



14550 Old St. Augustine Road  
Jacksonville, Florida 32258  
Phone: 904.271.6081  
Fax: 904.271.6649  
e-baptisthealth.com

Dear Prospective Volunteer:

Thank you for your interest in Baptist Medical Center South Volunteer Program. We look forward to having members of our community join us. Our goal is to provide the best possible volunteer service to the patients at Baptist South.

Please complete the enclosed application (with complete addresses and **zip codes** for references) and return it at your earliest convenience. As soon as we receive your completed application and responses from your references, we will contact you.

We appreciate your interest and are looking forward to meeting you and discussing your active participation in the Volunteer Program.

Please join us for a most rewarding volunteer service.

Sincerely,

A handwritten signature in black ink that reads "Erin Wallner". The signature is fluid and cursive, with a long horizontal stroke at the end.

Erin Wallner  
Community Outreach Coordinator

Enclosures

**Return application to:**  
Baptist Medical Center South  
Volunteer Program  
14550 Old St. Augustine Road  
Jacksonville, Fl 32258



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## Volunteer Application

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

SS#: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/ZIP: \_\_\_\_\_

Present occupation: \_\_\_\_\_ Previous occupation (if retired): \_\_\_\_\_

How did you become interested in our volunteer program? \_\_\_\_\_

Have you done volunteer work previously?  Yes  No If yes, please describe. \_\_\_\_\_

Foreign languages spoken and understood \_\_\_\_\_

**Areas of Interest:**

- Front Desk/Ambassador
- Library Services
- Patient Care Areas

- Surgical Services
- Gift Shop
- Emergency Services

**Times Available:**

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning 8-12					
Afternoon 12-4					

**References:** Please PRINT two (2) non-relative references:

**A. Reference One**

1. Name \_\_\_\_\_
2. Address \_\_\_\_\_
3. City \_\_\_\_\_
4. State \_\_\_\_\_
5. ZIP Code \_\_\_\_\_
6. Telephone \_\_\_\_\_
7. Relationship \_\_\_\_\_

**B. Reference Two**

1. Name \_\_\_\_\_
2. Address \_\_\_\_\_
3. City \_\_\_\_\_
4. State \_\_\_\_\_
5. ZIP Code \_\_\_\_\_
6. Telephone \_\_\_\_\_
7. Relationship \_\_\_\_\_

**Emergency Contact:**

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

Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

I hereby apply for Active membership in the Volunteer Program. When assigned, I agree to abide by the rules and regulations governing the organization and the medical center. Specifically, I agree to contribute **a minimum of 100 hours per year (Part-time residents: 50 hours per year)**; attend **up to two (2) general meetings** annually.

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

\_\_\_\_\_  
Date

*Your signature indicates your approval for us to check your references and to process a background check. The Volunteer is not obligated to provide a placement, nor are you obligated to accept the position offered.*



## Background Investigation

To be considered for volunteering with Baptist Medical Center South or affiliates, applicants are subject to a background investigation with the Florida Department of Law Enforcement and other state, out-of-state, and local agencies.

Applicants are evaluated on the merits of their qualifications for positions available regardless of the individual's race, sex, color, national origin, age, disability, religion, marital status, or status as a veteran.

Have you ever been convicted of, or pled guilty, no contest or *nolo contendere* to a crime? This includes DUI or DWI, a criminal conviction, debarment, sanction, or exclusion related to Medicare, Medicaid, or any other federal or state-funded health care program(s), or ineligibility for participation in a federally or state-funded health care program.  Yes  No

If yes, give details (date, place, offense(s), disposition, etc.): \_\_\_\_\_

Have you ever been charged with a crime and either been placed on a court ordered probation, had adjudication withheld, entered a pre-trial intervention program, or have any criminal charges now pending?  Yes  No If yes, give details: \_\_\_\_\_

### Please PRINT All Information and Sign at the Bottom

The following information is required to perform the background investigation:

First and middle names should be as it appears on your birth certificate.

In the **other name field**, include all last names that you have ever had.

List all states where you have resided outside of Florida within the past seven (7) years.

State(s): \_\_\_\_\_ County(ies): \_\_\_\_\_

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

FOR EMPLOYMENT OFFICE

USE ONLY

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

FDLE

Middle Name \_\_\_\_\_

Other Name(s) \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth/Year \_\_\_\_\_

Sex: Male  Female  Race: White  Black  Asian   
Hispanic  Other

Driver License # \_\_\_\_\_ State \_\_\_\_\_

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

\_\_\_\_\_  
Date

## Immunization History

(Please print)

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Work Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your general health is: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_

Please check if you have had any of the following:

	NO	YES (approx. date)	IMMUNIZATION (approx. date)
<b>Measles</b>			
<b>Chicken Pox</b>			
<b>Mumps</b>			
<b>Tetanus</b>			
<b>Hepatitis</b> (specify type)			
<b>Tuberculosis (TB)</b> <u>or</u> if POSITIVE TB Test provide date and results of last chest x-ray			
<b>Other</b>			

Are there any accommodations or limitations that you would like the Baptist South Volunteer Office to be aware of when assigning you to your area of volunteer service, including medical conditions that restrict your ability to hear, see, stoop, lift or push?

NO \_\_\_\_\_ YES (please specify): \_\_\_\_\_

Comments: \_\_\_\_\_

By signing below I verify that my responses are complete and correct.

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

\_\_\_\_\_  
Date