

How did you hear about our Volunteer Program? (please check all that apply)

- Atrium Health Union Website
- Atrium Health Union Employee
- Atrium Health Union Volunteer
- Other _____
- Atrium Health Union Sponsored Event – Name of Event _____

Which Atrium Health Union location are you interested in volunteering at?

- Atrium Health Union
- Atrium Health Waxhaw

If you are 18 years or less, please have a parent/guardian sign to indicate they know you will receive a TB skin test as part of your volunteer experience. _____

Your application and reference form must be returned to the hospital before an orientation will be scheduled. Thank you for your interest in our organization.

I hereby affirm that the information provided on this application (and any accompanying forms) is true and complete. I understand that any false or misleading representations or omissions may disqualify me from further consideration for the volunteer program and may result in discharge even if discovered at a later date.

Arrest and conviction records are obtained on all applicants. An arrest or conviction will not automatically eliminate you from consideration for volunteering. However, failure to list below all pending charges and/or convictions may lead to your disqualification or termination of volunteering with Atrium Health Union.

Have you ever been convicted of any criminal violation of law, or are you now under pending investigation or charges of violation of criminal law? 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.

___ YES ___ NO If yes, explain.

Are you required by law to volunteer community service hours? ___ YES ___ NO

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. Volunteer Services is not obligated to provide a placement, nor are you obligated to accept the position offered. All applications are held for 90 days.

Signature _____ Date _____

*If any records are under any name other than shown, please indicate.

Other Name (s)



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 Union 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 abovementioned reports at any time during my volunteer experience.

(Please PRINT the following information)

Name:

Last: _____ First: _____ Middle: _____

Maiden/Alias: (1) _____ (2) _____

Past 7 years Residences (List additional on reverse side or a separate Release Form in needed):

Current Street Address: _____

City: _____ State: _____ ZIP: _____

Years in Residence: (1) _____ Social Security Number: _____ - _____ - _____

Previous Address: _____

City: _____ State: _____ ZIP _____

Years in Residence: (2) _____ Drivers License #: State _____ Number: _____

For identification purposes:

Date of Birth:

Month _____ Day: _____ Year: _____ Race: _____ Gender: _____

Signature: _____ Date: _____

