



# DHCL Volunteer Application Packet

## Volunteer FAQ

◆ **How do I apply to become a volunteer?**

Volunteers must schedule an interview and submit an application packet. If it is a good fit and a volunteer position is offered, volunteers will schedule to attend a two hour orientation.

◆ **How do I set up an interview to become a volunteer?**

Call the Volunteer Services Coordinator at 302.223.1011 or email [Jennifer.Bobel@state.de.us](mailto:Jennifer.Bobel@state.de.us) to schedule an appointment for an interview.

◆ **Is there a minimum time commitment required to volunteer?**

We ask volunteers to commit to at least one 3 to 4 hour shift per week for at least 6 months.

◆ **When is the best time to apply to volunteer?**

Due to holiday preparations and programs, it is highly recommended that interested volunteers consider applying prior to October 1st, or after February 1st.

◆ **Do you have a program for high school students in the summer time?**

The student summer volunteer program applications are due by May 1st. Student summer orientation will be held on 2 dates TBA in early spring. Minimum age for volunteering is 14 years old without a parent .

◆ **What is included in the Volunteer Application Packet?**

The Volunteer Application Packet includes consent to check Public Sex Offender, Adult Abuse and Office of Inspector General registries & a child abuse registry consent form. (no cost to volunteer)

◆ **Is a flu vaccination required to volunteer?**

Flu vaccinations are required Nov 1st through May 1st. Volunteers must submit proof of vaccination and may be required to receive or to show proof of TB test.

# Delaware Hospital for the Chronically III Volunteer Opportunities

Do you have an **outgoing** personality? Are you willing to learn new things?  
Our residents need you!

**Activity Assistant** – Assist in our Activity Therapy program with craft activities, cooking group, Bingo and other games, parties, pushing residents in wheelchairs to and from activities, one on one visiting with residents. **\*Special Unit Activity Assistant-** assist staff with resident activities on specialized Alzheimer's/Dementia unit, pushing residents in wheelchairs and one on one visits. Requires a special person who is patient and willing to learn. Flexible hours.

**Friendly Visitors** – Make weekly visits with an assigned resident. Chat, a stroll or trip to the snack bar, go fishing, read a book, or other activity the resident may request. Flexible hours.

**Beauty Shop Assistant** – Assist cosmetologists with spa services- painting nails, hand massages, and transporting residents in wheelchairs to and from the beauty shop. Hours available are Monday through Friday from 8AM to 3PM.

**Physical Therapy Assistant**—Assist Physical Therapists, transport residents to and from Physical Therapy appointments. Hours available Monday—Friday from 8AM— 3PM.

**The Residents' Library** – Assist in the resident's library by shelving books, organizing returned and donated books, decorating display cases and assist residents select items.

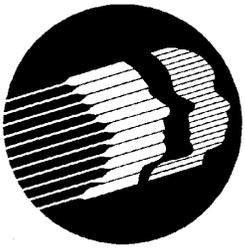
**\*Mobile Library cart** – take a cart with books and magazines from the library unit to unit offering to residents – especially those who are not able to visit the Library. Flexible hours.

**Gift Shop Assistant**— Assist the Women's Auxiliary operate the hospital gift shop, help residents, staff and visitors with purchases, and ring up sales. Hours available Monday —Friday from 11AM—4PM.

**Office Assistant** — Assist in a busy office with filing, logging donations, data input, shredding and general organization. Exceptional customer service, phone etiquette, penmanship, and attention to detail is required. Hours available Tuesday & Thursday 9AM-12PM and/or 1PM to 4PM. (currently filled)

**Donation Room Organizer** — Assist with keeping the donations organized and easily accessible in the Volunteer Services donation room. Keep shelves clean and tidy, organize donations according to season, clothing sizes etc. Hours available Tuesday & Thursday 9AM-12PM and/or 1PM to 4PM.

**Information Desk Volunteer** — Assist in the main lobby by greeting visitors, providing information to family, residents and guests. Exceptional customer service, phone etiquette, penmanship, and attention to detail is required. Hours available Monday— Friday 1PM to 4PM.



# Delaware Hospital for the Chronically III Volunteer Application

## Mission Statement

It is our mission to provide quality care and support to those we serve.

### Personal Information

Date \_\_\_\_\_

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

Nickname \_\_\_\_\_

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

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

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

### Personal History \*optional

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

Check appropriate blank \_\_\_ employed \_\_\_ unemployed \_\_\_ student \_\_\_ retired \_\_\_

Employer/School \_\_\_\_\_ Phone \_\_\_\_\_

Title/Position \_\_\_\_\_ May we contact if necessary? \_\_\_ yes \_\_\_ no

Have you ever been convicted of or pled guilty to a crime other than a misdemeanor or traffic violation? If no, state No. If yes, please explain. An answer must be provided or application will not be processed. \_\_\_\_\_

### Emergency Information

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Do you have any health or physical limitations that could affect your volunteer assignment? \_\_\_ yes \_\_\_ no

If yes, please explain:

### Volunteer Information

#### How did you learn about our Volunteer Program?

\_\_\_ Friend/Family member \_\_\_ Newspaper \_\_\_ Volunteer Match \_\_\_ Facebook \_\_\_

\_\_\_ School/Employer \_\_\_\_\_

What motivated you to volunteer?

Previous or current volunteer experience:

What are your special skills, experience, talents, and o hobbies that you can utilize as a volunteer:

## Commitment of Confidentiality

I, \_\_\_\_\_, understand my obligation to maintain complete confidentiality of information in order to protect residents and their families, as well as all members of DHCI and any affiliate from improper disclosure of information, particularly when the information is related to the health, business or personal matters of those listed above. I also understand that confidentiality must be maintained regardless of the source of information. I understand that if I violate confidentiality I will be released from volunteer service.

**Applicant Signature** \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Legal Guardian Signature** \_\_\_\_\_ Date \_\_\_\_\_  
(Required if Volunteer is under 18 years of age)

## Agreement

During the processing of this application and, if accepted into the Volunteer Program at the Delaware Hospital for the Chronically Ill (DHCI), I agree to the following.

1. I give permission for a tuberculosis skin testing (PPD) to be conducted once a year or as necessary.
2. I agree to abide by all facility rules and regulations and those of the Volunteer Department. I understand that if placed, my placement will be subject to the conditions of any applicable introductory period established by facility policies. I understand that I may end my volunteer service with the facility at any time. In order to remain in good standing and be considered for future service, a two week notice is required. In addition, my service may be discontinued by the facility at any time and for any reason. Finally I understand that a volunteer position and any related documents are in no way a contract, promise, or consideration of employment.
3. I give permission to DHCI to investigate any and all information concerning my application to determine my qualifications. This includes but is not limited to criminal background checks, adult abuse registry checks, child abuse registry checks, sex offender checks, employment checks and personal reference checks.
4. In the event of resignation or termination, I agree to return all facility property such as badges, books, etc.
5. I understand that I must commit at least twenty hours of volunteer service before any references can be completed on my behalf, unless otherwise arranged.

My signature below indicates that I have read, understand, and consent to the above statement. This authorization or photocopy shall serve as consent for the facility to request any information concerning my application.

**Applicant Signature** \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Legal Guardian Signature** \_\_\_\_\_ Date \_\_\_\_\_  
(Required if applicant is under 18 years of age)

## Affirmation

I \_\_\_\_\_ understand that falsifying any information on this application will disqualify me from being able to participate in the Volunteer Program. I affirm that all of the information I have provided on this application is accurate to the best of my knowledge.

**Applicant Signature** \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Legal Guardian Signature** \_\_\_\_\_ Date \_\_\_\_\_  
(Required if Volunteer is under 18 years of age)

### STUDENT APPLICANTS ONLY

Name of School presently attending \_\_\_\_\_

Grade \_\_\_\_\_ Course of Study \_\_\_\_\_

Volunteering for a School Project? \_\_\_\_\_ yes \_\_\_\_\_ no Amount of hours needed \_\_\_\_\_ hours

Volunteering for Delaware credit? \_\_\_\_\_ yes \_\_\_\_\_ no Amount of hours needed \_\_\_\_\_ hours

Parent/Legal Guardian Name \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

#### Parent/Legal Guardian Permission

I \_\_\_\_\_ as the parent/legal guardian of the above applicant give him/her permission, if accepted, to be part of the Volunteer Services Program at DHCI.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

#### STUDENT VOLUNTEER TUBERCULOSIS TESTING PERMISSION FORM

Please print all information except your signature and return the form so that testing may be scheduled.  
If you have any questions, please contact the Employee Health Nurse @ 302-223-1318.

I, \_\_\_\_\_, give permission for my minor child to be tested for Tuberculosis. I am not aware of any active symptoms at this time or any past diagnosis of Tuberculosis.

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_

#### OFFICE USE ONLY

Date Received: \_\_\_\_\_ Interview Date: \_\_\_\_\_

Orientation Date: \_\_\_\_\_ Badge Issue Date: \_\_\_\_\_

PPD Testing Dates: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Adult Abuse Check Date: \_\_\_\_\_ Child Abuse Check Date: \_\_\_\_\_

Sex Offender Check Date: \_\_\_\_\_

Approve

Deny

Volunteer Coordinator Signature: \_\_\_\_\_

Termination Date: \_\_\_\_\_ Badge Returned: \_\_\_\_\_



# Delaware Hospital for the Chronically Ill Volunteer Services Applicant Survey

In which areas of the Hospital would you be interested in volunteering?  
Check all that apply.

	Friendly Visitor		Activity Assistant– Special Unit
	Activity Assistant		Office Assistant
	Beauty Shop		Donation Room Organizer
	Adult Day Care		Women’s Auxiliary Gift Shop
	Physical Therapy Assistant		Talents or Skills
	Library/ Cart		High School Student Summer Program (June— August, Application due 5/1)

Other please explain:

## Day & Time Availability

I am interested in working \_\_\_\_\_ hours per week.

Please indicated which days you are available: Sun / Mon / Tues / Wed / Thurs / Fri /Sat

What time of the day are you available? \_\_\_\_\_ AM/PM until \_\_\_\_\_ AM/PM

Applicants Name: \_\_\_\_\_

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



# DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Fax or Mail Request to:

DSCYF, OCCL  
Criminal History Unit  
1825 Faulkland Road  
Wilmington, DE 19805

Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- Allow 15 working days for results to be processed
- Do not use a cover sheet
- Do not send duplicate requests
- Form must be submitted to DSCYF within 90 days of signature date in order to be processed

## PART I. APPLICANT INFORMATION (*PLEASE PRINT CLEARLY*)

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

Other Name(s) used: \_\_\_\_\_ DE Drivers License # \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
mm / dd / yyyy

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Have you ever been involved in a substantiated case of child abuse or neglect? [ ] Yes [ ] No

If Yes, explain: \_\_\_\_\_

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

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

Parent / Guardian Signature (If applicant is under the age of 18) \_\_\_\_\_

## PART II. AGENCY/ORGANIZATION INFORMATION - (*MUST BE COMPLETED IN ORDER TO PROCESS*)

**Please check only one:**

EDUCATION  HEALTH CARE FACILITY  CHILD CARE  OTHER \_\_\_\_\_

Agency Identification Number (if applicable): 1085

Requesting Agency Name: Delaware Hospital for the Chronically Ill--Volunteer Services

Address: 100 Sunnyside Road, Smyrna, DE 19977

Phone: (302)223-1011 Fax: (302)223-1275 Contact Person: Jennifer Bobel

### DSCYF USE ONLY:

The individual listed above ( \_\_\_ is listed) ( \_\_\_ is NOT listed) on the Delaware Child Protection Registry.

Date: \_\_\_\_\_ DSCYF Criminal History Unit \_\_\_\_\_