ROCHESTER
REGIONAL HEALTH

Unity Guest Services Department

Application for Helping Hands PROGRAM

Name ____ Male Female
(Please circle one)

Address ____

City, State ____ Zip Code ________

Phone: Home ________________ Work ________________ Cell ________________

Person to notify in case of emergency ____

Emergency Phone ________________

Your E-mail address_______________________

Birth Date __________ (month and day only)

EDUCATION: Name of School Number of Years

High School ____

WORK EXPERIENCE (Please include any volunteer experience)

Employer Position Duties Dates Phone

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Why do you want to participate in the Helping Hands program?

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Time available for program: Hours per week? _________ Preferred days/time? _____________

If you are under 18 years of age, you will need to show your **work permit**, and **have a parent or guardian sign the permission statement below.**

Work Permit # __________

Permission Statement

I give permission for ____________________________ to participate in the Helping Hands Program.

DATE: ________________ **SIGNATURE**: ____________________________

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REFERENCES:
PLEASE DO NOT USE RELATIVES.
Please list the names, addresses and telephone numbers of at least two (2) people who can vouch for your reputation, character, and work record, and who have known you for at least one year. One of these should be a work reference, if applicable.

1. Name ____ Phone ______________________
Email Address ______________________
Address ____
Relationship to you:

2. Name ____ Phone ______________________
Email Address ______________________
Address ____
Relationship to you:

APPLICANT'S STATEMENT

1. I understand that acceptance to Helping Hands program will require a commitment pledge to be signed by applicant to participate.
2. If accepted as a Guest Services volunteer, I agree to abide by Unity's rules and regulations.
3. The information contained in this application is complete and true to the best of my knowledge.
4. Any misrepresentation or omission of facts will be cause for immediate dismissal.
5. I authorize Unity Hospital, Volunteer Services to contact any references for full information.
6. I agree to have a health assessment at Unity's Employee Health office if I am offered a Guest Services assignment, and ANNUALLY THEREAFTER.
7. I understand that no management representative has any authority to enter into any agreement for volunteer work which is contrary to the conditions listed above.
8. I understand that as a volunteer, I will be expected to observe confidentiality with respect to all information I may possess regarding my interactions with Rochester Regional Health, its clients, patients, residents and staff, and any knowledge of the contents of confidential records. Failure to adhere to this agreement is grounds for immediate dismissal. I also agree to maintain confidentiality after I leave Unity for whatever reason.
9. I hereby authorize Unity Hospital, Rochester Regional Health, to obtain personal reference and criminal record checks.

Signature ________________________________Date_________________________
Interviewed by______________________________________Date_________________
Identification reviewed by: ______________ Type of ID: _____________Date: ______________

Rochester Regional Health is an Equal Opportunity Organization and complies fully with Federal and New York State laws prohibiting discrimination because of sex, age, color, creed, marital status, nationality or origin, ancestry, availability for military service, disability, or any other characteristic protected by federal, state, or local law.

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