Dear Prospective Volunteer:

Thank you for your interest in becoming a Frankford Hospital volunteer. An exciting experience and special commitment may be about to begin. Volunteerism at Frankford Hospitals is an integral part of the health care received by our patients. Volunteers have the opportunity to work in a wide variety of hospital departments, including the Information/Reception Desk, Gift Shop and various clinical and support services departments.

Application and information sheets are enclosed for your review, completion, and signature. Please return the completed application to the Volunteer Services Department. Prior to placement, applicants are interviewed to assure that your interests, talents, and schedule are considered and are a fit to the needs and schedules of the Hospital departments.

As a Volunteer, you are a vital part of our commitment to provide exceptional patient care and customer service to the patients and communities we serve. Again, thank you for your interest and I look forward to hearing from you.

Sincerely,

Patricia Lyall
Director, Volunteer Services

/cab
Enclosures

Interview Date/Time ______________________________
Start Date: ______________________________________
Assignment: ______________________________________

TORRESDALE __________
FRANKFORD __________
BUCKS COUNTY ________

ADULT APPLICATION

Name ____

Address ____

City/State/Zip _____________________________________

Referred by _______________________________________

Home Phone: ________________________
Work Phone: ________________________
Cell Phone: __________________________
Email Address: _______________________

Date of Birth: ________________________
SSN: _______________________________

Can we call you at work? _________

Are you a Student _________ Homemaker __________ Employed __________ Retired __________

Are you currently attending college? _______ If yes, where ____

Are you doing this for credit? ___ Yes ___ No If yes, who is your advisor? __________________________

What do you plan to do after graduation? ____

Are you available: Weekends ___________ Evenings ___________ Weekdays __________

VOLUNTEER EXPERIENCE

1. Agency ____________________________ Responsibilities __________________________________

   ____

   From __________________________________to ____

2 Agency ____________________________ Responsibilities __________________________________

   ____

   From __________________________________ to ____

EMPLOYMENT EXPERIENCE

1. Company _____________________________Responsibilities _________________________________

   ____

   From ___________________________________ to ______________________________________

2. Company _________________________ Responsibilities __________________________________

   ____

   From ____________________________________ to _____________________________________

Are you able to perform all functions of the volunteer position for which you are applying, with or without reasonable accommodation? ______ Yes ______ No

If no, please explain: ____

What do you want to gain from your volunteer experience? ______________________________

____

_____ Walking	_____ Telephone Work	_____ Working Independently
_____ Selling	_____ Services for Patients	_____ Varied Duties
_____ Helping the staff	_____ Meeting the Public	_____ Being seated mostly
_____ Clerical Duties	_____ Consistent, predictable tasks	_____ Driving car for deliver of meals (BC)

What days and hours (including weekends) are you available? ______________________________

____

To the best of your knowledge, will you be available as a volunteer for at least six months from this date?

Yes _______ No _______

Have you ever been convicted of a crime? Yes _______ No _______. If yes, please describe the nature of the offense, the date of the offense, and your rehabilitation since conviction. (A conviction record will not necessarily bar you from a volunteer position with the hospital.) The hospital will conduct a criminal background check if you are accepted into the volunteer program.

____

____

Is there any other information you would like to offer that would help in the process of placing you as a volunteer? ____

____

The information I have provided above is accurate to the best of my knowledge.

Date: ______________________________ Signature ______________________________

Return the completed application to:

Volunteer Services Department
Frankford Hospitals
Red Lion & Knights Roads
Philadelphia, PA 19114

Or fax/email your completed application to:

Fax: 215-612-5027
Email: plyall@fhcs.org

Rev: 4/06

IMMUNIZATION POLICY FOR PROSPECTIVE VOLUNTEERS

Frankford Hospitals requires that all employees and volunteers born in or after 1957 show proof of immunity for measles, mumps and rubella.

MEASLES Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of receipt of two doses of measles containing vaccine (measles, MR, or MMR) given on or after twelve months of age.
- prior health care provider diagnosed measles.
- laboratory evidence of measles immunity.
- born before 1957.

MUMPS Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of one dose of mumps containing vaccine (mumps or MMR) given on or after twelve months of age.
- documentation of health care provider diagnosed mumps disease.

RUBELLA Any one of the following are acceptable as proof of immunity:

- laboratory evidence of rubella immunity.
- documentation of one dose of rubella containing vaccine (rubella, MR, or MMR).

Anyone unable to show proof of immunity for measles/mumps/rubella, will be required to receive the necessary immunization from their family physician as a condition of volunteering.

Volunteers excluded from measles/mumps/rubella immunization are pregnant volunteers and volunteers with immuno-suppression.

If I can be of any further assistance, please call me at 215-612-4170 (TC).

Patti Lyall
Director, Volunteer Services

(Please see reverse side)

THIS IS TO CERTIFY THAT ____

has had the vaccine or immunity from measles, mumps and rubella.

________________________ ________________________________
Date Physician Name (please print)

____
Physician Signature