VOLUNTEER SERVICES
HARRINGTON HEALTHCARE SYSTEM
100 SOUTH STREET
SOUTHBRIDGE, MA 01550

Date:_____ **Date of Birth**:_____

Last Name:_____**First Name**:_____

Mailing Address:
Street:_____City:_____ State:_____ Zip:_____

Telephone: Home:_____ Cell:_____

E-mail Address:_____**@**_____

Present Occupation:_____ Work #:_____

Person to contact in case of emergency:

Name:_____ Relationship:_____

Address:_____ Telephone (Home):_____

(Work):_____

(Cell):_____

Work Availability:
Weekdays/Days:_____ Evenings:_____

Weekends/Days:_____ Evenings:_____

Location: Check Mark Location of Interest:
____ Harrington Main Campus ___ Harrington 61 Pine/G.B. Wells ___ Harrington Healthcare at Hubbard
____The Cancer Center at Harrington ____Harrington Healthcare at Charlton

Foreign language(s) spoken fluently:_____

Areas of interest: 1._____ 2._____ 3._____

References: For Example: Adult Friends, Clergy, Teacher, Supervisor, or Coach. No Relatives maybe used as a reference.

1. Name:_____ Telephone:_____

   Address:_____

2. Name:_____ Telephone:_____

   Address:_____

Volunteer Services complies with all state and local regulations and meets requirements of the Joint Commission on Accreditation of Healthcare Organizations.

Applicant Signature:_____

Revised 3/27/12

Voluntary Self Identification

Government agencies require reports on status of applicants. This data is for analysis and affirmative action only. Submission is voluntary. Failure to supply this information will not jeopardize or adversely affect any consideration you may receive for volunteering.

Race/Ethnicity: ___Hispanic or Latino ___White* ___Black or African American*
___Native Hawaiian or Other Pacific Islander* ___Asian ___American Indian or Alaska Native
___ Two or More Races* (All persons who identify with more than one of the above five races.)
**Not Hispanic or Latino*

Languages spoken fluently: __English ___Spanish ___French ___Portuguese ___Laotian
___Cambodian ___Vietnamese ___American Sign Language ___Other:_____

Handicapped, Disabled Veteran and/or Vietnam Era Veteran (Please check all that apply):
___Handicapped – any person who (1) has a physical impairment which substantially limits one or more of such person's major life activities; (2) has a record of such impairment; or (3) is regarded as having such impairment.
___Disabled Veteran – a person entitled to disability compensation under laws administered by the Veteran's Administration for disability rated a thirty per centum or more of a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.
___Vietnam Era Veteran – a person who (1) served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1964 and May 7, 1975 and was discharged or released therefore with other than a dishonorable discharge or (2) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed between August 5, 1964 and May 7, 1975.
___Other Veteran – any Veteran who served in the military, ground, naval or air service of the United States on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized.

APPLICANT INFORMATION

(For Office Use Only)

Interview Date: **Start Date:** **Age:** **School/Grade**:

Availability – Days: **Hours**:

Possible Placement (1) **(2)**

Notes:

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

HARRINGTON MEMORIAL HOSPITAL is registered under the provisions of M.G.L. c. 6, section 172 to receive CORI for the purpose of screening current and otherwise prospective employees, subcontractors, volunteers, license applicants, current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services (DCJIS). I hereby acknowledge and provide permission to **HARRINGTON MEMORIAL HOSPITAL** to submit a CORI check for my information to DCJIS. This authorization is valid for one year from date of my signature. I may withdraw this authorization at any time by providing **HARRINGTON MEMORIAL HOSPITAL** with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYEMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: **HARRINGTON MEMORIAL HOSPITAL,** may conduct subsequent CORI checks within one year of the date of this Form was signed by me provided, however, that **HARRINGTON MEMORIAL HOSPITAL** must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature Printed Name

Date: _____

SUBJECT INFORMATION:

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ SUFFIX _____

MAIDEN NAME (OR OTHER NAME(S) BY WHICH YOU HAVE BEEN KNOWN) _____

DATE OF BIRTH _____ PLACE OF BIRFTH _____

LAST SIX DIGITS OF YOUR SOCIAL SECURITY NUMBER: _____-_____

SEX: _____ HEIGHT: _____FT. _____IN. EYE COLOR _____ RACE: _____

DRIVER'S LICENSE OR ID NUMBER: _____ STATE OF ISSUE: _____

MOTHER'S FULL MAIDEN NAME _____ FATHER'S FULL NAME _____

CURRENT AND FORMER ADDRESSES:

Street Number & Name _____ City/Town _____ State _____ Zip _____

Street Number & Name _____ City/Town _____ State _____ Zip _____

The above information was verified by reviewing the following form(s) of government issued identification:

_____

_____

VERIFIED BY: _____ _____

Name of Verifying Employee (please print) Signature of Verifying Employee

HH **RETURN TO: DEPT. OF PUBLIC SAFETY, HARRINGTON MEMORIAL HOSPITAL**