Wolfson Children's Hospital Auxiliary

800 Prudential Drive, Jacksonville, Florida 32207 ~ 904.202.8008 ~ fax: 202.8007

*MEMBERSHIP APPLICATION

(PLEASE PRINT OR TYPE)

*Must be 18 years of age or older

Mr.
Mrs. Name ____
Ms. Last First Middle

Preferred first name spelling for ID Badge: ____________________

Birthdate: ____________________ Spouse's Name: ______________________________

Present Address: ____
Number Street Apartment Number

____
City State Zip

Home Telephone: ____________________ Work Telephone: ____________________

E-Mail: ____________________ Cell (optional): ____________________

Social Security No.: ____________________ Occupation: ____________________
Student: ____________________

EMPLOYMENT and/or STUDENT HISTORY:

____ Years: ______________
____ Years: ______________
____ Years: ______________

REFERENCES: Include first and last name, **complete address, zip code**, **telephone** and **e-mail** of **three** references you have known for more than one year. Non-relatives only and provide at least one work reference. **To avoid a delay in processing your application, please provide complete information, including zip codes and email.**

Name	*Address/ Zip*	*Email*	*Preferred Method*
1.			□ Email □ Mail
2.			□ Email □ Mail
3.			□ Email □ Mail

List day and time can you give on a weekly basis: ______________________________

How did you learn about the WCH Auxiliary? ______________________________

____

Reason for Volunteering: ______________________________

Previous volunteer experience(s) & location(s): ______________________________

____

(Over →)

Special interests, skills, and/or hobbies:

___ Advertising	___ Fundraising	___ Public Speaking
___ Art	___ Nursing	___ Secretarial
___ Bookkeeping	___ Planning	___ Writing
___ Calligraphy	___ Photography	Other: __________
___ Crafts	___ Public Relations	________________
___ Event Planning	___ Music:	________________
	Instrument type: _________	
	Vocal: ________________	

Languages: ____

EMERGENCY CONTACTS:

Name: ________________________________ Relationship: ________________________

Home: (_____)_______________ Cell: (_____)_____________ Work: (_____)_____ ________

Name: ________________________________ Relationship: ________________________

Home: (_____)________________ Cell: (_____)_____________ Work: (_____)___ _______

I hereby apply for Active Membership in the Wolfson Children's Hospital Auxiliary and agree to abide by the rules and regulations governing the Auxiliary and the hospital. To the best of my knowledge, the above information is accurate and correct.

As a WCH Auxilian, I agree to the following requirements:

- Attend Orientation before being assigned to a service;
- Join the Auxiliary with the intent of volunteering for a **minimum of six (6) consecutive months**;
- Volunteer regularly, once weekly, in the assigned service for a minimum of fifty (50) hours per year.

Applicants must complete a Background Check Request Form for criminal background histories by state and/or federal agencies. Persons who have been convicted of any felony offenses or misdemeanor offenses, including those involving drugs, child abuse, assault, or any violent behaviors are not eligible to volunteer at Wolfson Children's Hospital.

Applicants are evaluated individually on the merits of their qualifications, regardless of the individual's race, sex, color, national origin, age, disability, religion, marital status, or status as a veteran, for service positions which are available.

By signing below, you indicate your approval for the Auxiliary to check references. The Auxiliary is not obligated to provide a service placement, nor are you obligated to accept the service position offered.

________________________ ____

Date Applicant's Signature

THANK YOU!

You may return your completed documents via fax to 904.202.8007, via e-mail to WCHAuxiliary@bmcjax.com or via U. S. Mail to the address provided at the top of this Application Form.

Children's Hospital Auxiliary
800 Prudential Drive
Jacksonville, FL 32207
Phone 904.202.8008
Fax:904.202.8007

BACKGROUND INVESTIGATION

FAIR CREDIT REPORTING ACT- DISCLOSURE TO VOLUNTEER APPLICANTS
Pursuant to the Fair Credit Reporting Act, 15 U.S.C. 1681-1681u, Baptist Health is providing this notice that Baptist Health may obtain a consumer report, (which may include a credit report, criminal history, motor vehicle report, abuse registries, and workers' compensation) concerning you in conjunction with either your application and/or decisions concerning your volunteer status with Baptist Health at any time.

FAIR CREDIT REPORTING ACT - AUTHORIZATION TO OBTAIN CONSUMER REPORT
I hereby authorize Baptist Health either directly, or through its agent, to obtain a consumer report, (a credit report, criminal history, motor vehicle report, abuse registries, and workers' compensation as part of a required physical) concerning me during the application process or at any time I may be volunteering. It is my understanding that Baptist Health may use a consumer report obtained based on this authorization in decisions concerning my status with Baptist Health Applicants are subject to a background investigation with Florida Department of Law Enforcement and other state, out of state, and local agencies.

Applicants are evaluated on the merits of their qualifications regardless of the individual's race, sex, color, national origin, age, handicap, religion, marital status, status as a veteran, or any other legally protected status. Applicants and volunteers will not automatically be disqualified from a service position based solely on a criminal record. Each incident will be judged on its own merits with respect to the date of the incident and conviction, seriousness, nature of the crime, rehabilitation, duties relatedness, and any other relevant considerations.

Have you ever been convicted of or pled guilty, no contest, or *nolo contendere* to a crime? This includes a DUI or DWI, a criminal conviction, debarment, sanction, or exclusion related to Medicare, Medicaid or any other federal or state-funded health care program(s), or ineligibility for participation in a federally or state-funded health care program. _____YES _____NO
If yes, give details (date, place, offense(s), disposition, etc): ______________________________________

Have you ever been charged with a crime and either been placed on a court ordered probation, had adjudication withheld, entered a pre-trial intervention program, or have any criminal charges now pending? ______YES _____NO If yes, give details:____

PLEASE PRINT ALL INFORMATION ON THE NEXT PAGE AND SIGN AT THE BOTTOM
The following information is required to perform the background investigation:
- First and middle names should be as they appear on your birth certificate.
- In the "other name field," include all last names that you have ever had.

Other Name(s) than current: ____

Sex: Male ____ Female ____
Race: White ____ Black ____ Asian ____ Hispanic ____ Other ______________________

List all states outside of Florida in which you have resided within the past seven (7) years.
State(s): ________________________________ County(ies): ____________________________________

____ ____________________________
Signature of Applicant Date

Clearstar Form

The WCH Auxiliary office will fax this document to ClearStar services.

Applicant: Please complete only the *top two sections*. Thank you!

Applicant Information (***Print Only***)

Full Name: Last	First	Middle	(Maiden)

Social Security Number	Date of Birth

Address: Street	City	State	Zip

Criminal History Information

Please include other areas in which you would like a criminal history search performed. The most accurate way for SingleSource Services to locate the county of residence is through the Zip Code. You may list city and state or only the Zip Code. Jurisdiction No. 1 is the applicant's current resident city and state listed above.

Jurisdiction No. 2			Jurisdiction No. 3		
City	State	Zip	City	State	Zip

Special Instructions or special attention desired:

Volunteer Package includes:

- **National Social Security Search**
- **MSCHS**
- **Discovery**

MSCHS: Multi-State Criminal History Search

Note: The Multi-State Sex Offender Search is included in the MSCHS.

THE FOLLOWING SECTION (BELOW) IS FOR THE AUXILIARY OFFICE TO COMPLETE.

The Auxiliary secretary or volunteer completes this form and faxes it to Clear Star Services with the applicant's completed Release Form.

Billing Code: WCHA
Reference: Wolfson Children's Hospital Auxiliary

Company: **Wolfson Children's Hospital Auxiliary**

Contact:
☐ Jeannie Poon
☑ Dana Severidt
☐ Amy Cristus
Ronald McDonald House

Phone No.: 904.202.8008

Fax No.: 904. 202.8007

☐ NSSS (National Social Security Search)
☐ Criminal ☐ County ☐ Statewide
☐ Multi-State Criminal History Search
☐ Multi-State Sex Offender Search
☐ Federal Criminal
☐ Education
☐ Verify Previous Employment

☐ Credit History
☐ Driving Record
☐ Professional License
☐ Professional References
☐ Drug Screening
☐ Civil Records Search
☑ **Package – Volunteer**

CONFIDENTIAL
SingleSource Services

T:/New Mem/Background Investigation Form/Revised 2018

WOLFSON CHILDREN'S HOSPITAL
800 Prudential Drive, Jacksonville, FL 32207 ~ 904.202.8008 ~ Fax: 904.202.8007

Please print:

Name: ______________________________________ Telephone: __________________________

Address: _____________________________________ Work Telephone: ___________________

City: _________________________________ State: ____________ Zip: ____________________

IMMUNIZATION HISTORY

Please confirm if you have had any of the diseases listed below.

1. Complete all lines.

2. You are required to attach documentation of your Immunization Records. If you do not have access to your Immunization records, a voucher will be provided so that you can have a titer drawn at the Baptist Medical Center Lab on the first floor of the Women's Pavilion.

3. Volunteens (15 – 17 year olds) must provide school health records, including current TB test results.

	NO **I have not been immunized.**	**YES** Please note approximate date of each disease. **I have actually had the disease.**	**IMMUNIZATION** **Approximate dates of immunization must be provided.** ***You are required to attach documentation of your complete Immunization History.***
MMR (Measles, Mumps, Rubella) two doses OR have had a case of Measles, Mumps, Rubella.			Dose 1: _____/_____/_____ Dose 2: _____/_____/_____
Chicken Pox (Varicella – two injections or the shingles vaccine for adults over 55 years of age)			Dose 1: _____/_____/_____ Dose 2: _____/_____/_____
TDaP (Tetanus/Diphtheria/Pertussis)			
Hepatitis A (Two injections)			
Hepatitis B (Two injections)			
Tuberculosis (TB): Must have a skin test by PPD (Mantoux), and if there is a POSITIVE PPD result, must provide the date and results of last chest X-ray.			
Other			

Are there any accommodations or limitations of which the healthcare facility should know when assigning your area of volunteer service?____

NO: _____ YES (If so, please specify): ____

Comments: ____

My responses are complete and correct:

______________________________ ______________________________

Signature of Applicant Date

Health Form reviewed by BMC/WCH Infection Control Nurse: 4-2018