

The Center for Health Care Services
3031 IH 10 West San Antonio, Texas 78201
(210) 261-1105 Fax (210) 737-9607

Volunteer Application



Name: (last, first, middle initial): _____

Address: _____
Street City State Zip

Telephone: Home: _____ Cell: _____ E-mail: _____

Are you presently employed?: Yes No If yes, please indicate your Job Title _____
Employer Name: _____ Duties _____

Work History: _____

Have you ever been convicted of a crime, including DWI/DUI, plead guilty or "no contest" to a criminal charge, or entered into an agreement setting forth the conditions for the eventual dismissal of a criminal case? | Yes | No If Yes, describe incident(s), city, state and charge.

Have you ever been found to be a perpetrator of Class I Client Abuse, Neglect or Exploitation in any employment or volunteer work? Yes | No

How were you referred to us? _____

Have you worked for or volunteered at CHCS before? | Yes No If Yes, please indicate where

What type of volunteer work would you like to do? | Administrative (central office) Clerical (clinic location) Medical Records | Other _____

Do you have a preference on location? List _____

Describe the time commitment you are able to make to volunteer:

Frequency: Every day 2-3 times per week | Once per week | Other _____

Days: Monday Tuesday Wednesday Thursday Friday

From Date _____ to Date _____

From Time _____ to Time _____

PERSONAL OR WORK RELATED REFERENCES List 1 – 2 Individuals to whom we can speak about your character and skills

Name	Relationship	Phone / Email
1. _____	_____	_____
2. _____	_____	_____

BY SIGNING THIS DOCUMENT, YOU ARE ATTESTING TO THE ACCURACY AND TRUTHFULNESS OF YOUR ANSWERS

Signature _____

Date _____

VOLUNTEER CANDIDATE CONSENT TO BACKGROUND SEARCH AND INVESTIGATION

CONSUMER NOTIFICATION: This is to inform you that a consumer report is being obtained from a consumer reporting agency for the purpose of evaluating you for employment, promotion, reassignment, and/or retention as an student/volunteer. The report may include, among other items, criminal background information, confirmation of your educational and employment history, an investigative consumer report (for which you may request a disclosure of nature and scope) as to your work performance, and confirmation of any references provided.

The undersigned hereby authorizes CENTER FOR HEALTH CARE SERVICES and/or its agents to make an investigation of my background, references, character, employment, credit, motor vehicle, education, and criminal history record information which may be in any state or local files, including those maintained by both public and private organizations, and all public records, for the purpose of confirming the information contained in my application and/or obtaining other information which may be material to my qualifications for employment. I further agree to a test for controlled substances, if requested. A telephone facsimile (fax) or xerographic copy of this consent shall be considered as valid as the original consent.

In the event of my Volunteer Work, this authorization shall remain in effect for the duration of such placement. Prior to taking adverse action as a result of any investigations resulting from this authorization, CHCS shall provide to me a copy of the consumer report or investigativ consumer report which caused such adverse action and a summary of my rights under the Fair Credit Reporting Act.

I release CHCS and/or its agents and any person or entity which provides information pursuant to this authorization from any and all liabilities, claims, or lawsuits in regard to the information obtained from any and all of the above-referenced sources.

Signature: _____ Date: _____

Please type or print legibly the information requested below, black ink only.
True and Complete

Legal Name: First _____ Middle _____ Last _____

Maiden or Other Names Used: _____ Dates Used: _____

Present Street _____ Dates of residence
Address: _____ (e.g. 2003 to 2016): _____ to _____

City: _____ County _____ State: _____ Zip: _____

Other cities and states lived in during the past seven years:

City: _____ State: _____ Dates of residence: _____

_____ to _____

City: _____ State: _____ Dates of residence: _____ to _____

City: _____ State: _____ Dates of residence: _____ to _____

Driver's _____ State of _____
License Number: _____ Issue: _____

Social
Date of Birth: _____ Security Number: _____

Note: The above information is required to ensure positive identification and is in no manner used as qualification for employment. California, Minnesota, and Oklahoma applicants check this box if requesting copy of report be sent to address above.

CENTER FOR HEALTH CARE SERVICES REQUEST FOR PROCESSING

Criminal History, County
Criminal History, Statewide

Criminal History, Federal District
Criminal & Sex Offender Database, National

Consent to State & Federal Background Data Base Search - Volunteer

Notification:

In accordance with Department of Health & Human Service (DSHS), Centers for Medicare & Medicaid Services, Texas Administrative Code 40, Chapter 93, and Texas Health & Safety Code, Chapter 253, The Center for Health Care Services is required to search the following data bases to determine if an applicant, volunteer or contractor is listed as unemployable or is listed as an excluded provider on either registry.

- *State & Federal Office of Inspector General Database*
- *Employability Status Check Search – consolidated results from DADS' Nurse Aide Registry, Medication Aide Registry & Employee Misconduct Registry*
- *CANRS – Client Abuse & Neglect Registry System*

The undersigned hereby authorizes The Center for Health Care Services (hereinafter referred to as the Center) to make an investigation of my background through the above named databases upon my application for student placement.

I also understand that my name will be checked against the OIG and Employability Status Check databases each **month** for the duration of my employment or association with the Center in accordance with the DSHS standards.

I release the Center and/or its agents and any person or entity which provides information pursuant to this authorization from any and all liabilities, claims, or lawsuits in regard to the information obtained from any and all of the above-referenced sources.

Signature _____

Date _____

Please print legibly

Legal Name: (as it appears on Social Security Card)

First: _____ Middle: _____ Last: _____

Maiden or other names used:

Date of Birth: _____

Social Security Number: _____

Note: *The above information is required to ensure positive identification and is in no manner used as a qualification for employment.*

Please forward the Student Application, Volunteer Candidate Consent to Background Search & Investigation Form, and the Consent to State and Federal Background Data Base Search Forms to:

The Center for Health Care Services, Marisol Lucio – mlucio@chcsbc.org or Fax 210-737-9607

PRE-EMPLOYMENT

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For Internal Use:

Volunteer Assignment

Volunteer Name _____ Sponsoring Agency _____

Unit Assignment _____ Address _____

Unit Supervisor _____ Start Date _____ End Date _____