1813 Laurel Street Columbia, SC 29201 |Phone: (803) 254-6644 | Fax: (803) 254-2209
www.schivaidscouncil.org

Volunteer/Intern Application

Please print. Thank you.

Name:_____ Date:_____

Address:_____ City/Zip:_____

County:_____ Birthday_____

Employer: _____ Position:_____

Phone (Cell):_____ Phone (Work):_____

Phone (Home):_____ Date available to Start: _____

Is it okay to leave messages at your home or work or on your cell? __ Yes __ No _____

Email Address:_____

EDUCATION

Name of School Graduation Date Diploma/Major

_____

_____

_____

What area of Volunteer Service are you interested in?

__ Education/Outreach __ Advocacy/Policy __ PR/Marketing __ Communication __ Fund Raising __ Grant Writing __ Girls' & Women's Issues __ GLBT Issues __ HIV/AIDS Ministry __ Administrative __ Information Technology (IT) __As Assigned __ Internship __ Other (please explain below)

_____

_____

Revised 5/09/19
TAB

Describe the skills you bring that you feel would be beneficial to the organization?

_____
_____
_____

What other organizations have you volunteered with and what was your position?

_____
_____
_____

What did you like best about your last volunteer position?

_____
_____
_____

What did you like least about your last volunteer position?

_____
_____
_____

How did you hear about our volunteer program? __ Web __ Newspaper __Mail __Friend __Family __ Presentation/Event __School __House of Worship __Other: _____

Have you ever been convicted of a misdemeanor or felony offense to include crimes against children? __ Yes __ No If yes, please explain:

_____
_____

Are you willing to submit to a background check? ___Yes ___No

Do you have any physical limitations that would prevent you from performing volunteer assignments? __ Yes __ No
If yes, please explain:

_____
_____

When are you currently available to volunteer? Please specify the days of the week and hours during which you are potentially available each day (see page 3):

Monday _____ am/pm (until_____ am/pm Tuesday _____am/pm (until) _____ am/pm

Wednesday_____ am/pm (until) _____ am/pm Thursday _____ am/pm (until) _____ am/pm

Friday _____ am/pm (until) _____ am/pm Saturday _____ am/pm (until) _____ am/pm

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Can you commit to a minimum of five volunteer hours per month? ___Yes ___No

How long do you anticipate being a volunteer with the Wright Wellness Center?

_____

PLEASE ATTACH A CURRENT RESUME, IF AVAILABLE.

Emergency Contact Information:

Physician's Name: _____Phone:_____
Address, City, Zip: _____

Whom should we contact in the event of an emergency?
Name: _____ Phone: _____
Relationship: _____ Alternate Phone: _____

Release of Liability

This is to certify that I wish to participate by volunteering my services at the Wright Wellness Center. I hereby release the Wright Wellness Center, its agents, and employees from any liability or any consequences of my request to participate in this service. I make this release entirely of my own free will, without any threats, coercion or encouragement from any employee of the Wright Wellness Center.

_____ _____
Volunteer Signature Date

OFFICE USE ONLY	
Date Application Received: _____	Date of Interview: _____
Date of WWC Orientation: _____	□ Scheduled □Complete

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ALL SCHC/WWC VOLUNTEERS, SERVICE LEARNING STUDENTS & INTERNS AGREE TO:

1. Commit to a minimum of five (5) volunteer hours per month, for as long as you are available. Should you choose to discontinue your service as a volunteer, you agree to notify the Volunteer Coordinator or Human Resources Representative.
2. Maintain CONFIDENTIALITY at all times.
3. Attend any training that may be required.
4. Return all phone calls in a timely manner.
5. Follow all policy and procedures outlined during initial orientation.
6. Notify the Volunteer Coordinator or Human Resources Representative of any problems or concerns regarding a volunteer assignment.
7. Follow through on all accepted assignments
8. Follow all procedures as presented with regard to: buddy support, office assistance, or any volunteer assignments.
9. Provide feedback in an appropriate manner to staff, clients and other volunteers.
10. Carry yourself in an appropriate/professional manner when representing JHN Wellness in any meetings or training.

VOLUNTEERS WILL BE TERMINATED FOR ANY OF THE FOLLOWING:

1. Breaching CONFIDENTIALITY in any way.
2. Rudeness to a client, any member of client's support network, other volunteers, staff, or anyone for whom such rudeness might reflect negatively on SCHC.
3. Intentional negligence
4. Failure to drive safely, failure to obey posted traffic speeds, failure to use seat belts, failure to ensure client uses seat belts.
5. Being under the influence of a controlled substance or alcohol while serving as a representative of JHN Wellness.
6. Drinking alcohol or doing drugs while with a client or around a client.
7. Buying alcohol or drugs for a client.
8. Selling alcohol or drugs to a client.
9. Engaging in any behavior which could be considered illegal.
10. Having sex with a client.
11. Giving or lending money to a client 12. Borrowing or taking money from a client.

I AGREE THAT I HAVE READ AND UNDERSTAND ALL OF THE ABOVE, AND AGREE TO ADHERE.

_____ _____

Printed Name Signature

_____

Date

TO: All Employees, Contracted Individuals and Volunteers

FROM: Dr. Bambi Gaddist, Executive Director

Subject: Breach of Confidentiality

I agree to use the information obtained from the patient's records for continuing education, medical review, and study, and will preserve and protect privileged contents of the records and any other confidential information obtained. In addition, I acknowledge that any results obtained through this study/review are the sole use of Wright Wellness Center. Further, it's understood that this material is subject to Section 40-70-20 of the Code of Laws of the State of South Carolina concerning the confidentiality of materials and information acquired by the Quality Assurance Committee.

I understand that under Section 1166(b) of the Social Security Act, penalties may be fined of not more than $1,000.00 and/or imprisonment for not more than six months for breach of confidentiality of medical, identifying data, patterns of care, etc., on Medicare, Medicaid, and ChampVA patients.

_____ _____

Employee/Contracted Individual/Volunteer Date

Media Release Form

The Wright Wellness Center, and its designees, and affiliates will be using various individual, and/or group photographic, video images or personal information to document projects, and events using different types of media publication.

I irrevocably and absolutely consent to the unrestricted use of and waive any right to inspect or approve the finished images, copy, text, or other printed matter that may be used in conjunction therewith, and the eventual use to which the images may be applied.

By signing this form I, _____,
am granting permission to Wright Wellness Center, its designees, and affiliates to use my photo, video images, or personal information for different types of media publication.

E-mail Address_____
Printed Name_____
Signature_____
Date_____