GCMH Volunteer Application

Grundy County Memorial Hospital
UnityPoint Health

Applicant Information

Full Name: _____ **SSN:** _____
Last *First* *M.I.*

Address: _____ **Birthdate:** _____
Street Address/ Apartment/Unit #

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Address: _____
Street Address/ Apartment/Unit #

_____
City *State* *ZIP Code*

Cell Phone: _____

Work or Volunteer History

Company: _____ **Contact:** _____

Responsibilities: _____

Company: _____ **Contact:** _____

Responsibilities: _____

Company: _____ **Contact:** _____

Responsibilities: _____

Company: _____ **Contact:** _____

Responsibilities: _____

References

Please list two personal or professional references. ***(Please exclude relatives)***

Full Name: _____ **Relationship:** _____

Email: _____ **Phone:** _____

Address: _____

Full Name: _____ **Relationship:** _____

Email: _____ **Phone:** _____

Address: _____

Volunteer Interest

How did you hear about volunteering at GCMH: _____

_____

Why would you like to volunteer at GCMH: _____

_____

Please list any hobbies, skills, or interests 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

Grundy County Memorial Hospital
UnityPoint Health

Medical Information Release Form

I hereby authorize my provider: _____ to provide Grundy County Memorial Hospital with the requested information regarding my health.

Volunteer's Signature: _____ Date: _____

Below completed by your provider

Name: _____ Date of Birth: _____

The above-named person:

DOES NOT have any physical, mental, infectious, or medical disability which the Volunteer Services Manager should be aware of before assigning this person to an area in a hospital. ☐

DOES have physical, mental, infectious, or medical disability which the Volunteer Services Coordinator should be aware of before assigning this person to an area in the hospital. ☐

Explanation: _____

_____

_____

This person should NOT perform the following task:

Sitting (4 hours) ☐

Standing/Walking (4 hours) ☐

Pushing wheelchairs ☐

Lifting over how many pounds? _____

Provider's Signature: _____ Date: _____

STATE OF IOWA
Criminal History Record Check Request Form

DCI Account Number: _____
(if applicable)

Mail or Fax completed forms to:

Iowa Division of Criminal Investigation
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

Send results to:

Name _____

Address _____

_____

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 complete 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 dhsabuseregistry@dhs.state.ia.us, 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.

☐ Address ☐ Fax ☐ Email

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 information is being requested:

Name (last, first, middle)		Birth Date	Social Security Number	
Address	City	County	State	Zip Code

List maiden name, previous married names, and any alias:

What is the purpose of your request for child or dependent adult abuse information?

I have read and understand the legal provisions for handling child and dependent adult abuse information which is printed on the second page of this form.

Signature of Requestor	Date

Section 2: ***To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information.***

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 Abuse Registry or designee.***

☐ 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.

☐ This request for information is denied because the form is incomplete.

Signature of Registry Staff or Designee	Date

Comments