Dear Prospective Volunteer,

Thank you for your interest in volunteering at Sinai Hospital! As a healthcare facility dedicated to our patients and our community, we are always looking for individuals to help us build ties to the community and improve the patient care experience at Sinai Hospital.

The Sinai Hospital Volunteer Application includes an Information Sheet, Health Screening form, three Reference Check forms, a FCRA Notice/Acknowledgement and an Application Checklist. The forms are mandatory due to state law, and ultimately provide safety and security for the vulnerable population that we serve. Please complete and return all forms Volunteer Services at Sinai Hospital in order to be considered for placement.

Once you have completed your application you may and send it to our office via fax, (410) 601-2180, or email them to schrzano@lifebridgehealth.org. Once ALL pages of your application have been received, you will be contacted for an interview.

Feel free to contact me at (410) 601-5023 if you have any questions. We hope to hear from you soon!

Regards,

Sarah Chrzanowski
Volunteer Manager
Please print all information clearly

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<th>Name</th>
<th>Date of Application</th>
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<td>Primary Phone #</td>
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<td>Secondary Phone #</td>
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Date of Birth ____________________ Social Security # __________________

Primary Emergency Contact    Secondary Emergency Contact

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<td>Phone #</td>
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Are you currently a student?     Yes/No
If you are a student, are you applying for a position that will count towards any type of service hours or official internship program?    Yes/No   If yes, please complete internship application

Are you currently employed by LifeBridge Health? Yes/No

How did you hear about our program? If you were referred, who referred you?__________________

What are your areas of interest? (Check all that apply)

- Patient Visits/Delivering Flowers
- Clerical or Reception Desks
- Gift Shop or Gift Cart
- Special Projects and Mailings
- Other: _________________________________

What days and hours are you interested in volunteering?

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Signature: __________________________________ Date: __________________

To be completed by Volunteer Department: Date received:
Reference forms present? Y/N   Background check form present? Y/N   Health form present? Y/N
**Sinai Hospital**  
**Volunteer Services**  
**Student Application Addendum**

Name ____________________  Age _____  School _________________________

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<tr>
<th>Education level</th>
<th>9th grade</th>
<th>10th grade</th>
<th>11th grade</th>
<th>12th grade</th>
<th>Some college</th>
<th>Bachelor’s Degree</th>
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Advisor/Contact ____________________  Advisor’s phone number ____________________

Is this a formal internship program? Yes/No

Will you be receiving credit for this experience? Yes/No

What documentation does your school require?

How many hours a week does your program require? _____________

Why are you interested in volunteering at Sinai Hospital?  
______________________________________________________________________________  
______________________________________________________________________________  
______________________________________________________________________________

Have you ever been convicted of a crime? Yes/No

If yes, please explain when, where and disposition of case:

To be completed by parent or legal guardian

I authorize Sinai Hospital to give medical treatment to (please print name __________________) in the event of an emergency. I also consent for my child’s participation in the Student Volunteer Program.

Signature of parent or guardian: ____________________  Date: ______________

To be completed by applicant

I agree that the above information is correct as of the date it has been filed. I also agree to the rules and regulations of the Volunteer Department. I understand that my relationship with the Volunteer Department may be terminated if any of the information I have provided above is found to be false, if I violate the standards and expectations of the hospital and/or if I fail to meet my school/program obligations.

Signature of applicant: ____________________  Date: ______________
Sinai Hospital
Volunteer Application

Health Screen Form

Name: ___________________________ Date of Birth: __________________________

Please give this form to your health care provider for completion, and return to Volunteer Services. The information below is required to volunteer at Sinai Hospital. Tuberculin skin tests can be administered free of charge at Sinai’s Employee Health Office if you do not have one on file within the last year. It is your personal and financial responsibility to provide documentation of immunity to Measles, Mumps, Rubella and Chicken Pox.

Dear Health Care Provider:

The above individual has applied to work as a volunteer at Sinai Hospital of Baltimore. In this role, they may have contact with newborns, children or patients with a compromised immune system. To ensure their safety, along with the safety of our patients, we thank you in advance for providing us with the following information:

1. Tuberculin skin test performed within last 12 months? _____ No _____ Yes
   Date: ________ Result:_________ If positive, last chest x-ray Date: ________ Result: ________

2. Immunization Status:
   Has this individual been vaccinated for:
   Measles, Mumps, Rubella _____ No _____ Yes Date: __________________________
   Chicken Pox _____ No _____ Yes Date: __________________________

3. Please stamp or print Health Care Provider name, including complete address

I have personally evaluated the above potential volunteer within the previous twelve (12) months and find him/her mentally and physically able to perform duties at Sinai Hospital.

______________________________________ _____________________ _______________
Signature of Health Care Provider   Phone Number  Date

I hereby authorize the release of this information to:
   Volunteer Department
   Sinai Hospital of Baltimore
   2401 West Belvedere Ave.
   Baltimore, Maryland 21215
   Fax: 410-601-2180

______________________________________ _____________________ _______________
Signature of Applicant    Phone Number  Date
Please give this form to a personal or business reference. Once the form is completed and signed, please send it to Volunteer Services.

_____________________ has applied to be a volunteer at Sinai Hospital of Baltimore. Your name was provided as a personal/business reference. We would appreciate your taking a few minutes to answer the below questions about this individual. Any information you give us will be kept private. I have enclosed a return envelope for your convenience. You may also fax this form to the Volunteer Office at Sinai Hospital at 410-601-2180. Thank you in advance for your cooperation.

Length of time you have known this individual __________

How do you know this individual?
_____ personal friend _____ co-worker _____ previous volunteer placement _____ other: _____________

Do you feel this individual would be an appropriate volunteer in an acute care hospital?
_____ yes   _____ no

Do you feel this individual has good customer service skills?
_____ yes   _____ no

Do you feel this individual is trustworthy and reliable?
_____ yes   _____ no

Comments: _______________________________________________________________________
_________________________________________________________________________________

Your name (please print) ______________________________  Title ______________________
Signature ___________________________________________  Date ______________________
Phone ______________________________

I hereby authorize the above individual to provide information to Sinai Hospital of Baltimore Volunteer Department.

Applicant name ______________________________________
Applicant signature ________________________________  Date ______________________
Reference Check

Please give this form to a personal or business reference. Once the form is completed and signed, please send it to Volunteer Services.

_____________________ has applied to be a volunteer at Sinai Hospital of Baltimore. Your name was provided as a personal/business reference. We would appreciate your taking a few minutes to answer the below questions about this individual. Any information you give us will be kept private. I have enclosed a return envelope for your convenience. You may also fax this form to the Volunteer Office at Sinai Hospital at 410-601-2180. Thank you in advance for your cooperation.

Length of time you have known this individual __________

How do you know this individual?
_____ personal friend   _____co-worker   _____ previous volunteer placement   _____ other: _____________

Do you feel this individual would be an appropriate volunteer in an acute care hospital?
_____ yes   _____ no

Do you feel this individual has good customer service skills?
_____ yes   _____ no

Do you feel this individual is trustworthy and reliable?
_____ yes   _____ no

Comments: _______________________________________________________________________

________________________________________________________________________________

Your name (please print) ______________________________ Title ______________________

Signature ___________________________________________  Date ______________________

Phone _______________________________

I hereby authorize the above individual to provide information to Sinai Hospital of Baltimore Volunteer Department.

Applicant name _______________________________________

Applicant signature ___________________________________  Date ______________________
The Sinai Hospital
Department of Volunteer Services
Application Checklist

The following are the steps to become a volunteer at Sinai Hospital. Check each step once it has been completed. When all indicator boxes are checked you will then be a Sinai Volunteer!

1. Complete and send in your Application Packet.
   - Application Form
   - Parental Consent Form (if under 18 yrs and/or attending high school)
   - Health Screen Form (or copy of vaccination records)
   - 2 Reference Checks (only 2 required if you are under 18)
   - TB & Flu Parental Consent Forms (if shots will be administered at Sinai)

2. Screening Interview with Volunteer Manager
   Note: The Volunteer Manager will contact you for your interview once your application is received.

3. Interview with the supervisor from your potential assignment site. (You will need to schedule this interview.)

4. Submit completed Placement Interview Form to Volunteer Services.

5. Complete a mandatory online hospital orientation.
   - Volunteer Training Certificate of Completion

6. Have TB screening.
   Note: You may either submit written documentation of your TB screening taken at your wellness center or medical practitioner’s office within the past year or receive the TB screening free of charge at the Department of Occupational Health. This department is located on the fifth floor of the Hoffberger Building, suite 54. The office hours are 7:30 a.m. to 4:00 p.m., Monday through Friday. Appointments are walk in. Please note there are no TB screenings on Thursdays. Remember, you must return in 48 to 72 hours to the Dept. of Occupational Health to have the TB screening evaluated. Failure to do so will result in a repeated screening. Once you have the TB screening evaluated, please bring a form stating that you qualify to be a volunteer to Volunteer Services.

7. Have picture taken for hospital identification badge.
   Note: Badging must be scheduled with the Volunteer Manager. The Badge Office is located on the ground floor of the main hospital. The office hours are 8:00 a.m. to 3:30 p.m., Monday through Friday. The office is closed for lunch between 1pm and 2pm. You must present a valid picture identification to receive a Sinai Badge.

8. Procedure for signing in and out:
   A. Sign in AND out using the kiosk in Volunteer Services. To report off site hours, call (410) 601-5007, and select option 2.

9. Volunteer Benefits: Free parking and 10 percent discount at the GreenSpring Cafè.
   - Parking will be assigned during orientation.
   - You must present your badge to receive a discount in the GreenSpring Cafè.
In connection with my application for employment, and/or employment with (LifeBridge Health) ("Company"), I, ______________________ (applicant's or employee's name), understand and am hereby notified and authorize Company to procure a consumer report from a consumer reporting agency in accordance with the Fair Credit Reporting Act, 15 U.S.C. 1681 et seq. (the "FCRA"), or any "person" as defined under the California Consumer Credit Reporting Agencies Act (if a CA applicant) for evaluation of me for employment (i.e. employment, promotion, reassignment, or retention as an employee). I understand that these consumer reports may contain information from public records, including written, oral, or other communications bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, which may or may not be used as a factor for employment purposes. I further understand that such inquires may include, but are not limited to, criminal history, motor vehicle records, employment history and verification, income verification, DOT verifications, military background, civil listings, education background, and professional background, from any individual, corporation, partnership, law enforcement agency, institution, school, organization, credit bureau, state board, licensing agency, and other entities, including present and past employers.

In connection with my application for employment and/or employment with Company, I further understand and am hereby notified that Company may procure an investigative consumer report concerning me from a consumer reporting agency or any "person" as defined by the California Consumer Credit Reporting Agencies Act (if a CA applicant). I understand that an investigative consumer report may contain information from public records, including but not limited to, written, oral or other communications bearing on my credit worthiness, credit standing, character, general reputation, personal characteristics, or mode of living, which may be obtained through personal interviews with neighbors, friends or associates of me and may or may not be used as a factor for employment purposes. I further understand that such inquiries may include, but are not limited to, investigations regarding worker’s compensation, harassment, violence, theft, or fraud.

I have received and reviewed a copy of the Summary of Rights under the FCRA and the California Investigative Consumer Reporting Agencies Act (If a California applicant). I understand that I have the right to request, in writing, information regarding the nature and scope of any investigative report prepared on me.

I authorize without reservation any party or agency contacted by this employer to furnish the above referenced information. I further authorize ongoing procurement of the above-referenced reports at any time, either during the time my application for employment is being considered or throughout the duration of my employment in the event that I am hired or am a current Company employee.

My Social Security number is ___________________________. My Date of Birth ("DOB") is ___/___/____.** Please see below.

**If ME, MI, MN, OH, PA, RI, or WV applicant DO NOT provide DOB.

Instead call 877-292-3331 within 2 hours of submitting your application.

My Previous Name (if any) is ________________________.

My Drivers License number is ___________________ and was issued by the state of ________.

If you have had another Drivers License in the last three years please put that number here: _______________________.

My High School, named ________________________, is located in (City) ________, (State)_______.

Current Address:

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<tr>
<th>No. Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
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Previous Addresses within the last seven (7) years: (Attach additional pages if necessary)

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<th>Years</th>
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</table>

Oklahoma, Minnesota and California applicants only:

You have the right to receive a copy of your Consumer Credit Report free of charge should one be requested for employment purposes.

☐ I wish to be furnished with a copy of my consumer credit report should one be ordered.

Applicant Signature: __________________________ Date: __________________________

I acknowledge that I have voluntarily provided the above information for employment purposes, and I have carefully read and I understand this authorization.

**The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.

Client Account Number: 927902 – LifeBridge Health

Private Eyes, Inc. 190 North Wiget Lane, Suite 220, Walnut Creek, CA 94598 at (925) 827-3333 or (877) 292-3331 Fax (877) 292-3330