Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands
1178 Hinemlu' St., Garapan, Saipan, MP 96950

VOLUNTEER APPLICATION FORM

GENERAL INSTRUCTIONS: Before completing, please read the Agreement and Certification section at the end of the Volunteer Application. Type or print all answers clearly with a dark ball point pen. Answer all questions fullly and accurately, sign, date, and return the application to the Office of Human Resources for processing.

I. PERSONAL INFORMATION

Name *(First, Middle, Last)* :	Other name(s) which you are or have been known by:
Gender: ☐ M ☐ F	Date of Birth *(MM/DD/YYYY)* :
Street Address: Mailing Address:	Home #: Cell #: Business #: Email Address: Emergency Contact Person: Emergency Contact #/ Relation:

At which location are you interested in Volunteering? (*Please mark an "x" in the box as applicable.)*

☐	☐	☐
Commonwealth Health Center (CHC)	**Tinian Health Center (THC)**	**Rota Health Center (RHC)**

☐ Medical Services _____ *(Ex: Hospital, Outpatient Services, Ancillary Services, Dialysis)*

☐ Population Health Services _____ *(Ex: Public Health, WIC Program, Environmental Health, Mental & Behavioral Health, Emergency Preparedness)*

☐ Admin & Corporate Support *(Ex: HR, Health & Vital Statistics, Grants Management, Corporate Compliance, IT)*

Please provide a resume/CV should you choose to include any additional spaces.

High School:		Location:	
College:		Location:	
Other:		Location:	

DEGREE PROGRAM

Current educational status (choose one).

☐ ***High School Student*** ☐ ***Pre-Med Student*** ☐ ***Medical Student*** ☐ ***Other (specify): _____***

II. WORK EXPERIENCE

Fill each block completely. Start with your present employer and work back. Describe all of your work, listing your most important duites first. Please provide a resume should you choose to include additional information.

Are you currently employed? ☐ Yes ☐ No

Are you a former employee of the Commonwealth Healthcare Corporation? ☐ Yes ☐ No

If answered *YES* , what is your reason for leaving?

Name of Employer:	Position Title:
Address of Employer:	Dates of Employment (Month/ Year) :
Name of Employer:	Position Title:
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1. Why do you want to volunteer with CHCC? (Please explain. Use additional sheet should you need to include more information.)	
2. Are you receiving credit hours for school? *(If yes, how many hours needed?)* _____	☐ Yes ☐ No
3. Are you required certain hours to meet license certification? *(If yes, how many hours needed?)* _____	☐ Yes ☐ No
3. Are you currently pursuing a degree in medical field? (Pre-Med, Nursing, Pharmacy, etc) *(If yes, please specify) :*_____	☐ Yes ☐ No
4. Are you interested in a career in healthcare? *(If yes, what field?)*_____	☐ Yes ☐ No

5. What are your hours of availability?

☐ Morning 7:30 am-11:30 am

☐ Afternoon 12:30 pm-4:30 pm

Days available: Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐

(Upon selection and placement, please notify your mentor of any schedule changes or special accomodations)

6. What is the soonest available time for you to start? *(Please indicate a timeframe, **not to exceed 6 months**)*

Effective Date: _____ *Not to Exceed Date:* _____

7. Have you ever been convicted of a crime? *(If so, please describe fully the conviction(s) listing the nature of the offense(s), your age at the time of the offense(s), and your rehabilitation since the conviction(s) on the lines provided .*	☐ Yes ☐ No _____ _____ _____
8. Volunteer Preference:	☐ Office/ Administrative / Clerical / IT Support / Outreach ☐ Observe and/or Shadow Clinical Staff/ Medical Provider *(as approved)* ☐ Other:_____

9. List any volunteer experience you've had in the past.

10. How did you hear about us?

☐ Friend ☐ Website ☐ CHCC Employee
☐ Relative ☐ Brochure ☐ Other: _____

11. Reference List. *Please list the names, addresses, and telephone numbers of at least two (2) people who can vouch for your reputation, character, and work record, and who have known you for at least One year. One of these should be a work reference (if applicable).*

BY SUPPLYING THE INFORMATION BELOW, YOU ARE AUTHORIZING THE COMMONWEALTH HEALTHCARE CORPORATION TO PERFORM REFERENCE CHECKS.

Name:	Email:	Name:	Email:
Contact Number:	Business/ Occupation:	Contact Number:	Business/ Occupation:
Address:	Number of years known:	Address:	Number of years known:

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CERTIFICATION and AUTHORIZATION

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. If accepted for a volunteer assignment with the Commonwealth Healthcare Corporation, I agree to abide by the Commonwealth Healthcare Corporation's rules and regulations.

I authorize the Commonwealth Healthcare Corporation to investigate all statement contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be neccesary for determining my eligibility as a volunteer.

By initialing in the boxes below, I agree to the following:

☐ I will be expected to observe confidentiality with respect to all information I may possess regarding my interactions with the Commonwealth Healthcare Corporation, its clients, patients, residents, and staff, and any knowledge of the contents of confidential records. Failure to adhere to this agreement is grounds for immediate dismissal. I also agree to maintain confidentiality after I leave the Commonwealth Healthcare Corporation for whatever reason.

☐ I understand that services are performed during normal business hours of 7:30 am - 4:30 pm, Monday to Friday, not to include Holidays and only on the premises of assignment and that my service does not reserve the right to travel. (Unless waived/approved by the CEO to go beyond the mentioned hours and days).

☐ I understand that my volunteer assignment is entered into voluntarily and that I am free to resign at anytime, and that the Commonwealth Healthcare Corporation may terminate the volunteer relationship at any time whenever it is in the best interest of Corporation to do so.

☐ I agree to have a health assessment at the Commonwealth Healthcare Corporation's Employee Health Office if I am offered a volunteer assignment and ANNUALLY THEREAFTER.

Volunteer Print Name/Sign: _____ Date: _____

If under the age of 18:

Print Name/Sign: _____ Date: _____
(Parent/Guardian)

Thank you for your interest in volunteering with the Commonwealth Healthcare Corporation.

HUMAN RESOURCES OFFICE USE ONLY:

APPLICATION RECEIVED DATE: _____ **RECEIVED and REVIEWED BY:** _____

Assigned Supervisor: _____ _____
Name Department

Concurred by: _____
HR Authorized Signature

Approval:

☐ Approved ☐ Disapproved

_____ _____
Esther L. Muna, Chief Executive Officer Date