

# Information for Aggieland Volunteer Applicants

Howdy! Thank you for your interest in becoming an Aggieland Volunteer at the College Station Medical Center! Before you can start volunteering, there are some steps you need to take. Please follow the instructions below to get the process started.

**STEP 1: Complete the “Aggieland Volunteer Application.”**

**STEP 2: Complete the “Aggieland Volunteer Opportunities” sheet.** At the top of this sheet, please list the hours that you are available to volunteer. Then, indicate your top three preferences as to where in the hospital you would like to do your volunteer work. Place a “1” next to your top choice, a “2” next to your second choice, a “3” next to your third choice, and a “√” next to all others that you would find acceptable. If you are accepted as a volunteer, we will do our best to accommodate your preferences. However, since the volunteer schedule is made on a “first come, first serve” basis, we cannot guarantee that you will be placed in one of your preferred areas.

**STEP 3: Read and complete the “Substance Test Consent, Release, and Disclosure Form.”** All volunteers at The Med are required to undergo a urinalysis. A list of prescription drugs that will trigger a positive test is on the second page of this form. If you are taking any of these medications, you will simply need to show a prescription for them when the positive results come in. The results of this screening are kept confidential. You will need to sign this document in the presence of a witness. Anyone over 18 may serve as your witness.

**STEP 4: Complete a drug test.** Take the “Substance Test Consent, Release, and Disclosure Form” to the College Station Medical Center lab, where you will give a urine sample. If you need help finding the lab, just ask the front desk personnel and they will direct you. There is no charge for this screening, and no appointment is necessary.

**STEP 5: Read and complete the “Certification and Authorization for Volunteers.”** All volunteers at The Med are also required to submit to a background check. This document gives us permission to run this background check. Once again, please know that the results of this background check will remain confidential.

**STEP 6: Call Jeff Borcharding, Director of Volunteer Services at 979-764-5164.** Jeff will sign you up for an orientation session and explain the rest of the process.

**STEP 7: Get a TB skin test.** You will also be required to get a TB skin test before you are allowed to volunteer. Jeff Borcharding will give you more information about this during your orientation.

Thank you again for your interest in volunteering at The Med. The assistance of our volunteers has a huge impact on both our patients and staff. If you have any questions, please call **979-764-5164**.



College Station  
Medical Center



**AGGIELAND VOLUNTEER APPLICATION**

**PERSONAL INFORMATION**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Hometown: \_\_\_\_\_

Do you speak any foreign languages?  No  Yes- If yes, please list.

\_\_\_\_\_

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**EMERGENCY INFORMATION**

Emergency Contact \_\_\_\_\_

Relationship to you \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**QUESTIONNAIRE**

**1. Why are you interested in volunteering?**

\_\_\_\_\_

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\_\_\_\_\_

**2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)?** No  Yes  – If yes, please describe the service requirements.

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**3. Is there anything that may adversely affect your ability to perform volunteer work?** No  Yes  – If yes, please describe in detail

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**4. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested?**

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**5. Do you have any physical, visual or hearing needs we need to consider?**  
No  Yes  – If yes, please explain: \_\_\_\_\_

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**6. Are you physically able to transport patients in a wheelchair?** Yes  No

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**EDUCATION:**

Currently enrolled at (check one):  Blinn JC  TAMU  Other: \_\_\_\_\_

Classification: Fr  So  Jr  Sr  Graduate School  Current GPA: \_\_\_\_\_

Degree/Major: \_\_\_\_\_

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**OTHER:**

**1. Have you ever been convicted of a felony?** Yes  No

**2. Have you ever been convicted of a misdemeanor?** Yes  No

If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

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3. How did you hear about this volunteer program? \_\_\_\_\_

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4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type?      No  Yes  – Please list: \_\_\_\_\_

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**Certification and Authorization**

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

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

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

# COLLEGE STATION MEDICAL CENTER

## Aggieland Volunteer Opportunities

Name \_\_\_\_\_

**AVAILABILITY:** Please list all hours available each day:

M: \_\_\_\_\_ F: \_\_\_\_\_

T: \_\_\_\_\_ Sa: \_\_\_\_\_

W: \_\_\_\_\_ Su: \_\_\_\_\_

Th: \_\_\_\_\_ # of weekly hrs desired (4 min): \_\_\_\_\_

**PREFERRED AREAS:** In the list below, please put a “1” next to your most preferred area, a “2” next to your second most preferred area, a “3” next to your third most preferred area, and an “J” next to all other areas that you would find acceptable.

### Non-Clinical

*M-F, 8am-5pm*

- Administration
- Human Resources
- Health Information Management (Medical Records)
- Business Office
- Marketing
- Dietary
- Admitting / Registration
- Case Management

*Pharmacy (M-F, 7am-11pm; Sa-Su, 8am-6pm)*

### Clinical

*7am-11pm, 7days/week*

- Emergency Department
- ICU
- Labor and Delivery
- Medical
- NICU
- Nursery
- Pediatrics
- Post Partum
- Surgical / Oncology / PCU

*M-F, 8am-5pm*

- Diagnostic Imaging
- Respiratory Therapy

*M-F, 6am-2pm*

- Surgical Services
- Cardiac Cath Lab

### Physical Therapy

*8am-5pm, M—F*

- Inpatient Rehab (2<sup>nd</sup> Floor)
- Outpatient Therapy (4<sup>th</sup> Floor 1602 Rock Prairie Road)
- Speech Pathology

## SUBSTANCE TEST CONSENT, RELEASE AND DISCLOSURE FORM

**Applicant/Employee/Contractor Name:** \_\_\_\_\_

As an applicant/employee/contractor/volunteer, I understand that CHS/Community Health Systems, Inc. and its affiliates (“CHS”) have a strict policy prohibiting the use of Substances including, but not limited to, illegal (“street”) drugs and prescription drugs without a current, valid prescription. I understand that CHS screens for groups of Substances that are commonly used (see list below).

If I am an applicant and test positive for Substances, I understand that I will generally not be eligible for employment or for volunteering. If I am employee and test positive for Substances, I understand that my employment may be terminated. If I am a contractor or volunteer and test positive for Substances, I understand that my contractual or volunteer relationship with CHS may be terminated. However, if I test positive for the use of Substances as a result of the use of prescription drugs for which I have a current, valid prescription and such use is consistent with the prescription, such positive test generally will not limit my status with CHS; provided that, in certain cases, I understand that my status may still be affected by the use of prescription drugs if my position involves patient care or hazardous settings and the use of such drugs could limit my ability to safely perform my duties and obligations to CHS.

I understand that I am being asked to provide a breath, blood, urine, hair, and/or saliva specimen (collectively, a “Specimen”) for testing to determine the presence of alcohol, drugs, or other Substances in my system. I understand that I do not have to provide such Specimens. However, if I choose not to do so, I understand that my refusal will result in the following, as applicable: my permanent disqualification from consideration for employment with CHS; termination of my employment with CHS and ineligibility for rehire; or termination of my contractor or volunteer relationship with CHS and ineligibility to contract or volunteer with CHS in the future.

I hereby give consent to and authorize this facility and its affiliates together with each of their agents, employees, physicians, and other health care providers (collectively, the “Testing Group”) to take Specimens and to use such Specimens in any manner that the Testing Group deems appropriate, including, but not limited to, releasing such Specimens to testing laboratories, hospitals, other persons or service providers for testing. I hereby give consent to and authorize the Testing Group to conduct tests for Substances including, but not limited to, drug and alcohol and to release the results of the tests or other information concerning the Specimens to CHS and any of its representatives or to any other persons or firms designated by the Testing Group or CHS. I further consent to and authorize disclosure by the Testing Group and/or CHS to any law enforcement or licensing authorities upon request of such entities without the necessity of a subpoena or other legal process.

I hereby release the Testing Group; any testing laboratory, hospitals, persons, or service providers conducting tests for the Testing Group; and CHS together with any of its officers, agents, employees, physicians, and other health care providers from any and all claims, causes of action, damages, or liabilities arising out of or relating to the testing or use or dissemination of test results, including, but not limited to, all claims for injuries or damages arising out of our relating to the collection of Specimens, procedures, the release of information or results concerning such testing, any action taken regarding any employability or continued employment as a result of such testing and/or test results, and any action taken regarding continued contractual relationship as a result of such testing and/or test results.

Employees (*not applicants or contractors*) are given the opportunity to disclose the illegal use of Substances, **in advance of testing only**, that may result in a positive test to potentially avoid termination of employment. The advance disclosure of drugs for which an employee does not have a current, valid prescription may subject an employee to rehabilitation and reinstatement provisions under the CHS Substance Abuse Policy. This advance disclosure opportunity may be utilized one time only during the employment relationship.

I also understand that, if the test is positive, applicants/employees/contractors/volunteers may be required to disclose any lawful use of Substances and/or provide explanations for a positive result other than the illegal use of such Substances. This may include the disclosure of medication taken under a lawful prescription. I further understand CHS is not inquiring about any medical condition or disability – only the name of the Substance.

Substances to be tested for include, but are not limited to, the following:

<b>Drug Group</b>	<b>Common Names</b>
Amphetamines	Adderall, Dexidrine, Desoxyn, meth, crystal meth, speed, MDA, bennies, uppers
Cocaine Metabolite	Procaine (Novocaine), crack, coke, rock, benzoylecgonine
Marijuana Metabolites	Cannabinoids, cannabis, grass, dope, reefer, weed, pot, hash, THC
Opiate Metabolites	Empirin w/codeine, Tylenol w/codeine, Robitussin A-C, Laudanum, Roxanol, heroin, codeine, morphine
Phencyclidine	PCP, angel dust, hog
Barbiturates	Amytal, Nebutal, Seconal, Phenobarbital, Barbitol, Butalbital, barbs, reds, yellows, downers
Benzodiazepines	Alprazolam, Ativan, Halcyon, Librium, Valium, Xanax, Versed, Benzadrine, downers, sleeping pills
Methadone	Amidone, Dolophine, fizzies
Methaqualone	Quaalude, ludes
Propoxyphene	Darvon, Darvocet, Dolene, yellow footballs
Meperidine	Demerol
Oxycodone	Oxycontin, Percocet, Percodan, Endocet
Hydromorphone	Dilaudid
Hydrocodone	Lortab, Vicodin
Fentanyl	Actiq, Duragesic, Sublimaze, apache, china white

### Consent and Disclosure

**I have read the foregoing and:**

**1. Consent (check one)**

- I consent to provide a Specimen for use in the manner described herein; or**
  
- I refuse to provide a Specimen for use in the manner described herein. I understand that my refusal is grounds for disqualification from employment consideration, immediate termination of employment, or immediate termination of contractual relationship, as applicable.**

**2. Disclosure (check one)**

- I wish to disclose that I am currently taking the following Substances:**  
\_\_\_\_\_
  
- I understand that, for any prescription drugs, I must provide a copy of a current, valid prescription to the Medical Review Officer or other designated representative prior to being cleared regarding any positive results.**
  
- I do not wish to disclose any Substances.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date

### Additional Consent for Individuals under the Age of 18

As the parent and/or guardian of the individual named above, I hereby consent to and authorize the provision of the Specimens to CHS and the Testing Group and consent to the disclosure of Substances, if applicable. **I understand that I will be notified if the results for the individual named above has a positive result for an illegal substance.**

\_\_\_\_\_  
Parent and/or Guardian's Signature

\_\_\_\_\_  
Date

**CERTIFICATION AND AUTHORIZATION  
FOR VOLUNTEERS**

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Community Health Systems (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

\_\_\_\_\_

Date

\_\_\_\_\_

Print legal first, middle and last name

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

DOB

\_\_\_\_\_

Driver's License # & State Issued

\_\_\_\_\_

Street Address

\_\_\_\_\_

City, State, Zip