



## VOLUNTEER SERVICES JOB DESCRIPTION

**Organization:** Metroplex Health System

**Contact Information:** Nance Travis, Coordinator of Volunteer Services (254) 519-8147

**Position Title:** Metroplex Health System Volunteer,  
Metroplex Adventist Hospital or Rollins Brook Community Hospital

**Major Responsibilities:** Serve as a hospital volunteer within an assigned unit or department according to vacancies that exist. Over 50 units/departments utilize volunteer services. Each volunteer will be trained by the unit or department to which he/she is assigned prior to beginning work.

**Mission and Goals:** Members of the Metroplex Health System Volunteer Services, being attuned to the needs of others, strive through dedicated and compassionate Christian service to provide support in a cooperative and encouraging manner to staff, physicians, patients and visitors of Metroplex and Rollins Brook hospitals.

### **The Volunteers members:**

- ❖ Serve others by providing volunteer assistance in every area of the hospital where needed
- ❖ Show care, concern, and appreciation for all patients, visitors, doctors, employees, and other volunteers
- ❖ Serve as ambassadors for the Metroplex Health System
- ❖ Support the mission of the Metroplex Health System by raising and disbursing funds

Applicants will complete an application packet and submit this packet to the Information Desk. Volunteers must be a minimum of 15 years of age.

### **Expectations of all Volunteers:**

- ❖ Uphold the SHARE standards established by Adventist Health System (see SHARE commitment inside the Volunteer Handbook).
- ❖ Schedule a personal interview with the Volunteer Coordinator for acceptance into the training program.
- ❖ If accepted into the training program, attend a 4.5 hour training/orientation program.
- ❖ Agree to a complete background (security check) for clearance.
- ❖ Have all necessary TB and immunizations prior to beginning service. (TB tests must be within the last 3 months.) Be professional in dress and demeanor (this includes no visible tattoos or body piercing).
- ❖ Recognize that the Volunteer Coordinator directs the entire program, and all volunteers are to follow the chain of command.

## FEES FOR VOLUNTEERS:

- ❖ Adult volunteers will pay a non-refundable membership fee of \$30. Student volunteers will pay a non-refundable fee of \$15.

## Benefits:

- ❖ Receive 10% discounts at the Gift Shop when you show your badge at the time of purchase.
- ❖ Receive a free meal, not to exceed \$6.00, in Café Metro for every 4 hours of volunteer service.
- ❖ Additional benefits such as a fall retreat, a spring outing, other social events sponsored by Metroplex Health System.
- ❖ Discounts for amusement parks
- ❖ TB testing and immunizations
- ❖ Free quarterly health screenings
- ❖ Opportunity to contribute to your community
- ❖ The Blessings of serving within a Christian environment

**Time Commitment:** A weekly minimum of four (4) hours of service is required by each volunteer. An eight-hour commitment is preferred. Volunteers may select from the following the shift which best fits their schedules:

8AM – 12Noon      12:30PM – 4:30PM      4:30PM – 8:30PM

**Extended Hours:** Includes the 4:40PM – 8:30 PM shift and weekend duty

**ABSENCES: Any absence must be reported to the Volunteer Coordinator and the volunteer's direct unit supervisor. Two consecutive absences without prior notification constitute grounds for termination from the Volunteer Program.**

## Preferred Education, Experience and Skill Requirements

Metroplex seeks volunteers who are:

- ❖ . Caring
- ❖ . Eager to serve
- ❖ . Respectful of others
- ❖ . Responsible
- ❖ . Demonstrate a positive attitude
- ❖ . Display responsible communications and interaction with others and
- ❖ . Have skills needed in the units in which they serve

**Work Locations:** Metroplex Adventist Hospital (Killeen) and Rollins Brook Community Hospital (Lampasas)

**Training/Other:** Initial Training and Orientation (4.5 hours)

**Evaluation/Feedback:** Volunteer Recognition/Annual Evaluation plus Work Experience Description and Reference Letter as needed



Volunteer Experience (List positions, employers, and dates):

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Have you ever been convicted of, or are you currently serving probation for, any crime, excluding minor traffic offenses?  Yes  No

*Note: Conviction of a crime is not an automatic ban to consideration of volunteer applications. Background checks will be required prior to your volunteer service.*

Check all of the following in which you are proficient.

- Copy Machine     Typing     Calculator     Cash Register
- Computer     MS Word     MS Excel     MS PowerPoint

Any areas of proficiency or special skills not listed above:

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List any languages, other than English, in which you are proficient.

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**Special Interest, Skills and Talents**

In which of the following areas do you think you could be of assistance? Mark all that apply.

- Bulletin Boards     Print Media (newsletter, brochures, etc.)     Photography
- Videography     Interpersonal Relationships     Writing
- Interior Design     Floral Arrangement     Cooking
- Planning/Organizing     Public Speaking     Physical Activity

Computer Programs (Specify): \_\_\_\_\_

Other (Specify): \_\_\_\_\_

Why do you want to volunteer with Metroplex Health System?

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Did someone ask you to volunteer? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, who? \_\_\_\_\_

Are you currently seeking employment? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, where? \_\_\_\_\_

Are you volunteering to fulfill a requirement? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain the requirement?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any additional information in which you think might be helpful in determining your assignment/placement.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a Social Security Number? \_\_\_\_\_ Yes \_\_\_\_\_ No If you do not have a Social Security Number, we cannot accept your volunteer application. You have to show a valid Social Security card during training in order to have a background check processed.

I agree to give regular and dependable service to the hospital and to uphold the mission and policies of the Metroplex Health System Volunteer Services.

\_\_\_\_\_  
Signature Date

**VOLUNTEER INFORMATION**

Name as you would like it to appear on your name tag: \_\_\_\_\_

**Contact Information:**

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Other: \_\_\_\_\_

**Uniform:** \_\_\_\_\_ Vest \_\_\_\_\_ Smock (Students/Adult volunteers involved in certain activities may choose a polo shirt)

Size: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL \_\_\_\_\_ XXL \_\_\_\_\_ XXXL

**Availability:** How many hours each week would you like to work? \_\_\_\_\_

When are you available? \_\_\_\_\_ Mornings \_\_\_\_\_ Afternoons \_\_\_\_\_ Both \_\_\_\_\_ Weekends/EH

Which days do you prefer to work?  
\_\_\_\_\_  
\_\_\_\_\_

List in order the areas you would prefer to work.

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

**REMINDER:** Volunteers are not to rearrange their schedule. This is the sole responsibility of the Volunteer Coordinator’s office. If a transfer to another unit is requested, every effort will be made to honor this request.

Hours of Service are recorded on Volgistics, an electronic database and will be accessible to volunteers.

**RECOGNITION:** The volunteer fiscal year is from June 1 – May 31. After a fiscal year of volunteer service, the volunteer is entitled to receive a Metroplex Health System medallion and a one year service bar which is attached to the medallion. Service bars in increments of 500 hours are also awarded if the volunteer so desires. Opportunities are available to serve on special committees and leadership positions.

**STATEMENT OF CONFIDENTIALITY**

I understand that as a volunteer at a Metroplex Health System facility, I may have access to patients' confidential information, to include medical records and reports. Additionally, I may have access to other confidential information regarding the hospital and its doctors and staff. This accessing should only be done to the extent that performance of my duties requires and I will not read, discuss or release any information without proper authorization.

In the event that I should breach any confidentiality, I understand that I will be subject to immediate dismissal as a volunteer. I also understand that I may be liable for damages and/or penalties which may result from such a breach of confidentiality. This statement will be filed with the Coordinator of Volunteer Services.

Name: (please print) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTICE AND AUTHORIZATION  
REGARDING BACKGROUND CHECK REPORT**

**(VOLUNTEERS)**

The purpose of this Notice and Authorization is to inform you that Metroplex Health System conducts a criminal record check on all volunteers under the federal Fair Credit Reporting Act. These criminal record checks are performed in compliance with the Federal Fair Credit Reporting Act to ensure a safe working environment.

Metroplex Health System requires, as a prerequisite to providing volunteer services, that all individuals seeking to volunteer their services consent to a criminal record check and provide certain identifying information to facilitate this process. Failure to consent to a criminal record check will result in an individual's ineligibility to provide volunteer services to Metroplex Health System.

I authorized Metroplex Health System and its authorized representatives to obtain a criminal record report on me as part of Metroplex Health System's background investigation. This authorization shall remain valid and serve as an ongoing authorization for Metroplex Health System and its authorized representatives to obtain criminal record reports on me at any time while I am providing volunteer services to Metroplex Health System. I authorize any person, organization, governmental authority, or other party to release and disclose information and cooperate in obtaining and producing of criminal reports about me.

I hereby release Metroplex Health System and its authorized representatives from any and all claims, actions, and liabilities arising from or relating to Metroplex Health System conducting this background investigation and obtaining and considering information about me through a criminal record report. I understand that this release does not limit my rights, if any, under the Fair Credit Reporting Act.

By signing below, I acknowledge receipt of this disclosure and authorize Metroplex Health System to request a criminal record report on me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_