



8118 Good Luck Road  
Lanham, Maryland 20706-3596  
301-552-8675

## Pastoral Care Volunteer Application

Dear Pastoral Care Volunteer Candidate:

Thank you for your interest in the Pastoral Care Volunteer Program at Doctors Community Hospital! Our hospital enjoys working with dependable and friendly volunteers who complement the quality care provided to patients, families, visitors and the community by our existing hospital staff.

The Volunteer Program at our hospital, in its effort to provide an efficient and competent volunteer team, follows a set of **Guidelines for Adult Volunteers**. Enclosed is a copy for your review.

1. Please complete the **Adult Volunteer Service Application including the Pastoral Care Volunteer Form and the Background Check Form** and return it to Volunteer Services with two (2) **Letters of Reference**, one must be from your **religious/spiritual leader**. **A copy of ordination certificate is applicable is requested.**
2. Please plan to attend **one required Volunteer Orientation session**. Orientations are held periodically and volunteer candidates may participate in any one of the below dates:

### **Orientation:**

<i>Thursday, March 13, 2019</i>	<i>10:00am-12:00pm</i>
<i>Thursday, March 28, 2019</i>	<i>6:00pm – 8:00pm</i>
<i>Thursday, May 2, 2019</i>	<i>10:00am-12:00pm</i>
<i>Thursday, June 6, 2019</i>	<i>10:00am-12:00pm</i>

All classes are held in the North Building, behind the hospital, signs will be posted listing the specific location

**NOTE: We follow the Prince Georges' County School closing for inclement weather events. If schools programs are canceled the Orientation will be cancel.**

4. Then the **next step** is to confirm your participation in the above listed session by calling the Volunteer Services office at 301-552-8675; please leave a message.
5. A personal interview with the Pastoral Care leadership and further training will be required **after** you have attended a Volunteer Orientation session.

**A commitment of one year or 200 hours of service is strongly encouraged.**

I look forward to hearing from you soon!

Sincerely,

Mary P. Dudley

Director, Community Relations/Volunteer Services

(over)

# DOCTORS COMMUNITY HOSPITAL

## Guidelines for Pastoral Care Volunteers

*MISSION: The Volunteer Services Department of Doctors Community Hospital has been established to provide efficient and competent volunteers to supplement and complement the quality care provided to patients, families, visitors and the community by our existing hospital staff.*

### REQUIREMENTS AND GENERAL GUIDELINE

1. The Volunteer Program is open to all persons 18 years of age and over, who are able to donate at least 4 hours of service on a regular basis.
2. Please complete the **Adult Volunteer Service Application including the Pastoral Care Volunteer Form and the Background Check Form** and return it to Volunteer Services with two (2) **Letters of Reference**, one must be from your **religious/spiritual leader**. **A copy of ordination certificate is applicable is requested.**
3. Volunteers are required to attend one Volunteer Orientation Session. Day and evening orientations are held periodically throughout the year. There will be further training provided for Pastoral Care Volunteers.
4. All Volunteers must have a **physical examination, flu shot (required) and TB/blood test** prior to entry into the program. It is free, instructions will be provided at the Volunteer Orientation.
5. **All volunteers over 18 years of age will be required to consent to a background check.**
6. An interview must be scheduled to after all the requirements have been completed.
7. Volunteers will need to purchase a uniform smock/jacket (\$20) through the Volunteer Office. Checks should be payable to DCH (Doctors Community Hospital). Upon completion of all interviews, a hospital identification badge will be issued. Both must be worn at all times while on duty.
9. Volunteers must strongly adhere to the **confidentiality and privacy** of all patients and staff.
10. Doctors Community Hospital is not obligated and does not guarantee the hiring of volunteers into paid positions. A time commitment of **one year or 200 hours** of service is required.

### COURTESIES PROVIDED:

- Volunteers who serve 4 or more hours a day are entitled to one “free” meal up to \$7.50.
- Volunteers are welcome to attend most employee social functions or training workshops.
- Volunteers will receive service awards after 100 hours of service. The service awards are given to active volunteers for milestone hours of service at the Annual Volunteer Appreciation.

# Doctors Community Hospital Adult Volunteer Service Application-Pastoral Care

For official use only. Please leave blank

Vol # \_\_\_\_\_

ID# \_\_\_\_\_

◆ Name (Last, First, MI) \_\_\_\_\_

◆ Nickname \_\_\_\_\_ ◆ Check one: Mr.  Mrs.  Ms.

◆ Street Address \_\_\_\_\_

◆ City, State & Zip \_\_\_\_\_

◆ Home Phone \_\_\_\_\_ ◆ Work Phone \_\_\_\_\_ ◆ Cell Phone \_\_\_\_\_

◆ E-Mail \_\_\_\_\_

◆ Date of Birth \_\_\_\_\_ ◆ License Plate \_\_\_\_\_ ◆ State \_\_\_\_\_

◆ How did you hear about this Volunteer Program? (*circle*): 1 Phoned Hospital 2 Newspaper  
3 Word of Mouth-Name: \_\_\_\_\_ 4 School 5 Human Resources 6 Visiting Hospital 7  
Website 8 Other: \_\_\_\_\_

◆ Marital Status (*circle*): Married Single Widowed Divorced

◆ Work Status (*circle*): Employed Unemployed Retired Student

◆ Previous Volunteer and/or Work Experience \_\_\_\_\_

◆ Are you a returning DCH Volunteer? No \_\_\_\_\_ Yes \_\_\_\_\_

◆ Why have you chosen to volunteer? \_\_\_\_\_

◆ Commitment to Service with DCH: Indefinitely \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_ Summer \_\_\_\_\_

◆ Availability: (Indicate preferred shift below ; M=Morning A=Afternoon E=Evening)

Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

◆ Do you speak/understand a language other than English *Specify*: \_\_\_\_\_

◆ Are there any limitations on your activities: No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

◆ Skills/Interests (*Circle*): 1 Clerical 2 Patient Care 3 Front Desk/Greeter 4 Telephone

5 Data/Word Processing 6 Verbal Skills 7 other \_\_\_\_\_

(over)

◆ Person(s) to call in an Emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

◆ Family Physician Name \_\_\_\_\_ Telephone \_\_\_\_\_

*I authorize the use of any information in this application to enable the hospital to verify my statements, and I authorize my present employer and any other persons to answer all questions asked by the hospital concerning my ability, character and reputation.*

◆ Applicant's Name (print) \_\_\_\_\_

◆ Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

◆ NOTE:        **Be sure to attach - TWO letters of reference**  
                              **Background Check Authorization Form**  
                              **Pastoral Care Volunteer Form**

**Return To: Volunteer Services  
Doctors Community Hospital  
Ste. 401, North Bldg.  
8118 Good Luck Road  
Lanham, MD 20706**

**Phone: 301-552-8675 or 301-552-8601**  
**Fax: 240-542-2965**

**BACKGROUND CHECK DISCLOSURE**

Private Eyes, Inc. (the "Company") will order a "consumer report" (a background check) on you in connection with your volunteer application, and if you are hired, or if you already work for the Company, may order additional background checks on you for employment purposes.

The Company may order an "investigative consumer report." Such reports typically include information from personal interviews, most commonly from an applicant's prior employers and references.

The background check may contain information concerning your character, general reputation, personal characteristics, mode of living, criminal history, credit worthiness, credit capacity and credit standing. Information may be obtained from private and public record sources, and for investigative consumer reports, from personal interviews as noted above. You have the right to request more information about the nature and scope of an investigative consumer report, if any, by contacting Private Eyes, Inc at 2700 Ygnacio Valley Road Suite #100, Walnut Creek, CA 94598.

**BACKGROUND CHECK AUTHORIZATION**

I authorize Doctors Community Hospital-VOLUNTEER (the company) to order my background check, including investigative consumer reports. I understand that, as allowed by law, the Company may rely on this authorization to order additional background checks, including investigative consumer reports, during my employment without asking me for my authorization again, as allowed by law.

I also authorize all of the following to disclose to Private Eyes, Inc. and its agents all information about or concerning me, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; the Department of Transportation, the military and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to Private Eyes, Inc. and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses, and may include inquiries regarding workers' compensation, harassment, violence, theft or fraud.

Additional information about your rights has been provided to you with this Background Check Authorization. Please review it BEFORE you sign.

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Maiden Name(s) \_\_\_\_\_ Years Used \_\_\_\_\_

Other Name(s) \_\_\_\_\_ Years Used \_\_\_\_\_

Social Security Number \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

Other Driver's Licenses Held in Past 5 Years (include states) \_\_\_\_\_

**FOR IDENTIFICATION PURPOSES ONLY:** Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

Telephone Number \_\_\_\_\_

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

City/State/ZIP \_\_\_\_\_

Residential Addresses Within Seven Years (use a separate sheet as needed)

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

City/State/ZIP \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) To \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

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

City/State/ZIP \_\_\_\_\_

From \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) To \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year)

<p>_____ Signature</p>	<p>_____/_____/_____ Date: (Month/Day/Year)</p>
----------------------------	---

Client Account Number: 927302 Doctors Community Hospital-VOLUNTEER

**Blank page**

**Revised 11/18**



*passion for caring.*

**Pastoral Care Volunteer Form**

Name (Last, First, MI) \_\_\_\_\_

Religion: \_\_\_\_\_

Place of Worship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**How often are you available to provide spiritual services?**

\_\_\_\_\_ Daily \_\_\_\_\_ Once a week \_\_\_\_\_ Every other week \_\_\_\_\_ Once a month

**What experience have you had in hospital ministry and grief support?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please submit copy of ordination certificate or letter of recommendation from religious/spiritual leader with this form and the Adult Volunteer Application.**

Yes	No	Please answer the following questions (required)
		Do you understand that you will not be paid for your spiritual care services?
		Do you understand you must know and respect patients' rights?
		Do you understand you will serve at a predetermined skill level of spiritual caregiving?
		Do you understand you will be required to attend quarterly spiritual care staff meeting?
		Do you understand you will be accountable to a chaplain/team leader?
		Are you willing to follow hospital policies, guidelines, and regulations?
		Are you willing to report all unusual incidents to nurses, security, or supervisor?
		Are you willing to be placed on the spiritual care call-back list?
		Would you be willing to attend Doctors Community Hospital's Lay Healthcare Chaplaincy Training? (Not Required)