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

Volunteer Services
301-552-8601

Dear Volunteer Candidate:

Thank you for your interest in the 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** and return it to Volunteer Services with two (2) **Letters of Reference**.

2. Be sure to return your application and reference letters as soon as possible, you will **NOT** be contacted, please follow step 3 and 4.

3. Plan to attend **one required Volunteer Orientation.** Orientations are held periodically and volunteer candidates may participate in any one of the below dates:

   Orientation:

   Date to be Determined! Please submit your application and you will be notified of next New Volunteer Orientation!

   All classes are held in the North Building, behind the hospital, 5th Floor DSE Room, signs will be posted listing the specific location

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

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 to determine areas of interest will be scheduled **after** you have attended an Orientation session.

A commitment of six consecutive months or 100 hours of service is strongly encouraged.

I look forward to hearing from you soon!

Sincerely,

Mary P. Dudley

Mary P. Dudley
Director, Community Relations/Volunteer Services

(over)

DOCTORS COMMUNITY HOSPITAL
Guidelines for Adult 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 Adult 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.

   Please Note: If you are seeking to do your volunteer service in a specific area such as Billing, Sterile Processing, Lab, ER or Pharmacy you may want to call and speak with the a staff person, most of these area are NOT available to volunteer or are very limited. We are not able to take Court Referred Community Service Volunteers.

2. Volunteers must complete and submit a **Volunteer Service Application** along with **Two (2) written Letters of Personal Reference.** These cannot be from a family member.

3. Volunteers are required to attend one Orientation Session. Day and evening orientations are held periodically throughout the year. On-the-job training will be provided in each department.

4. Adult Volunteers must have a **physical examination,** ***flu shot (required)*** and **TB/blood test** prior to entry into the volunteer 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 A Volunteer Interview must be scheduled to determine areas of interest 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 the Volunteer interview, 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 **six consecutive months or 100 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 held in the Spring.

VRS 2
Doctors Community Hospital
Adult Volunteer Service Application

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__________________________

For Official Use Only! Please leave blamk!
Assignment:
Day:
Time:

◆ Person(s) to call in an Emergency:

Name_________________________________ Relationship _________________________

Telephone: Home________________________ Work _______________________________

◆ Family Physician Name_______________________________Telephone_______________________
(over)

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

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**
Email: **MDudley@DCHweb,org**

Please complete the attached Background Check Authorization form

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, creditworthiness, 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)

______________________________________ ______/_______/_________

Signature Date: (Month/Day/Year)

Client Account Number: 927302 Doctors Community Hospital-VOLUNTEER

Rev: 7/19