



## Volunteer Application

Date \_\_\_\_\_

### Contact Information

Name	
Street Address	
City State Zip Code	
Birth Date	
Cell Phone/Home Phone	
Work Phone	
E-Mail Address	

### Availability- How Often Do You Want to Volunteer?

During which hours are you available for volunteer assignments?

- Weekday mornings       Weekend mornings  
 Weekday afternoons       Weekend afternoons  
 Weekday evenings       Weekend evenings

### Interests

Tell us in which areas you are interested in volunteering:

Clerical

- Special Trips or Events  
 Visiting/Reading or offering drinks to residents  
 Help with feeding residents (training is provided)  
 Transporting residents within the facility  
 Decorating for Holidays and changes of seasons  
 Help with group activities like bingo calling etc.  
 Help with Church Services or transport a resident to and from church  
 Present your hobby or interest  
 Other

### Special Skills or Qualifications

Education:  Less than High School Degree  High School Degree  College Degree

Will you receive academic credit for your volunteer work?  Yes  No

Summarize areas of study, special skills and qualifications you have acquired from education, employment, previous volunteer work, or through other activities, including hobbies or sports.

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### Previous Volunteer Experience

Summarize your previous volunteer experience.

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### References: Please identify two people not related to you.

Name	Relationship
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	
Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

### Emergency Contact

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	
Signature of Parent/Guardian	

### Back ground Check

Do you have a vehicle or access to transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any special requirements or medical conditions that we should be aware of as you volunteer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last seven year, have you been convicted of a violation other than a minor traffic offense? If you have been convicted, please describe the nature of the offense and the date it occurred.	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. If the volunteer is under 18 years of age, then I am giving my consent for my child to volunteer at St. Catherine's Nursing Center.

Name (printed)	
Volunteer Signature <b>OR</b> Parent/Guardian Signature if under 18 years of age.	
Date	

### Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us. If you have any questions, please contact Mary Grist, Coordinator of Volunteers by phone at 301-447-3971 or e-mail [mgrist@scncah.org](mailto:mgrist@scncah.org). Please return the completed application to St. Catherine's Nursing Center, 331 South Seton Avenue, Emmitsburg, Maryland 21727-9200.

Created on 11/24/2006

I promise that I have read the volunteer manual. I have been given an orientation and an overview of the requirements of a volunteer at St. Catherine's Nursing Center. I am willing to abide by the regulations for a volunteer at St. Catherine's Nursing Center. If I am uncertain of how to act in any situation, I agree to ask a staff member for help and guidance. I know that if I have questions or concerns, I can also ask for help from the Coordinator of Volunteer Programs.

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Signature

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Date

**AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A  
CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT**

I, the undersigned consumer, do hereby authorize St. Catherine's Nursing Center, by and through its independent contractor, **KROLL BACKGROUND AMERICA, INC. ("KBA")**, to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character, general reputation, personal characteristics discerned through employment and education verifications; personal references; personal interviews; my driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record. I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **KBA**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681et.seq. I further authorize any person, business entity or governmental agency who may have information relative to the above to disclose the same to **ST. CATHERINE'S NURSING CENTER**, by and through **KBA**, including, but not limited to, any and all courts, public agencies, law enforcement agencies and regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release **ST. CATHERINE'S NURSING CENTER**, by and through **KBA** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability claims and/or demands by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said Company. Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application for employment will be terminated based on any false, omitted or fraudulent information.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ **Other Names Used/Dates Used** \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Daytime Telephone Number: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_ Date of Birth\*: \_\_\_\_\_ Male Female\*  
(please circle one)

**Addresses for the Past Seven Years:**

Street/ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_ Dates \_\_\_\_\_

Street/ P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_ Dates \_\_\_\_\_

ADDITIONAL SERVICES REQUESTED: \_\_\_\_\_

**FOR MARYLAND HEALTHCARE FACILITIES ONLY**

**Addresses where you have been employed outside the State of Maryland for the past 7 years (required by Maryland Senate Bill 312)**

1. \_\_\_\_\_ 2. \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

