GCMH Volunteer Application

Grundy County
Memorial Hospital
UnityPoint Health

		Applicant informa	lion		
Full Name.	Last	First	N.I.	SSN:	
	Last	F1131	IVI.1.		
			-		
Address:	Street Address/ Apartment/Unit #		Birt	hdate:	
	Street Address/ Apartment/Unit #				
	City		State	ZIP Code	
	-				
Phone:		Email:			
		Emergency Cont	act		
		Emergency cont			
Name:			Relationship:		
Address:					
	Street Address/ Apartment/Unit #				
	-				
	City		State	ZIP Code	
Cell Phone:					
	Wa	ork or Volunteer H	listory		
Company:			Contact:		
Responsibi	lities:				
Component			Contract		
Company:			Contact:		
Deeneneihi	14100				
Responsibilities:					
Company:			Contact:		
Responsibilities:					
Company:			Contact:		
Responsibi	lities:				

References

Please list two personal or professional	references. (Please exclude relatives)
Full Name:	Relationship:
Email:	Bhono
Address:	
Full Name:	Relationship:
Email:	Phone:
Address:	
How did you hear about volunteering at G	Volunteer Interest
Why would you like to volunteer at GCMH:	·
Please list any hobbies, skills, or interests	s you have that might be helpful in your volunteer work.

Statement of Agreement and Signature

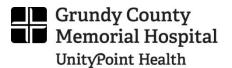
I am interested in serving as a volunteer at Grundy County Memorial Hospital and I am prepared to devote a minimum of one year to this organization. I agree to abide by the Policies and Procedures of the hospital and follow the Dress Code. I agree to keep all patient/resident information completely confidential and uphold all confidentiality requirements. I understand that I must complete the application in its entirety, receive a TB test, attend Orientation, and strictly adhere to the Volunteer Services guidelines.

I understand that this organization is not obligated to provide a placement, nor am I obligated to accept the position offered. All information in this application is accurate. I will hold this organization blameless if I incur an injury as a result of my work as a volunteer. I agree to return my photo ID badge when I leave the Volunteer program.

Signature:

Date:

GCMH Volunteer Services



Medical Information Release Form

hereby authorize my provider:to provide Grundy County Memor				
with the requested information regarding my hea	lth.			
Volunteer's Signature:	Date	Date:		
Below com	pleted by your provider			
Name:	Date of Birth:			
The above-named person:				
DOES NOT have any physical, mental, infectious, Manager should be aware of before assigning thi		Services		
DOES have physical, mental, infectious, or medic Coordinator should be aware of before assigning				
Explanation:				
This person should NOT perform the following ta				
	Sitting (4 hours)			
Standi	ng/Walking (4 hours)			
	Pushing wheelchairs			
Lifting over	r how many pounds?	<u>-</u>		

STATE OF IOWA Criminal History Record Check Request Form	
DCI Account Number:	(if



Mail or Fax completed forms to:	(if applicable) Send results to:
Iowa Division of Criminal Investigation	Name
Support Operations Bureau, 1 st Floor 215 E. 7 th Street	Address
Des Moines, Iowa 50319	
(515) 725-6066	
(515) 725-6080 Fax	Phone
	Fax

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
Date of Birth (mandatory)	Gender (mandatory)	Social Security Number (recommended)
	□Male □Female	

Release Authorization: Without a signed release from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For <u>complete</u> criminal history record information, as allowed by law, always obtain a signed release from the subject of the request.

This form (DCI-77) is the only approved release authorization form for this purpose.

Release Authorization: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law. I understand this can include information concerning completed deferred judgments and arrests without dispositions.

Release Authorization Signature:

	Iowa Criminal History Record Check Results	(DCI use only)
As of	, a search of the provided name and date of birth revealed:	
	No Iowa Criminal History Record found with DCI	
	Iowa Criminal History Record attached, DCI #	
	DCI initials	

Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person for whom information is requested and email to <u>dhsabuseregistry@dhs.state.ia.us</u>, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

Child Abuse Registry

Dependent Adult Abuse Registry

Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

Section 1: To be completed by the person or agency requesting the information.					
Requester: Last First	Agency Name			Telephone Number ()	
Address			Fax Number ()		
City		State	Zip Code	Email	
List the name and address of the person whose inf	formation	is being requ	lested:		
Name (last, first, middle)			Birth Date	Social Sec	urity Number
Address	City		County	State	Zip Code
List maiden name, previous married names, and a	<mark>ny alias:</mark>			·	
What is the purpose of your request for child or dep	pendent a	adult abuse ir	nformation?		
I have read and understand the legal provisions for on the second page of this form.	r handling	g child and de	pendent adult abuse	e information	which is printed
Signature of Requestor				Date	
Section 2: To be completed by the person child or dependent adult abuse		• •	partment of Humai	n Services t	o release their
I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (Iowa Code section 235A.15) or dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct.					
Signature of Person Authorizing Date					
Section 3: To be completed by the Central A	buse R	egistry or de	esignee.		
 The person whose information is being requested is listed on the Child Abuse Registry as having abused a child. The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child. The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult. The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult. The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult. The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult. This request for information is denied because the form is incomplete. 					
Signature of Registry Staff or Designee				Date	
Comments					