



Volunteer Services

Dear Volunteer Applicant,

Thank you for your interest in our Adult Volunteer Program here at Lexington Medical Center. We are delighted that you are considering us as a place to volunteer your time for our patients, visitors and employees. We have an application process that is outlined below:

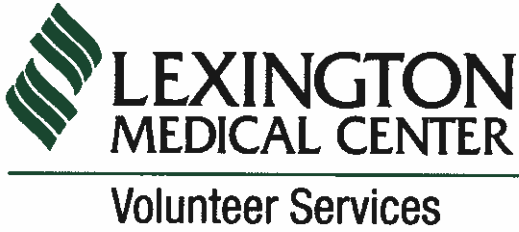
1. Complete Application (on-line or bring your application with you to the interview)
2. Call (803) 791-2573 to schedule an interview
3. Attend Orientation (Invitation to attend a mandatory orientation will be mailed)
4. Complete free health assessment with Employee Health (by appointment only)
5. Provide proof of COVID-19 vaccination. All volunteers must be vaccinated.

Steps 3 and 4 will be discussed in detail at the time of your interview. If you have any further questions, please do not hesitate to call 791-2573. I look forward to meeting you.

Thank you.

Ann Wingate, Director

Volunteer Services



Please complete this application if you are interested in becoming a Lexington Medical Center volunteer.

Lexington Medical Center is an equal opportunity employer and pledges to provide equal opportunities without regard to race, color, religion, age, sex, national origin, disability or veteran's status. Lexington Medical Center provides a smoke-free work environment.

2720 Sunset Blvd.
West Columbia, SC 29169
803.791.2573

Adult Volunteer Program Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____
Date of Birth: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Availability:
Morning: _____ Afternoon: _____ Evening: _____
Weekends: _____

Volunteer Position Preference: _____

Please list any special skills, hobbies, and/or interests.

Why do you want to volunteer?

Have you been convicted of anything other than a minor traffic violation? YES NO

If yes, explain: _____

Education

Highest Level of Education Completed: _____

From: _____ To: _____ Did you graduate? YES NO Diploma: _____

Previous Employment and/or Volunteer Experience

Please list any professional and/or volunteer experience: _____

If currently employed, please list your employer: _____

Job Title: _____

Responsibilities: _____

May we contact your current supervisor for a reference? YES NO

References

Please list two references. Relatives cannot be listed.

Full Name: _____ Relationship: _____
Email: _____

Full Name: _____ Relationship: _____
Email: _____

Physician

Personal Physician Name: _____

Phone: _____

Address: _____

Street Address _____ *Apartment/Unit #* _____

City _____ *State* _____ *ZIP Code* _____

Disclaimer and Signature

I certify that the information I have given on this application is true and complete and agree that any false information including that given at the time of physical examination is cause for dismissal. The company, schools and person named above may give information regarding me and I release them from all liability for doing so. I understand that any offer by the Volunteer Services Department is conditional on satisfactory replies from references, background check, health reference and physical examination, which includes blood and/or urine tests to detect the presence of illegal drugs or alcohol. This is not a contract for the Volunteer Services Department and Lexington Medical Center has the right to separate you from the volunteer program at any time as you have the right to leave at any time. If qualified for volunteer service, I agree to abide by the rules and regulations of Lexington Medical Center, the policies and procedures of the Volunteer Services Department and the department to which I am assigned. I will respect the confidentiality of patient information and abide by all HIPAA guidelines.

Signature: _____

Date: _____

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and /or "investigative consumer reports" by Lexington Medical Center – Human Resources (Volunteer) ("the Company") at any time after receipt of this authorization and throughout my employment (volunteer), if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc. Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows: *In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

*A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

*By requesting a copy be sent to a specified addressee by certified mail. CRA's complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRA's.

“Proper Identification” includes documents such as a valid driver’s license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person’s presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge is one is obtained by the Company whenever you have a right to receive such a copy under California law

Signature

Date

Full Name (First/Middle/Last)

Social Security Number (SSN)*

Driver License State/Number

Date of Birth*

Current Address

City ,State and Zip Code

*SSN and DOB will be used for identification purposes and will not be used as selection criteria.

FCRA:VOLUNTEER:003311:201501

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Lexington Medical Center – Human Resources (Volunteer) (“the Company”) may obtain information about you from a third party consumer reporting agency for volunteer purposes. Thus, you may be the subject of a “consumer report” and/or an “investigative consumer report” which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records (“driving records”), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033.

www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your affiliation with the Company to the extent permitted by law.

Signature

Date

Social Security Number

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Date of Birth

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First Name	Middle Name	Last Name
Other Names Used		

Current Residential Address		
City	State	Zip Code

List each **CITY, STATE** and **ZIP CODE** (if known) where you have lived during the past seven years:

City	State	Zip Code	From Date	To Date	

Driver's License Number	State of Issue
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