Luminis Health℠

Doctors Community Medical Center Foundation

Dear Volunteer Candidate:

Thank you for your interest in the Volunteer Program at Doctors Community Medical Center! Our hospital enjoys working with dependable and friendly volunteers who complement the quality care provided to patients, families, visitors, and the community by our hospital staff.

The Volunteer Program follows a set of Guidelines for Adult Volunteers in an effort to provide an efficient and competent volunteer team. Enclosed is a copy for your review.

1. Please complete the Adult Volunteer Service Application and return it to Volunteer Services along with two (2) letters of reference.

2. Plan to attend, vis Zoom, one required Volunteer Orientation**.**

3. Upon submission of your application, you will be notified of the next volunteer orientations.

4. All orientations are held via Zoom, until further notice. Please contact Volunteer Serivices at 301-552-8670 to register.

5. A personal interview to determine areas of interest will be scheduled after your application has been processed. A commitment of six consecutive months or 100 hours of service is encouraged.

I look forward to hearing from you soon!

Sincerely,

Darin Hutchins

Darin Hutchins
Special Giving Officer, Doctors Community Medical Center Foundation

(over)

DOCTORS COMMUNITY MEDICAL CENTER
Guidelines for Adult Volunteers

MISSION: The Volunteer Services Department of Doctors CommunityMedical Center has been established to provide efficient and competent volunteers to supplement and complement the quality care provided to patients, families, visitors, and the community by our hospital staff.

REQUIREMENTS AND GENERAL GUIDELINES

1. The Adult Volunteer Program is open to all people 18 years of age and over who are able to volunteer at least 4 hours of service on a regular basis.

2. If you wish to volunteer in a specific area such as Billing, Sterile Processing, Lab, ER or Pharmacy, please inform us. We are unable to take Court Referred Community Service volunteers.

3. New Volunteers must complete and submit a Volunteer Service Application along with two (2) written Letters of Personal Reference **(**not from a family member).

4. New Volunteers are required to attend one orientation via Zoom. Additional volunteer training will be provided in each department.

5. New Adult Volunteers must receive a physical examination, flu shot , TB/blood test and COVID-19 vaccine prior to volunteering. All services are free and instructions will be provided at the volunteer orientation.

6. All new volunteers over 18 years of age will be required to consent to a background check.

7. A volunteer interview will be scheduled to determine areas of interest after all the requirements have been completed.

8. Volunteers must purchase a uniform smock/jacket ($20) through the Volunteer Office. Checks should be payable to DCMC Foundation (Doctors Community Medical Center). Upon completion of the volunteer interview, a hospital identification badge will be issued. Both must be worn at all times while on duty.

9. Volunteers must adhere to the ***confidentiality and privacy*** of all patients and staff.

10. Doctors Community Medical Center is not obligated and does not guarantee the hiring of volunteers into paid positions. A time commitment of **six consecutive months or 100 hours** of service is requested.

BENEFITS PROVIDED:

- Volunteers who serve 4 or more hours a day are entitled to one "free" meal up to $7.50.
- Volunteers are welcome to attend most employee social functions or training workshops.
- Volunteers will receive service awards after 100 hours of service. The service awards are given to active volunteers for milestone hours of service at the Annual Volunteer Appreciation event held in the spring.

Doctors Community Medical Center

New Volunteer Application for Adult Volunteer Service

For official use only. Please leave blank !

Vol # _____

ID#_____

♦Name (Last, First, MI)) _____

♦Nickname_____ ♦Check one*:* Mr. ☐ Mrs. ☐ Ms. ☐

♦Street Address_____

♦City, State & Zip_____

♦Home Phone_____ ♦ Work Phone_____♦Cell Phone_____

♦E-Mail_____

♦Date of Birth_____♦License Plate_____ ♦State_____

♦How did you hear about this Volunteer Program? *(circle)*: **1** Phone Call to Hospital **2** Newspaper **3** Word of Mouth-Name: _____ **4** School **5** Human Resources **6** Visiting Hospital **7** Website **8** Other: _____

♦Marital Status (circle): Married Single Widowed Divorced

♦Work Status (circle): Employed Unemployed Retired Student

♦Previous Volunteer and/or Work Experience_____

_____

♦Are you a returning DCMC Volunteer? No_____ Yes_____

♦Why have you chosen to volunteer?_____

♦Commitment to Service with DCMC: Indefinitely_____ Months_____ Years_____ Summer_____

♦Availability: (Indicate preferred shift below) M=Morning A=Afternoon E=Evening

Mon_____ Tue_____ Wed_____ Thurs _____ Fri_____ Sat_____ Sun_____

♦Do you speak/understand a language other than English? (*Specify*):_____

♦Are there any limitations on your activities?: No_____ Yes (explain)_____

♦Skills/Interests *(circle)*: **1** Clerical **2** Patient Care **3** Front Desk/Greeter 4 Telephone **5** Data/Word Processing 6 Verbal Skills 7 other_____

For Official Use Only! Please leave blamk!
Assignment:
Day:
Time:

♦Emergency Contact::

Name_____ Relationship _____

Telephone: Home_____ Work _____

♦Family Physician Name_____Telephone_____

I authorize the use of any information in this application to help the hospital verify my statements, and I authorize my present employer and any other persons to answer all questions asked by the hospital concerning my ability, character, and reputation.

♦Have you received the vaccine? (Required to volunteer) Yes_____ No_____

♦Applicant's Name (print) _____

♦Applicant's Signature_____Date_____

♦***NOTE:*** **Be sure to attach - TWO letters of reference**
Background Check Authorization Form

Return To: **Volunteer Services**
Doctors Community Medical Center
Ste. 403, North Bldg.
8118 Good Luck Road
Lanham, MD 20706

Phone: **301-552-8670**
Fax: **240-965-8449**
Email: **Dhutch100@DCHweb.org**

Please complete the attached Background Check Authorization form

BACKGROUND CHECK DISCLOSURE

Private Eyes, Inc. (the "Company") will order a "consumer report" (a background check) on you in connection with your volunteer application, and if you are hired, or if you already work for the Company, may order additional background checks on you for employment purposes.

The Company may order an "investigative consumer report." Such reports typically include information from personal interviews, most commonly from an applicant's prior employers and references.

The background check may contain information concerning your character, general reputation, personal characteristics, mode of living, criminal history, creditworthiness, credit capacity and credit standing. Information may be obtained from private and public record sources, and for investigative consumer reports, from personal interviews as noted above. You have the right to request more information about the nature and scope of an investigative consumer report, if any, by contacting Private Eyes, Inc at 2700 Ygnacio Valley Road Suite #100, Walnut Creek, CA 94598.

BACKGROUND CHECK AUTHORIZATION

I authorize Doctors Community Hospital-VOLUNTEER (the company) to order my background check, including investigative consumer reports. I understand that, as allowed by law, the Company may rely on this authorization to order additional background checks, including investigative consumer reports, during my employment without asking me for my authorization again, as allowed by law.

I also authorize all of the following to disclose to Private Eyes, Inc. and its agents all information about or concerning me, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; the Department of Transportation, the military and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to Private Eyes, Inc. and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses, and may include inquiries regarding workers' compensation, harassment, violence, theft or fraud.

Additional information about your rights has been provided to you with this Background Check Authorization. Please review it BEFORE you sign.

Last Name _____ First _____ Middle _____

Maiden Name(s) _____ Years Used _____

Other Name(s) _____ Years Used _____

Social Security Number _____

Driver's License Number _____ State ___

Other Driver's Licenses Held in Past 5 Years (include states) _____

FOR IDENTIFICATION PURPOSES ONLY: Date of Birth ____/____/____ (Month/Day/Year)

Telephone number:_____

Present Street Address _____

City/State/ZIP _____

Residential Addresses Within Seven Years (*use a separate sheet as needed*)

Prior Street Address _____

City/State/ZIP _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

Prior Street Address _____

City/State/ZIP _____

From _____/_____/_____ (Month/Day/Year) To _____/_____/_____ (Month/Day/Year)

_____ _____/_____/_____

Signature Date: (Month/Day/Year)

Client Account Number: 927302 Doctors Community Hospital-VOLUNTEER

Rev: 7/19