**Lake Huron Foundation Volunteer Organization**

**MEMBERSHIP APPLICATION**

(Please print clearly.)

Thank you for applying for membership to the Lake Huron Foundation Volunteer Organization to volunteer your time, talent, and services. Volunteering at a hospital is a wonderful way to give of yourself to your community. This is a membership organization that collects dues of $10.00 yearly.

Please complete this Membership Application and Agreement and return to: Lake Huron Foundation Volunteer Organization, 2601 Electric Ave., Port Huron, MI 48060. Please call (810) 216-1523 with questions.

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| **Identification Information (Please list your legal name)** |
| Last Name | First Name | Middle Name |
| Is any additional information relative to change of name, use of an assumed name, or nickname necessary to enable a check on you background? **Yes\_\_\_\_ No\_\_\_\_** If yes, please explain. |
| Street Address | City | Zip Code  |
| Home Phone | Work Phone | Cell Phone |
| E-mail address:  |
| **Emergency contact** |
| Name | Relationship | Phone |
| **Experience, Skills, and Interests (Tell us about yourself)** |
| How did you hear about the Lake Huron Foundation Volunteer Organization?LHMC Employee/Volunteer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Website\_\_\_\_\_\_ Hospital Visit\_\_\_\_\_\_\_ Flyer/Ad\_\_\_\_\_\_\_ Event\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is your reason for wanting to volunteer? |
| Please describe your volunteer experience and list any of your past or present memberships to organizations, clubs, professional societies, or other associations.  |
| Are you working as a volunteer to get hours for a school or higher education program?**Yes\_\_\_\_ No\_\_\_\_**If yes, what documentation do you need from us? |
| Do you read, speak, or write a language other than English?**Yes\_\_\_\_ No\_\_\_\_**If yes, are you willing to interpret non-medical information for patients/visitors? **Yes\_\_\_\_ No\_\_\_\_****List other language(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| There are criteria and physical requirements for each position. It is our intention to assign our volunteers to roles that mutually benefit both them and the hospital by matching their skills to existing needs with the organization. We will discuss placement options with you before we assign you to a position. Do you have a particular role or area in mind?Do you need accommodations for a medical condition or physical limitation?**Yes\_\_\_\_ No\_\_\_\_**If yes, please list: |
| **Conviction Record (This must be completed to be considered for volunteering)** |
| Have you ever been convicted of a felony or a misdemeanor that has not been judicially expunged, sealed, or eradicated? **Yes\_\_\_\_ No\_\_\_\_** |
| Do you have any felony or misdemeanor charges pending against you that are unresolved?**Yes\_\_\_\_ No\_\_\_\_** |
| If dealing with patients, have you been arrested for any sex-related offenses for which registration as a sex offender may be required? **Yes\_\_\_\_ No\_\_\_\_** |
| If yes to any above, please explain. *(Positive responses will not necessarily bar you from a position.)* |

**Agreement:**

* I will provide government issued ID to verify my identity. I agree to authorize agencies and persons contacted for reference or background information to release information.
* I understand any misrepresentation or material omission of information in this application may be cause for dismissal.
* I understand the Lake Huron Foundation Volunteer Organization does not guarantee a volunteer position and that there are necessary qualifications, requirements, competencies, and physical criteria for these positions. Every effort will be made to match me to a position that accommodates my skills and fulfills the needs of LHFVO/LHMC.
* I understand that state and national hospital regulatory agencies require that persons working in a hospital setting receive orientation/training and complete an annual TB Surveillance form or test, whichever is appropriate. COVID-19 vaccination and annual Influenza vaccination is required for all volunteers. Failure or refusal to comply may result in temporary suspension from LHFVO until completed or dismissal.
* I agree to read and abide by the policies, procedures, expectations, ethics, and customer service standards as presented in the mandatory training and orientation and to perform the duties expected of me to the best of my ability. This includes adhering to HIPAA regulations and not offering medical advice unless volunteering in a clinical role where such is deemed appropriate.

* I understand that I donate my services to the hospital without contemplation of compensation or future employment.
* I understand that my LHFVO membership may be suspended or terminated at any time due to failure or refusal to comply with policies and regulations, absences without notification, unsatisfactory attitude, performance, or appearance, or anything else deemed to be contrary to the best interest of LHFVO/LHMC.
* I agree to make a strong effort to fulfill my commitment to be punctual, conscientious, and to conduct myself with dignity, courtesy, and with consideration of others.

**I hereby certify that all the information included on this application is true and complete to the best of my knowledge.**

**Signature Date**