clerical _____ patient areas _____ shuttle golf cart _____ gift shop

Positions preferred: _____

Days preferred: _____Mon _____Tues _____Wed _____Thurs _____Fri

Shifts Available-: 8 am – 12 pm_____ 12 – 4 pm_____ Other_____

All new volunteers are asked to commit to at least one full year of service.

How long do you anticipate volunteering at Atrium Health Lincoln? _____

Completing an application does not assure placement. Applications will be reviewed to see if your availability matches a current opening. Applicants will be chosen on the basis of personal interests and qualifications, keeping in mind the best interest of both the applicant and the medical center. The first 90 days will be mutually probationary. A signature indicates that future employment is not guaranteed, is an approval to check references, conduct criminal background checks, contact your physician regarding physical/emotional health, and obligates you to adhere to all the rules and regulations of Atrium Health Lincoln.

Date_____ Signature_____

***This application will not be accepted without signatures.**

Volunteer Reference Form

Name of applicant: _____

Please complete this reference form in regard to the applicant's suitability to become a volunteer at Atrium Health Lincoln. We appreciate your honest opinion and hope that you will feel free to express any concerns that you may have. If you wish to further discuss any issues, please call (980) 212-1962. Thank you for your assistance.

Name: _____Phone: _____
Relationship to applicant: _____
How long have you known the applicant? _____
Please describe any special skills, strengths and abilities this applicant will bring to the volunteer program:

_____
_____
_____

Do you consider the applicant a responsible/dependable person? Why or why not?

_____
_____
_____

Please rate his or her maturity level: (low) 1 2 3 4 5 (high)

Does the applicant express willingness to work in the healthcare field?

Would you recommend the applicant as a volunteer for Atrium Health Lincoln? Why or why not? _____

_____
_____

Additional comments:_____

_____

Signature: _____Date _____

Mail to:
Atrium Health Lincoln
Volunteer Services Department
Attn: Jackie Gardella
P.O. Box 677
Lincolnton, NC 28093

Fax: 980-212-1753

Volunteer Reference Form

Name of applicant:_____

Please complete this reference form in regard to the applicant's suitability to become a volunteer at Atrium Health Lincoln. We appreciate your honest opinion and hope that you will feel free to express any concerns that you may have. If you wish to further discuss any issues, please call (980) 212-1962. Thank you for your assistance.

Name: _____Phone:_____
Relationship to applicant: _____
How long have you known the applicant?_____
Please describe any special skills, strengths and abilities this applicant will bring to the volunteer program:
_____
_____
_____
Do you consider the applicant a responsible/dependable person? Why or why not?
_____
_____
_____
Please rate his or her maturity level: (low) 1 2 3 4 5 (high)

Does the applicant express willingness to work in the healthcare field?

Would you recommend the applicant as a volunteer for Atrium Health Lincoln? Why or why not?_____
_____
_____
Additional comments: _____
_____

Signature: _____Date_____

Mail to:
Atrium Health Lincoln
Volunteer Services Department
Attn: Jackie Gardella
P.O. Box 677
Lincolnton, NC 28093

Fax: 980-212-1753

Background Disclosure
Atrium Health obtains arrest and conviction records on all potential volunteers. An arrest or conviction will not automatically eliminate you from consideration for volunteering. However, failure to list all pending charges and/or convictions may lead to your disqualification or termination of volunteering with Atrium Health. Examples may include, but should not be limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud, embezzlement, etc.

Have you ever been convicted of any criminal violation of law, or are you now subject to a pending investigation of charges for violation of criminal law? _____

If yes, please explain _____

Emergency Contact Information:

(1) Name_____Relationship_____
Home Phone ( ) _____ Work Phone ( ) _____

(2) Name_____Relationship_____
Home Phone ( ) _____Work Phone ( ) _____

TIME AVAILABLE: Please (√) times available:

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Morning							
Afternoon							
Evening							

As a volunteer I agree:

I will consider as confidential all information which I may hear or see, directly or indirectly, concerning a patient, patient family member, doctor, or other health care professional and I will not seek information from any of the above in regard to a patient.

I hereby certify that the answers on this application and any resulting from interviews are true and correct and that any misrepresentations or omissions of facts, misleading, or false information on my part will be grounds for dismissal as a volunteer. Acceptance as a volunteer is contingent upon satisfactory references, verification of information submitted on the application and satisfactory completion of mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions related to my application.

My services are donated to Atrium Health without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

I authorize Atrium Health to administer emergency medical treatment to me while volunteering. I understand that Atrium Health is not responsible for volunteers after their assigned volunteer shift has ended.

_____ _____
Applicant's Signature Date

****PLEASE NOTE****
Your signature indicates your approval for us to check references. Filing an application does not assure volunteer placement since the number of applicants usually exceeds the number of available openings. The Volunteer Services Department is not obligated to provide a placement, nor are you obligated to accept the position offered. All applications are held for 90 days.

The first 90 days of the volunteer experience will be mutually probationary.
Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex.

ADULT VOLUNTEER INFORMATION AND RELEASE AUTHORIZATION

Terms of Volunteer Service

Because volunteer service is based on mutual consent, both ATRIUM HEALTH and you may terminate your volunteer service at any time, for any reason, with or without cause, and without prior notice. All ATRIUM HEALTH decisions with regard to termination of volunteer service are based on ATRIUM HEALTH policies and procedures.

ATRIUM HEALTH values integrity in the workplace. Any false or misleading representations or omissions contained in your volunteer application may disqualify you from further consideration for volunteer services and may result in discharge even if discovered at a later date. ATRIUM HEALTH may contact any persons and organizations named in your volunteer application to confirm or explain the information provided.

BACKGROUND VERIFICATION DISCLOSURE

As part of the volunteer services process, Atrium Health may obtain a Consumer Report and/or an Investigative Consumer Report. The Fair Credit Reporting Act as amended by the Consumer Reporting Reform Act of 1996, requires that we advise you that for purposes of volunteer services, a Consumer Report may be made which may include information about your criminal record, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided in the event the report contains information regarding your character, general reputation, personal characteristics, or mode of living. Examples may include, but should not be limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud, embezzlement, etc.

AUTHORIZATION, ACKNOWLEDGEMENT, AND RELEASE

During the application process and at any time during my affiliation with ATRIUM HEALTH, I hereby authorize BIB – Background Investigation Bureau, on behalf of ATRIUM HEALTH to procure a Consumer Report which I understand may include information as described above. This report may be compiled with information from credit bureaus, courts record repositories, departments of motor vehicles, past or present employers and education institutions, governmental occupational licensing, or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification, to the extent such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living.

I understand that I must report, in writing, any charge to the Volunteer Services designee by the next volunteer assignment. I further acknowledge that failure to report a charge will be grounds for immediate termination of my participation in the volunteer services program. I understand that I must report, in writing, any conviction or sanction to the Volunteer Services designee within five days of the occurrence. I further acknowledge that failure to report a conviction or sanction will be grounds for immediate termination of my participation in volunteer services program. I authorize the ongoing procurement of the above-mentioned reports at any time during my volunteer experience.

Name: _____
Last, First, Middle (Please Print)

Maiden or Other Name(s) Used: _____

Social Security Number: _____ **Date of Birth:** _____

Current Address: _____
_____

How long have you lived at this residence?: _____
(If less than 7 years, please indicate all previous addresses during this period below. Please attach an additional sheet if needed.)

Address:
_____

Address:
_____

Address:
_____

Address:
_____

_____ _____ _____
Volunteer Printed Name **Volunteer Signature** **Date**

Volunteer Services Health History

LOCATION: Please indicate: _____

Last Name_____ First Name_____

Social Security Number _____ - _____ - _____ Birth Date __/_____/____ Age _____

Street Address_____ City_____ State_____ Zip_____

Phone (____) - _____ - _____ In Emergency Notify_____ Phone (___) ____-

Volunteers must show evidence of **two** MMR immunizations or a positive titer (blood work results). If the volunteer lacks proof of any MMR component (measles, mumps or rubella) volunteer may go to their primary care physician to have them administer the MMR vaccine or draw a titer.
Volunteers must show evidence of two Varicella immunizations, or evidence of a positive titer (blood work results). If the volunteer lacks proof of the Varicella vaccines volunteer may go to their primary care physician to have them administer the Varicella vaccines or draw a titer.
All new volunteers must have a two-step TST (TB Skin Test) done. If a TST was administered outside of Teammate Health, the volunteer must provide documentation of test date, results and signature of administrator. If contraindications of having the TST placed are due to a previous positive skin test, then documentation and a chest x-ray within 12 months will need to be provided to Teammate Health. Parents must sign the TST consent form for volunteers under the age of 18 Teammate Health will place the 2nd TST.

Please attach documentation of the following from your Health Care Provider, Health Department or School:

		Dates	Dates	Dates
TST (TB Skin Test)		1._____	2. _____	
		Evidence of Titer	Vaccinations	
Hepatitis B/Declination	☐	1. _____	2. _____	3. _____
Measles (Red)		1. _____	2. _____	
Mumps		1. _____	2. _____	
Rubella (German Measles)		1. _____	2. _____	
Chicken Pox		1. _____	2. _____	
Influenza		_____ (If during flu season, Teammate Health will provide)		
Tdap		_____ (dated within 10 years)		

MMR
1. _____
2. _____
3.

The information provided on this form is correct to the best of my knowledge.

_____
Volunteer Signature Date

Teammate Health Comments:

_____