

Office Use Only: Date Received \_\_\_\_\_ NEO \_\_\_\_\_ Dept. \_\_\_\_\_

## Application Volunteer Services Russell Medical Auxiliary

### PERSONAL

(Please Print)

Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_  
No. and Street

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

Home Phone No. (\_\_\_\_) \_\_\_\_\_ Cell Phone No. (\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_

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

### EDUCATION

School:  
High School \_\_\_\_\_ Graduate? \_\_\_\_\_  
Name City State

College/Tech \_\_\_\_\_ Degree \_\_\_\_\_  
Name City State

### PAST EMPLOYMENT

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's City and State \_\_\_\_\_

Dates of Employment \_\_\_\_\_

## VOLUNTEER EXPERIENCE

Organization's Name and Type Projects or Duties

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## LICENSES AND SPECIAL SKILLS

List any professional or occupational license with expiration date

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Computer Skills? \_\_\_\_\_ Cash Register? \_\_\_\_\_

Foreign Language? \_\_\_\_\_ Interpret for Hearing Impaired? \_\_\_\_\_

Community Affiliations \_\_\_\_\_

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## REFERENCES

Name

Address

Phone Number

1. \_\_\_\_\_

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2. \_\_\_\_\_

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I give Permission for my References to be checked: \_\_\_\_\_

Signature

Date

## BACKGROUND CHECK

All applicants are required to complete and pass a background check before becoming an active volunteer. Background Investigation permission form is attached. Please sign and return with application.

### PERSONAL HEALTH INFORMATION

Do you have any health restrictions/disabilities? (If yes, please explain) \_\_\_\_\_

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Person to Contact in Case of Emergency:

Name \_\_\_\_\_

Phone Numbers \_\_\_\_\_

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Relation to You \_\_\_\_\_

### CONFIDENTIALITY ACKNOWLEDGMENT

I understand that any information, which is disclosed to me while I am volunteering in the hospital, is confidential and protected by federal law.

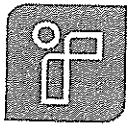
I hereby agree that I will abide by the policies of Russell Medical. I understand that if I am in violation of these policies, I will be terminated.

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Signature

Date

Please mail/return completed application to:  
Emily Williams, Foundation-Auxiliary Coordinator  
Russell Medical  
P.O. Box 939  
Alexander City, AL 35011  
Phone# 256-329-7177



# Russell Medical

MEMBER OF **UAB** HEALTH SYSTEM

## NOTICE – BACKGROUND INVESTIGATION

In connection with your application with **RUSSELL MEDICAL**, notice is hereby given that a consumer report and/or investigative consumer report may be obtained from a consumer reporting agency for employment or volunteer purposes. These reports may contain information about your character, general reputation, personal characteristics, and mode of living, whichever are applicable. They may involve personal interviews with sources such as neighbors, friends, or associates. The reports may also contain information about you relating to your criminal history, driving and/or motor vehicle records, education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report prepared by contacting **RUSSELL MEDICAL** and **Providence Screening**, 15105-D John J Delaney Dr.#113, Charlotte, NC 28277 – Phone: 704.225.0020 [www.providencescreening.com](http://www.providencescreening.com). The scope of this notice and below authorization is not limited to the present and will continue throughout the course of your assignment and allow **RUSSELL MEDICAL** to conduct future screenings for retention, promotion, or reassignment, as permitted by law and unless revoked by you in writing.

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

Other names (i.e. maiden name, nicknames, etc.): \_\_\_\_\_

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

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

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

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

CALIFORNIA, MASSACHUSETTS, MINNESOTA, and OKLAHOMA applicants or employees only:

Please check the box if you would like to receive a copy of your consumer report, free of charge if one is obtained by us.

Check here to receive copy of the report

## ACKNOWLEDGEMENT AND AUTHORIZATION

By signing below, I hereby authorize the obtaining of consumer reports and/or investigative consumer reports by **RUSSELL MEDICAL** at any time after receipt of this authorization and throughout the course of my employment or volunteering, if applicable.

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