2024 Volunteer Application

Last Name: _____ First Name: _____ Preferred Name: _____ MI: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Date of Birth: _____

Emergency Contact Information

Last Name: _____ First Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Volunteer's Physician: _____ Physician's Phone _____

References: Please List 2 - Personal & Former Work (if applicable)

Last: _____ First: _____ MI: _____ Last: _____ First: _____ MI: _____

Address: _____ Address: _____

Home #: _____ Work #: _____ Home #: _____ Work #: _____

Employment History

Employer: _____ Title: _____ Dates Employed: _____ Phone: _____

Employer: _____ Title: _____ Dates Employed: _____ Phone: _____

If applicable for your volunteer position, please provide a copy of your licensure or certification

General Information

Are you now, or have you ever been a volunteer in any organization? YES NO If so, where? _____

Have you ever been convicted of any felony or crime other than a minor traffic violation? YES NO

Have you ever pled guilty or no contest to a crime or have any criminal charges pending? YES NO

If so, please explain: _____

General Health- circle one: EXCELLENT GOOD FAIR POOR

Do you have any physical or health limitations? NO YES

If so, please explain: _____

How did you become interested in volunteering? Circle all that apply

Radio TV Website Newspaper Flier Friend Other:

Comments:

2150 Limestone Pkwy, Ste. 222, Gainesville, GA 30501 | P: 770-219-0276 | griefsupport.hospice@nghs.com

Why are you interested in volunteering with Camp Braveheart? _____

_____

Describe any experience working with children or adolescents. Please include formal training or volunteer experience (may attach additional pages): _____

_____

Availability

Camp Braveheart will take place from June 3-7, 2024 at Walter's Barn in Lula, GA. Volunteers are needed from 8:00 am until 4:00 pm. Friday we end at approximately 1 pm.

Please list your availability:

☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
☐ Full Day	☐ Full Day	☐ Full Day	☐ Full Day	☐ Full Day
☐ Partial Day (list hours)	☐ Partial Day (list hours)	☐ Partial Day (list hours)	☐ Partial Day (list hours)	☐ Partial Day (list hours)
_____	_____	_____	_____	_____

Volunteer Information / Preferences

1. Check area in which you have interest volunteering for. This information is used to assist with placement.

   ☐ **BIG BUDDY**: Direct work with supervision of campers. Assist with art projects and activities.
   5 day commitment required

   ☐ **FLOATER/RUNNER**: Assist with activity prep/facilitation and camper supervision as necessary. Food/snack assistance.
   May volunteer for a few hours up to an entire day

2. T-Shirt Size- circle one: S M L XL 2X 3X

3. Do you speak any languages other than English? YES NO
   If yes, please identify: _____

4. Are you CPR certified? YES NO
   If yes, please indicate the expiration date and ***provide a copy for your volunteer file****:* _____

For more information on volunteer opportunities offered at Hospice of NGMC, contact the Volunteer Coordinator at 770-219-0276.

Auxiliary Membership Opportunity

Northeast Georgia Health System (NGHS) Auxiliary is led by a board of Health System volunteers and designated Health System Management as ex-officio members. Board members are elected by the Auxiliary's Nominating Committee and approved by the Auxiliary Membership. Membership Dues are a minimum of $10 per year. The NGHS Auxiliary donates funds generated through volunteer efforts and Auxiliary projects to NGHS Foundation to enhance services of NGHS.

Agreement & Signature

I understand that volunteer applicants of Northeast Georgia Health System must fulfill all Volunteer Service requirements, including completion of the application, interview, NGHS health requirements, and NGHS Volunteer Orientation. I authorize Northeast Georgia Health System to check all references required and to perform a criminal background check to acquire reference information. I release the Health System from any liability based on such releases. I also certify the application information is accurate and complete and that the Health System may accept volunteers at its sole discretion and may release a volunteer at any time from serving the organization.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Interview Date: _____ Interviewers Initials: _____

Comments: _____

Please return completed form to griefsupport.hospice@nghs.com or mail to 2150 Limestone Pkwy, Ste. 222, Gainesville, GA 30501

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Parent/ Guardian Consent for Hospice Camp Braveheart Teen Volunteers

This consent form is provided to the parents/guardians of teen volunteers under the age of 18. Because you play an important role in your child's experience as a hospice volunteer, this form is intended to inform you of policies and procedures. We ask that you read this with your child and sign the statement below.

- All NGHS volunteers sign a Confidentiality and Security Agreement form agreeing to keep patient/family information confidential. We recognize that your child will benefit from sharing volunteer experiences with you. For this reason, we ask that you sign the Parent / Guardian Statement of Confidentiality below.

CONSENT

I, _____, parent / guardian of _____, do hereby consent
PRINT NAME PRINT NAME

for my teen to participate as a Hospice of Northeast Georgia Medical Center volunteer. My daughter/son _____ has my consent to serve as a teen volunteer for Camp Braveheart with Hospice of NGMC. I will support the responsibilities she/he accepts as a teen volunteer.

_____
SIGNATURE OR PARENT/GUARDIAN

Parent / Guardian Statement of Confidentiality

I understand the importance of patient confidentiality related to my child's hospice volunteer service and agree to keep in confidence any information that may be shared with me. All patient/family information is to be kept confidential.

Signature: _____ Printed Name: _____

Date: _____

Agreement

My parents/guardian and I understand that volunteer applicants of Northeast Georgia Health System are required to fulfill all Volunteer Service requirements, including completion of the application, interview, NGHS health requirements, and NGHS Volunteer Orientation. My parents and I authorize Northeast Georgia Health System to check all references required and to perform a criminal background check to acquire reference information. My parents and I release the Health System from any liability based on such releases. I also certify the application information is accurate and complete and that the Health System may accept volunteers at its sole discretion and may release a volunteer at any time from serving the organization.

_____
SIGNATURE OR PARENT/GUARDIAN

_____
SIGNATURE TEEN VOLUNTEER

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