



Name: \_\_\_\_\_

A conviction record will not necessarily disqualify an applicant from volunteering. The circumstances of a conviction will be considered in relation to the nature and duties of the service for which you apply.

Do you have a record of founded child or dependent adult abuse in this state or any other? \_\_\_\_\_

If yes, explain (give dates): \_\_\_\_\_

Have you ever been convicted of a crime in this state or any other? \_\_\_\_\_

If yes, explain (give dates): \_\_\_\_\_

The information contained on this application is accurate and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CONFIDENTIALITY STATEMENT**

I understand and agree that in the performance of my duties as a volunteer of Trinity Regional Medical Center I must hold in strictest confidence any observations I may make or hear regarding clients, client families or staff.

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, including termination, by Trinity Regional Medical Center and/or possible legal action by others (i.e., clients, families of clients, etc.).

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I agree to the required TRMC orientation and TB Skin Test with the understanding this is necessary before I begin actual volunteer service at Trinity Regional Medical Center. I also agree to complete the required safety and education programs.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OPPORTUNITIES FOR VOLUNTEERS ARE PROVIDED WITHOUT REGARD TO RELIGION, CREED, RACE, NATIONAL ORIGIN, AGE, OR SEX.

As a volunteer, I understand that my vest or jacket, parking tag and Photo ID are provided by the Trinity Regional Medical Center Auxiliary and I will return them if I no longer wish to continue as a volunteer.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

By signing below, I certify that the answers and information set out above are true, accurate and complete to the best of my knowledge. I acknowledge that if any answer or information is not true, accurate or complete, I may not be hired, or if hired, I may be discharged.

I authorize Trinity Regional Medical Center to investigate all statements contained in this application for volunteering to include criminal, child and dependent adult abuse information in accordance with Iowa Code, Section 134C.33, as well as my character and qualifications. I release Trinity Regional Medical Center from all liability for actions performed in good faith and without malice in connection with evaluation of my application.

I authorize my prior employers, references, and others with information regarding my work, educational history or my character, to provide TRMC with all information requested and to cooperate fully with the investigation of my character and qualifications. I agree to cooperate in such an investigation, and release from all liability and/or responsibility all persons, companies, or corporations supplying such information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only:**

Application Received:	_____
Interview Scheduled:	_____
Interview Complete:	_____
BG Check to HR:	_____
BG Check back:	_____
EH Stats:	_____
Orientation Dates:	_____
Programs Interested In:	_____
	_____
	_____
	_____
	_____