DHCI 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: tina.wagner@delaware.gov 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 summertime? 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 16 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 end of September 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 Ill 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.

Delaware Hospital for the Chronically Ill
Volunteer Application

Date:_____

Please indicate our areas of interest:

- ☐ Activity Assistant
- ☐ Activity Assistant- Special Unit
- ☐ Church Services
- ☐ Physical Therapy Assistant
- ☐ Office Assistant
- ☐ Pet Therapy
- ☐ Donation Organizer Room
- ☐ Music & Memory Assistant

First Name_____ Last Name_____ MI_____

Nickname_____

Address_____

City_____ Zip_____

Home Phone_____ Cell Phone _____

Email_____

Emergency Contact: _____ Relationship: _____

Phone:_____

Have you ever volunteered at Delaware Hosptial for the Chronically Ill? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

Have you had any criminal convictions for child abuse? ☐ Yes ☐ No

Why are you interested in volunteering at Delaware Hospital for the Chronically Ill?

_____

_____

_____

_____

Are you required to volunteer? ☐ Yes ☐ No

If yes, how many hours are needed? _____ Deadline: _____

Name of school/agency:_____

Please indicate the days and times you are available to volunteer:

Monday	Start time		End time		Friday	Start time		End time	
Tuesday	Start time		End time		Saturday	Start time		End time	
Wednesday	Start time		End time		Sunday	Start time		End time	
Thursday	Start time		End time						

References: List three references that have known for at least three years whom you authorize us to contact References may include supervisors, co-workers, faith leaders, teachers, or school counselors. One reference must be a family member or guardian.

Family Member	Email: Phone:	
Personal or Professional	Email: Phone:	
Personal or Professional	Email: Phone:	

Signature

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 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 an applicant is under 18 years of age)

Affirmation

I_____ understand that falsifying 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 an applicant 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 @ 302-354-1053.

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 CHILD PROTECTION REGISTRY CONSENT FORM

Web Portal

Request must be within 90 days of signature date in order to be processed

PART I - APPLICANT INFORMATION

Name (Last*, First*, Middle):

Other Name(s) used/Alias:

Social Security #:

Date of Birth (mm/dd/yyyy)*:

Gender*:

Race:

Ethnicity: (Hispanic/Non-Hispanic)

Address (Street, City, State, Zip):

Are you on the Delaware Child Protection Registry for any substantiated cases of child abuse/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 requester(s) with all substantiated cases of child abuse or neglect concerning me that are active on the Delaware 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 - REQUESTER INFORMATION

Check one option below and complete required information*:

1. ☐ Agency Request – Agency Name*:

2. ☐ Individual Request – Self

3. ☐ Individual Request – Share Results with Requesting Agency

   Requesting Agency 1 – Agency Name*:
   Requesting Agency 2 – Agency Name*:
   Requesting Agency 3 – Agency Name*:
   Requesting Agency 4 – Agency Name*:
   Requesting Agency 5 – Agency Name*:

* Mandatory (Agency Name is Mandatory.)