



NAME

VOLUNTEER APPLICATION

MT. WASHINGTON
PEDIATRIC HOSPITAL, INC.
An affiliate of North Arundel Health System, Inc.

1708 W. Rogers Avenue
Baltimore, Maryland 21209
(410) 578-8600



PROVIDING REHABILITATION
AND SPECIALTY CARE
FOR CHILDREN

**EDUCATION
AND
TRAINING**

CIRCLE HIGHEST GRADE COMPLETED:

GRADE SCHOOL HIGH SCHOOL COLLEGE GRADUATE
 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 1 2 3 4

SCHOOL OR PROGRAM	NAME	LOCATION	DATES ATTENDED FROM / TO	DEGREE OR MAJOR
HIGH SCHOOL				
COLLEGE (UNDERGRAD)				
COLLEGE (GRADUATE)				
APPRENTICE-SHIPS				
BUSINESS OR VOCATIONAL				

OTHER SPECIAL SKILLS OR TRAINING (E.G., HEALTH CARE, BUSINESS OR INDUSTRIAL EQUIPMENT OPERATED, SPECIAL COURSES, FLUENCY IN FOREIGN LANGUAGE, ETC.)

TYPING: APPROXIMATELY ___ WPM SHORTHAND: APPROXIMATELY ___ WPM

REFERENCES

LIST AT LEAST THREE (3) REFERENCES THAT ARE NOT RELATIVES OR EMPLOYERS:

NAME	RELATIONSHIP	COMPANY NAME AND ADDRESS	PHONE

**PRESENT
EMPLOYMENT,
IF APPLICABLE**

NAME AND ADDRESS OF EMPLOYER: _____

EMPLOYER'S PHONE: _____ DATE HIRED: _____

NAME AND TITLE OF SUPERVISOR: _____

TITLE/POSITION: _____ WORK HOURS: _____

HAVE YOU EVER BEEN CONVICTED OF A SERIOUS CRIME? NO YES

IF YES, EXPLAIN FULLY: _____

PLEASE NOTE: IT IS THE HOSPITAL'S POLICY TO CONSIDER THE NATURE , CHARACTER, DATE AND SEVERITY OF INDIVIDUAL CONVICTIONS, AND TAKE INTO ACCOUNT ANY REHABILITATION OR EXTENUATING CIRCUMSTANCES OF THE OFFENCE, AND HOW IT RELATES TO THE JOB, PRIOR TO RENDERING A DECISION ON PROSPECTIVE VOLUNTEERING.

DO YOU HAVE ANY PHYSICAL OR EMOTIONAL LIMITATIONS THAT MUST BE CONSIDERED WHEN PLACING YOU IN A VOLUNTEER POSITION? NO YES

IF YES, EXPLAIN FULLY: _____

Please Read and Sign The Following Statement:

I hereby affirm that all statements and answers made in connection with this application, and any subsequent inquiries requested, are true and correct. It is understood and agreed that any willfull misrepresentation by me will be sufficient cause for cancellation of the application and/or separation from the hospital's service at any time after I have begun to volunteer. I give Mt. Washington Pediatric Hospital, Inc., permission to contact employers, supervisors, and any other source concerning my activities, and I hereby release such reference sources from any liability for the consequences of information which they may release to Mt. Washington Pediatric Hospital, Inc.

Applicant's
Signature: _____ Date: _____

**Mt. Washington Pediatric Hospital, Inc.,
in conjunction with applicable laws,
does not discriminate on the basis of race, color,
religion, national origin, sex, age, physical or mental handicap,
or Veteran status in the selection and placement of volunteers.**

MT. WASHINGTON PEDIATRIC HOSPITAL, INC.
VOLUNTEER HEALTH ASSESSMENT

Identification Data: Fill in the following. Please print

Name _____ Date of Birth _____
Sex: Male _____ Female _____

Social Security Number _____ Area Code, Phone Number _____

Address _____ Volunteer Job Title _____

City, State and ZIP code _____

Health History: mark an "X" next to any of the following illnesses you now have or have ever had.

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Musculoskeletal problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Hives or rashes |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney/bladder trouble |
| <input type="checkbox"/> Cancer/tumor | <input type="checkbox"/> Liver disease/hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Bowel/Stomach problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Rheumatism/arthritis |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin disorders |

Have you had any work-related injuries or illnesses? yes no. If yes, explain _____

Do you have any drug allergies? Explain _____ Other allergies? _____

Immunization/ infectious disease history: Place an "X" next to those infections/immunizations you have had.

Measles German measles Mumps Chicken pox Polio

Have you ever had a tuberculosis skin test? yes no. Was there a reaction requiring a chest X-ray? yes no.

Have you ever been turned down for life insurance, military service or employment because of health problems? yes no. If yes, explain _____

Current health status: Mark an "X" next to the following for any current problem.

Never smoked Smoking currently Stopped smoking years ago

Alcohol consumption daily weekly never

Drug use Cough

Eye/vision problems Shortness of breath

Hearing Problems Frequent headaches

Do you wear glasses? yes no; contact lens yes no.

List any medications that you are taking _____

I testify that the information which I have given is accurate and complete.

Signature

Date

The following statement must be signed by your health provider (physician or health service)

I have examined the above prospective volunteer and find him/her mentally and physically able/
unable to perform duties at Mt. Washington Pediatric Hospital.

Print name of examiner

Signature

Address of examiner

Date of assessment



**AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A
CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT
(PLEASE PRINT OR TYPE)**

I, the undersigned consumer, do hereby authorize MT. WASHINGTON PEDIATRIC HOSPITAL, by and through its independent contractor, **KROLL BACKGROUND AMERICA, INC. ("KBA")**, to procure a consumer report and/or investigative consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character, general reputation personal characteristics and mode of living, discerned through employment and education verifications; personal references; personal interviews; my personal credit history based on reports from any credit bureau; my driving history including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to KBA, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681et. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to MT. WASHINGTON PEDIATRIC HOSPITAL, by and through KBA, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release MT. WASHINGTON PEDIATRIC HOSPITAL, KBA and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said Company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application for employment will be terminated based on any false, omitted or fraudulent information.

Signature: _____ Other Names Used (past 7 yrs) _____

Printed Name: _____ Date: _____

Current Address:	First	Middle	Last	Date:	
Street / P. O. Box	City	State	Zip Code	County	Dates

Address for the past 7 years:

Former Address:	City	State	Zip Code	County	Dates
Street / P. O. Box	City	State	Zip Code	County	Dates

Former Address:	City	State	Zip Code	County	Dates
Street / P. O. Box	City	State	Zip Code	County	Dates

Social Security Number: _____ Daytime Telephone Number: _____

Driver's License Number: _____ State of Issuance: _____ Date of Birth*: _____ Gender* _____

- Have you ever been convicted of a crime or convicted in a military court martial? Yes _____ No _____
- Have you ever been sanctioned or had your licenses suspended or revoked? Yes _____ No _____

