

# Volunteer Application

Applicant's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Notify in Case of Emergency:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

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## Employment/Volunteer Experience

Employer \_\_\_\_\_

Position \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Employer \_\_\_\_\_

Position \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Employer \_\_\_\_\_

Position \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_

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## Hobbies, Skills, Talents, Special Interests, Special Training (check all that apply)

Volunteer for:  Outings     Special Events     Mail Distribution     Letter Writing  
 Calendar Activities     Special Friend     Activities of Daily Living     1:1

Have you ever been arrested?     Yes     No

If yes, explain \_\_\_\_\_

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## Schedule Preferred

Sunday     Monday     Tuesday     Wednesday     Thursday     Friday     Saturday

If you are 17 years old or younger, please bring a permission letter from a parent or guardian.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Activity Director

\_\_\_\_\_  
Date

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# Volunteer Confidentiality Statement

I \_\_\_\_\_, hereby agree to regard all information received in the performance of my volunteer work in this health care facility as confidential.

I understand that this facility respects residents' rights with regard to privacy of information and I agree to respect these rights in the performance of my volunteer duties and keep "professional" confidentiality in all my statements outside the facility.

I agree to respect residents' rights to privacy, as well as those of the family and the facility whenever I make community presentations or participate in volunteer recruitment programs. The content of these presentations will be approved in advance by the Director of Volunteers or the Department Head.

Signed by:

\_\_\_\_\_  
Volunteer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director of Department

\_\_\_\_\_  
Date

## Permission Approval for Minors (under 18 years of age)

I, \_\_\_\_\_, give permission for  
\_\_\_\_\_ who is my \_\_\_\_\_  
to do volunteer work at \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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**Background Study Information)**

First Name: \_\_\_\_\_

\*Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Driver License Number & Expiration Date: (if any) \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_

\*Race : Asian \_\_\_\_\_  
Pac. Islander \_\_\_\_\_  
African American \_\_\_\_\_  
White \_\_\_\_\_  
Unknown Other \_\_\_\_\_  
Hispanic/Latino \_\_\_\_\_  
Two or more Races \_\_\_\_\_

\*Social Security No. \_\_\_\_\_

\*Phone No. \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_

Zip Code \_\_\_\_\_

Email \_\_\_\_\_

Other First Names Used \_\_\_\_\_

Other Last Names Used \_\_\_\_\_

Have you lived outside of Minnesota in the last 5 years? \_\_\_\_\_ If so, where  
\_\_\_\_\_. And year from: \_\_\_\_\_ To \_\_\_\_\_

What state were you born in? \_\_\_\_\_

**CONSENT TO COMPLETE BACKGROUND STUDY**

I have been informed of the 1995 Legislature amended Statutes, Chapter 144, requiring background studies to be completed on all individuals providing direct contact services in facilities licensed by the Minnesota Department of Health. Therefore, I understand that a background study will be done on all individuals providing direct contact services within Oak Hills Living Center, and that the results of the study will be communicated by DHS to the facility and to the person studied. The results shall be kept confidential and will not be released without written authorization. I have also been informed that future convictions for disqualifying crimes will be reported to DHS by the corrections system.

I have read the Privacy Notice and consent to the completion of the background study.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_