



Dear Prospective Member:

We welcome you as an applicant to the Parrish Medical Center Auxiliary. The following information will aid you in completing your applications and answer any questions you may have concerning our organization. Orientation is held monthly to acquaint prospective members with our hospital's mission, vision, values and healing environment.

Auxiliary membership is open to men and women interested in volunteer services with the hospital and who qualify for membership. Most of our members work on services within the hospital or at off-site facilities. The services include Information Desk, Courier/Escort, Gift Shop, Surgical Waiting Room, Lifeline, Tender Touch, Support Services and Courtesy Shuttle. Some of our services have direct patient contact, while others offer only minimal or no patient contact.

We work a seven-day week with the workday divided into three shifts--mornings, afternoon and evening. Each shift is generally four hours long and most members work one shift per week. Applicants who want to contribute more hours are urged to work on special projects as they arise or as a substitute. We try to assign members to the service, day and time preferred, but this is not always possible. Members may be asked to select an alternate schedule and/or service. We hope you will understand our need to fulfill service commitments to the hospital.

Uniforms are required. Uniform choices will be explained during the interview. Dues for active members are \$5 per year. General meetings are held twice a year, and service meetings are scheduled quarterly to update the Auxiliary on hospital programs and services. For more information, contact Membership Chairman Richard Hart at (321) 268-6333, ext. 7182.

Sincerely,

Parrish Medical Center Auxiliary



APPLICATION FOR VOLUNTEER SERVICE

Name: _____ Spouse's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone (H): _____ (C): _____ Birthday: _____
Email: _____ Employer: _____

Previous work experience:
As a volunteer: _____
As a paid employee: _____

Organizations that you are, or were, a member of (Please indicate any offices you held.):

Write or speak a foreign language? Yes No Please list: _____
General health condition? _____
Any physical limitations that prohibit pushing a wheelchair or walking 2-3 hours? Yes No
Any other limitations? _____
Have you ever been a hospital Auxiliary member? Yes No
When? _____ Where? _____
What are your reasons for joining this Auxiliary? _____

References: No relatives or doctors. Give Auxilian references if possible.

Name: _____ Telephone: _____
Address: _____
Email Address: _____
Name: _____ Telephone: _____
Address: _____
Email Address: _____

- I understand and agree to comply with the requirements of the Parrish Medical Center Auxiliary, its rules and regulations; and the rules and regulations of Parrish Medical Center.
- I will hold all information concerning patients, physicians and employees of this hospital in confidence.
- I agree to work a minimum of 25–50 hours a year to maintain an active membership.

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

PLEASE RETURN APPLICATION TO: Membership Chairman
Parrish Medical Center Auxiliary
951 North Washington Avenue
Titusville, FL 32796



CONFIDENTIAL PERSONAL PROFILE

Please take a few moments to complete your personal profile sheet for your file folder. This will assist us in identifying special skills and talents of our membership.

Name: _____ **Date:** _____

Address: _____

Telephone: _____ **Email:** _____

Are you retired? Yes No

Are You a Year-Round Resident? Yes No

Special Interests: _____

Special Skills (please mark all that apply):

- Accounting
- Computer
- Secretarial
- Special Events
- Writing

Other: _____

Hobbies and/or Talents: _____

Do you speak a language other than English? Yes No

If yes, what language(s)? _____

Experience in Other Organizations: _____

Are you interested in serving on a committee (please check all that interest you):

- | | |
|---|---|
| <input type="checkbox"/> Executive Board | <input type="checkbox"/> Service Chairman |
| <input type="checkbox"/> Nominating Committee | <input type="checkbox"/> Service Assistant Chairman |
| <input type="checkbox"/> Scholarship | <input type="checkbox"/> Special Events |

Thank you for taking the time to complete this form so that we may better serve you.



Consent to Photograph, Videotape, Film or Interview

Parrish Medical Center (PMC) is committed to protecting the privacy and confidentiality of our patients/community and their information.

I, _____,
(Please print: patient or his/her legal representative name)

hereby authorize and grant permission to PMC, and/or its representatives to:

- To photograph/videotape//film me (or my minor child) to document the progress of my medical care.
- To release pertinent medical and other information to the media about me (or my minor child's name) beyond the one word condition description (Good, Fair, Poor, Critical, Serious, or Undetermined).
- To interview me (or my minor child's name) for use by the news media: newspapers, magazines, radio, television, etc.
- To interview me (or my minor child's name) for use within PMC's marketing or publicity materials.
- To photograph/videotape/film me (or my minor child) for use in marketing or publicity materials.

In signing this agreement, I understand that:

1. Editing of these materials by individual media (*i.e.* television, newspaper, magazine) representatives will be done so at their discretion, and that this discretion is beyond PMC's control.
2. I have agreed to participate without monetary compensation.
3. I can revoke my consent at any time in writing, but if I do, it will not have any effect on any actions taken prior to my revocation.
4. I may refuse authorization and that this is strictly voluntary.

(Signature)

(Date)

(Witness)

Phone Number: _____

Mailing Address: _____

Email Address: _____



CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics similar to the one that binds the employees at Parrish Medical Center and its off-site family of services. Like them, I assume certain responsibilities and expect to account for my actions based on the organization's expectations. I will keep confidential matters confidential. As a volunteer, I have agreed to work with no monetary compensation. Once accepted as a volunteer worker, I expect to do my work according to the high standards expected of paid care partners.

I believe that all work should be carefully analyzed so work methods can be standardized. I believe that people should be studied in order to determine what jobs they can do, like to do, and that as far possible should be assigned to do.

I promise to be open-minded in my work, to be trained for it and bring interest and attention to it. I realize that I may have assets that my co-workers may not have and that I should use these to enrich the projects we are working on together. I also realize I may lack assets that my co-workers have. I will not let this make me feel inadequate, but will endeavor to assist in developing good teamwork.

I will learn how I can best serve the activity for which I have volunteered, and offer as much as I am sure I can give, but no more. I realize that I must live up to my promises and therefore will be careful that my agreement is simple and clear so it cannot be misunderstood.

I believe my attitude toward volunteer work should be professional. I believe that I have an obligation to my work, to those who direct my work, to my colleagues, to those for which my work is done and to the public.

Being eager to contribute all I can to Parrish Medical Center's healing environment, I accept this Code of Ethics for Volunteers as my code, to be followed carefully and cheerfully.

Print Name

Signature

Date



**VOLUNTEER SERVICES
WORKERS' COMPENSATION VERIFICATION FORM AND
STATEWIDE CRIMINAL HISTORY BACKGROUND CHECK**

RESEARCHERS ASSOCIATES, INC.
(850) 893-2548 / (850) 893-9518

Name of Applicant: _____

Social Security Number: _____

Date of Birth: _____

Has this person had a workers' compensation claim filed in the state of Florida in the last _____ years? Yes No

If Yes, Employer: _____

Date: _____

Type of Injury: _____

Time Lost: _____

Person Providing Information: _____

Checked BY

Date