HENRY FORD HEALTH℠ Holley Institute

Dear Potential Volunteer, Date: _____

Please take your time to complete the application below. Since we receive numerous applications, it will take time to respond back to you.

VOLUNTEER APPLICATION: ___ Adult _____ College _____ Teen _____ Social Security #_____

*First Name: _____ MI: ____ *Last Name: _____ * Gender _____

*Name (Preferred): _____ *DOB_____ *Home Address: _____

*City: _____ * State:____ *Zip code: _____ Mobile Phone: _____ Home Phone: _____

*Email Address: _____

*Are you 18 years of age or older? **Yes or No** * Are you a citizen of the US? **Yes or No**

*If not a US citizen, do you possess a valid U.S. immigration status that authorizes you to be lawfully present in the U.S. and to volunteer at a health care facility for duration of your proposed volunteer service? **Yes or No**

***Prior or existing work or volunteer experience**

Occupation/Title/Volunteer Exp:	Organization	Years Experience

***Your Hobbies/Special Skills or Languages you speak fluently:**

Hobbies	Special Skills	Languages

How did you learn about our volunteer program, and what appeals to you about volunteering in a healthcare setting?

_____

Are you a Henry Ford Health employee? **Yes or No** At which Henry Ford Health site: _____

Does your immediate family member work or volunteer for Henry Ford Health? **Yes or No**

If you are a student, please list school attending and current grade: _____
Anticipated Graduation year_____

Are you volunteering to meet an academic or other program requirement? **Yes or No**

AVAILABILITY: How many hours per week do you want to volunteer? _____

Date you can start volunteering: _____ End date, if applicable: _____

List times that you are available to volunteer:

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8am-12pm							
12pm – 4pm		Newborn hearing screening is in the morning only M-F					
4pm – 8pm							
Other							

EMERGENCY CONTACT

*Contact Name: _____ *Relationship: _____

*Mobile: _____ * Home: _____ * Work: _____

REFERENCE

Name	Relationship	Telephone	Best Time to Reach

APPLICATION AGREEMENT

I certify that all information I have and will provide throughout the selection process, including on this application and in interviews with Henry Ford Health (HFH), is true, correct, and complete to the best of my knowledge. I understand that information I provide may be verified and references may be contacted by HFH. I understand that misrepresentations or omissions may be cause for my immediate termination as a volunteer.

Signature:_____Date:_____

HENRY FORD HEALTH VOLUNTEER AGREEMENT STATEMENT

I understand that if I am selected as a volunteer at Henry Ford Health:

- I am not credentialed or authorized to act as an agent or employee of Henry Ford Health.
- I will not receive any compensation or benefits, including but not limited to, worker's compensation. I have not been given a promise of employment in return for my volunteer work. I have not been coerced and am doing this entirely of my own accord. Any hours I volunteer will be in accordance with a schedule mutually developed by me and the Volunteer Department.
- I am required to comply with the Henry Ford Health's policies/procedures, including but not limited to, confidentiality, harassment, disruptive behavior, nicotine and substance abuse, dress code and not to impose religious or other beliefs or values on patients, Henry Ford Health staff, families, or other volunteers. I will comply with the Confidentiality Statement that I have signed.
- Henry Ford Health and I each have the right to terminate my volunteer relationship at any time.
- I will be considerate of others and conduct myself in a courteous and professional manner and fulfill my commitment by completing all assignments to the best of my ability.
- **I will comply with a background check and initial/annual health screening requirements and complete all health testing required by Employee Health to become a volunteer.**

Signature: _____ Date: _____

PARENTAL/GUARDIAN PERMISSION FOR APPLICATION: ***This section is required for any person under the age of 18.***

I,_____, agree that my child (or ward)_____

may participate in the Henry Ford Health (HFH) Volunteer Program. I have read and understood all the Volunteer information provided. I will be responsible for transportation of my child to and from assignments and events.

Parent/Guardian Signature:_____Date: _____

Volunteer & Unpaid Student CONFIDENTIALITY AGREEMENT

Read the following before signing:

Henry Ford Health (HFH) information is one of its most valuable assets and must therefore be safeguarded by anyone who has access to it. All information within HFH, including information communicated/maintained via speaking (oral), paper, electronic, or any other medium, is the sole property of HFH. This includes, but is not limited to, financial information, personnel information, clinic information, planning information, business information and reports, vendor information, contracts, and prices, and all patient information including patient names.

I understand that, as a volunteer or unpaid student, I may have access to HFH confidential information and that I am prohibited from discussing or revealing or making copies of any HFH information, including but not limited to patient information, to anyone, in any manner, unless directed to do so by HFH or legal process. This prohibition applies during and after my volunteer/student position has ended and applies to all oral, written, or electronic disclosures. I understand that I should not access any information that is not needed for me to perform my duties.

I understand that the rules of confidentiality apply to intentional, unintentional, or casual disclosure of information, including unnecessary or unauthorized discussion of confidential matters (i.e., informal dialog in public areas such as hallways, cafeterias, or elevators).

I understand that access into any electronic system under my logon/password constitutes my "electronic signature" and that I should not give my login/password to anyone.

I understand that the unauthorized disclosure of information by me may violate State or Federal laws and could do irreparable injury to HFH or to the patient or employee. I understand that unauthorized access to or disclosure of information during or after ending my volunteer/student position could result in legal action being taken against me.

_____ _____

Name – Print Guardian's signature (if applicable)

_____ _____/ _____/_____

Signature Date

THIS DOCUMENT WILL BECOME A PART OF YOUR VOLUNTEER RECORD

Revised 7/26/24

HENRY FORD HEALTH

Volunteer Services

AUTHORIZATION FOR BACKGROUND INVESTIGATION

Read Carefully

I understand that my selection as a volunteer at Henry Ford Health (HFH) is dependent on the results of a background investigation about me.

I agree that HFH may perform a comprehensive background investigation now and at any time during my term as a volunteer if I am selected.

I understand this investigation may include information about my character, credit history, criminal history and motor vehicle records ("driving records"), as well as checking my education and/or employment history and other background checks. HFH will comply with applicable laws including the Fair Credit Report Act. HFH will use the information to evaluate me as a volunteer and to verify the accuracy of the information provided on my application and supplemental documents.

I know that if I am selected as a volunteer by HFH, I must update HFH any time the information I have provided changes.

Please Print Legibly

Name _____
(Last) **(First)** **(Middle)**

Maiden Names/Names Previously Used _____

Birth Date _____ **Gender** _____ **Race** _____

Signature of Applicant _____ ***Date*** _____

Parent/Guardian Signature _____ ***Date*** _____
(Required for any person under the age of 18)

If you wish to expunge or correct your record, please contact the following:

Michigan State Police-CJIC
Attn: Criminal History Record Correction
P.O. Box 30634
Lansing, MI 48909