Shadowing Student Application

Date: _____ T-Shirt/Polo Size: _____

Name: _____ Date of Birth: _____
Last First Middle

Home Address: _____
Street City/State Zip Code

Phone: (h) _____ (c) _____

E-Mail Address: _____

School Affiliation: _____

Contact Name at School: _____

Contact Information for School: _____

What Physician at SMH will you be working with? _____

Do you know what your schedule will be at SMH? _____
_____
_____

How many hours at SMH weekly (estimated)? _____

What date will privileges start? _____

What date will privileges end? _____

Were you ever employed by Slidell Memorial Hospital? □ Yes □ No

If yes, please indicate dates employee dates:_____to _____

Are any of your relatives currently employed by Slidell Memorial Hospital?

□ Yes Relatives' Name/Relationship:_____ □ No

Notice of Substance Detection Policy

The purpose of the Substance Detection Program is to promote optimum safety and well-being of volunteers, interns, employees, patients, and visitors. SMH is committed to providing a safe, productive, healthy, and wholesome environment. We are committed to taking reasonable and necessary steps to provide our hospital community with an environment that is free from the adverse effects of substance abuse, through creating and maintaining a drug-free workplace.

Are you willing to undergo a drug screen test (at our expense) prior to volunteering or interning for SMH?

□ Yes □ No

BACKGROUND CHECK:

We consider the safety and security of our patients, visitors and employees to be of the utmost importance. Applicants must complete an Authorization and Consent for Release of Information form to be screened at our cost for criminal background offenses by state and/or federal agencies. The existence of a criminal record does not constitute an automatic bar from volunteering or interning but will be considered in relation to your assignment and position requirements.

Have you ever been convicted of a felony or misdemeanor offense? □ Yes □ No

Are there any pending charges on your criminal background report? □ Yes □ No

Have you ever been sanctioned for Medicare fraud? □ Yes □ No

REFERENCES:

NAME	RELATIONSHIP	PHONE NUMBER

IN CASE OF EMERENCY CONTACT:

Name Home Address ZIP

RELATIONSHIP:_____E-Mail: _____

Phone: (h)_____ (c) _____

I certify that the statements made in this application are true and correct. I authorize Slidell Memorial Hospital and its agent acting on its behalf to investigate all statements contained in this application. I understand that this information may be disclosed to any party with legal and proper interest and I release Slidell Memorial Hospital from any liability whatsoever for supplying such information. **I understand that I will not be paid for my services as this is strictly volunteer work.** I have read and understand the above statements.

SIGNATURE OF APPLICANT:_____DATE: _____

Please return application packageto:

Slidell Memorial Hospital
Attention: Volunteer Services
1001 Gause Blvd.
Slidell, LA 70458

Department: Volunteer Services

PLEASE READ CAREFULLY

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

We truly welcome your application to volunteer or intern with, **SLIDELL MEMORIAL HOSPITAL,** (hereinafter referred as "Company"). We're proud that our success is the result of the quality and caliber of our volunteers. You are applying for a position whose acceptance will place you in a category of recognized Professionals. In pursuit of that excellence we require, as a condition of placement, and/or continued placement, that all applicants consent to and authorize a pre-volunteer verification of the background information submitted on their application or resume.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of volunteering is true and complete to the best of my knowledge. I understand that if I am accepted as a volunteer any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this company may now, or at any time while you are a volunteer, administer a personality profile, conduct a verification of your education, previous employment/work history, credit history, contact personal references, require that you provide a urine specimen to be tested for the presence of drugs or alcohol, motor vehicle records, worker's compensation from the Department of Labor and/or the Worker's Compensation Commission, and to receive any criminal history record information pertaining to me which may be in the files of any Federal, State, or Local criminal justice agency in any State and/or other information as deemed necessary to fulfill the job requirements.

In conformance with the Americans Disabilities Act, I acknowledge by my **signature**_____that I have been offered a volunteer position, contingent upon a satisfactory background investigation, and therefore, worker's compensation information obtained from the Department of Labor and/or the Worker's Compensation Commission is hereby authorized. If blank, the obtaining of worker's compensation information is not authorized. The results of this verification process will be used to determine eligibility under this Company's employment policies.

I authorize Verified Credentials, LLC, (hereinafter referred as "VC"), and any of its agents/designated by Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of this Company.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide VC and Slidell Memorial Hospital with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge the Company, our agent, VC, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if volunteering was denied based on information obtained by SMH, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

Volunteer/Intern: Please Print

_____, _____ **SS#:** _____

Last (Maiden) First M.I. U.S. Citizen: Yes_____No_____

Address: _____

_____ **Date of Birth:** _____

Telephone # Home_____**Cell**_____**Alternate**_____

Excluding current residence, list the last two City, State and ZIP codes that you have lived in:

_____

_____

Signature: _____ Date: _____