Lake Charles Memorial Health System
VOLUNTEERS

LCMHS VOLUNTEERS PROGRAM

Lake Charles Memorial Health System (LCMHS) sincerely appreciates your interest in the Summer Volunteer Program. We value your commitment to serving our community and look forward to reviewing your application.

The required volunteer service commitment is a minimum of 5-10 hours per week. Volunteer day-shift assignments are available Monday-Friday with two scheduling options: Morning (8:00 AM – 12:00 PM) and Afternoon (12:00 PM –4:00 PM). Exceptions may be made when operational needs warrant an adjusted schedule or when ad hoc roles are approved by the department leader (e.g., Evening shifts beginning at 5:00 PM or later for designated areas such as the Emergency Department Waiting Area).

Completed packets may be emailed to volunteerservices@lcmh.com or delivered to the Office of Volunteer Services, Main Campus, First Floor, Lake Charles Memorial Health System, 1701 Oak Park Blvd., Lake Charles LA 70601. Required application materials include:

1. Application form
2. Volunteer Agreement-18 years and older must have a drug screen and background check.
3. Disclosure of photos and videos
4. Two (2) Reference forms may be emailed separately to volunteerservices@lcmh.com or submitted with the applicant's packet in sealed envelopes. References must be provided by individuals who are not related to the applicant and who are able to offer an informed assessment of the applicant's character and dependability. Applications will not be processed until all required reference documentation has been received.
5. Medical documentation of a current negative TB test (within the past year) is required. Volunteers must also provide proof of flu vaccination if volunteering between October and March. If a current TB test or flu vaccine is not available, the volunteer agrees to receive the PPD skin test and flu vaccine administered by the LCMHS Employee Wellness Team at no cost.
6. Volunteer opportunities are extended to all individuals in a welcoming and inclusive environment, without regard to religion, creed, race, national origin, age, or sex.

Upon submission of your volunteer application and 2 references, if selected, the Human Resources Department will contact you to coordinate your processing appointment. During this in-person session, you will complete all required policy forms, review and finalize the orientation materials and meet with Employee Health. Acceptance into the program is contingent upon satisfactory references and verification of all submitted information.

The Volunteer Services Department is under no obligation to provide a placement, and the applicant is under no obligation to accept any volunteer position that may be offered.

If you have any questions, please contact volunteer services at *volunteerservices@lcmh.com*, or at their direct line 337-494-2493. You may also contact the numbers listed below.

Janet Broussard
Volunteer Services
Lake Charles Memorial Health System
1701 Oak Park Boulevard
Lake Charles, LA 70601
jabr8438@lcmh.com
Office: 337-494-2493
Mobile: 337-526-8438

Sol Halliburton
Executive Director, Philanthropy
Lake Charles Memorial Health System
1701 Oak Park Boulevard
Lake Charles, LA 70601
mshalliburton@lcmh.com
Office: 337-494-3226
Mobile: 201-779-8060

Lake Charles Memorial Health System
VOLUNTEERS

LCMHS VOLUNTEERS PROGRAM
APPLICATION FORM

Complete and submit to VolunteerServices@LCMH.com)

FIRST NAME _____ *LAST NAME* _____ *BDATE* _____

ADDRESS _____ *SS#* _____ *(18 and over-optional used for background check)*

CITY _____ *STATE* _____ *ZIP* _____ *GENDER:* ☐*Male* ☐*Female*

CELL _____ *EMAIL* _____

VOLUNTEER EXPERIENCE _____

_____

REASON/S FOR JOINING THIS PROGRAM _____

_____

CURRENT STATUS: ☐ *PART–TIME* ☐ *RETIRED* ☐ *UNEMPLOYED* ☐ *STUDENT:* ○ *COLLEGE* ○ *HIGH SCHOOL*

CURRENT PART-TIME JOB: ☐*YES (please answer questions below)*

COMPANY NAME _____ *DAYS* _____ *HRS* _____

STUDENT: UNIVERSITY _____ *MAJOR:* _____ *YEAR:* _____

HIGH SCHOOL _____ *YEAR:* _____

DO YOU KNOW OR ARE YOU RELATED TO ANYONE AT LAKE CHARLES MEMORIAL HOSPITAL? ☐*YES* ☐*NO*
IF YES, PROVIDE NAME, DEPARTMENT AND RELATIONSHIP _____

EMERGENCY CONTACT

NAME _____ *RELATIONSHIP:* _____
CELL _____ *WORK* _____ *EMAIL* _____
COMPANY _____ *CITY* _____ *ZIP* _____ _____

TIME COMMITMENT- *Select the shifts and hours you would prefer to volunteer each week. The minimum number of volunteer service hours is 5-10 hrs. per week. LCMHS does not guarantee that you will be placed on these shifts, although we will strive to accommodate you. Preferred START DATE:* _____ *END DATE:* _____

WEEKDAY	*MONDAY*	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*
Morning Shift 8:00 am – 12:00 pm					
Afternoon Shift 12:00 pm – 4:00 pm					

I certify that the information on this application is true and correct, and any omissions, misrepresentations or false information will be grounds for dismissal as a volunteer. I authorize all references contacted should be released from all liability in answering inquiries related to my application.

PREFERRED CAMPUS:

☐*OAK PARK MAIN CAMPUS*
1701 OAK PARK BOULEVARD
LAKE CHARLES, LA 70601

☐*WOMEN'S CAMPUS*
1900 WEST GAUTHIER ROAD
LAKE CHARLES, LA 70605

☐*MOSS MEMORIAL*
1100 WALTERS STREET
LAKE CHARLES, LA 70607

☐*OTHER* _____

APPLICANT

Name/Date (Print) _____/_____ *Signature* _____
Must be handwritten

PARENT/GUARDIAN (Applicant under the age of 18)

Name/Date (Print) _____/_____ *Signature* _____
Must be handwritten

Lake Charles Memorial Health System
VOLUNTEERS

LCMHS VOLUNTEERS PROGRAM
VOLUNTEER AGREEMENT FORM

(Complete and submit to VolunteerServices@LCMH.com)

I, _____("Volunteer"), would like to participate in the Lake Charles Memorial Health System (the "Hospital") Volunteers Program. As a condition of participation in this program, I agree to the following:

1. Volunteers understand that they will donate their services to LCMHS without contemplation of compensation and/or future employment.
2. Volunteer understands that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with organizational policies, rules, and regulations; (b) habitual tardiness and/or absences without prior notification; (c) unsatisfactory attitude, service, or appearance, or (d) any other circumstances which, in the judgement of the department director, would make my continued service as a volunteer contrary to the best interests of LCMHS.
3. Volunteers will always conduct themselves in a manner that does not disrupt the orderly operation of the Hospital.
4. Volunteers will not touch patients, participate in the care or treatment of patients, perform clinical procedures of any kind or nature, or make any entries in any medical record unless authorized by their supervisor.
5. Volunteers will not interact with patients and families without the supervision of their supervisor.
6. Volunteers will not access any LCMHS IT systems to protect the confidentiality of sensitive information related to patients/employees unless the supervisor has agreed to volunteer access.
7. Volunteers will not have any badge access
8. Volunteers will not observe any procedure/clinical activity without the presence of a supervisor and the permission of the patient/family.
9. Volunteers will keep strictly confidential and will not divulge the identity of any LCMHS patient or the medical condition or treatment of any LCMHS patient.
10. Volunteers will always wear an official LCMHS ID while on Hospital property identifying you as a Volunteer in the LCMHS Hospital's Volunteer Program.
11. Volunteers will abide by the Hospital's policies, procedures, rules, and regulations, as well as the instructions and direction of nursing and supervisory staff at the Hospital.
12. Volunteers will present medical certification for a current negative TB test within the past year, and present proof of Flu Vaccination (if volunteers schedule is between the months of October to March). If current TB test or flu vaccine certifications are not available, volunteer agrees to take the TB skin test and Flu vaccine administered by LCMHS Employee Wellness Team at no cost to volunteer.
13. Volunteers **18 years pf age or older** agree to undergo a **drug screening** and **background check** as part of the onboarding process. These services are provided **at no cost** to the volunteers.
14. Volunteers will appear for Volunteer orientation, arrive promptly on all scheduled dates, and report to their assigned program supervisor.
15. Volunteers must sign daily attendance sheets and upon completion of services must return LCMHS ID to their program Mentor/Sponsor or the Manager of Volunteer Services.
16. Volunteers agree to dress accordingly and will wear no exceptions to the LCMHS dress code policy (i.e. no shorts, tank tops, tube tops, t-shirts, open-toed shoes, etc.).
17. Volunteer work begins after HR approved LCMHS mandatory 30-minute orientation.

VOLUNTEER

_____ _____ _____

PRINTED NAME *SIGNATURE (Handwritten)* *DATE*

PARENT/GUARDIAN (APPLICANT UNDER THE AGE OF 18)

_____ _____ _____

PRINTED NAME *SIGNATURE-Handwritten* *DATE*

Lake Charles Memorial Health System
VOLUNTEERS

LCMHS VOLUNTEERS PROGRAM
AUTHORIZATION FOR DISCLOSURE OF PHOTOS AND VIDEOS FOR PROMOTIONAL PURPOSES (NON-PATIENT)

(Complete and submit to VolunteerServices@LCMH.com)

1. I allow Lake Charles Memorial Health System (the "Health System") to use and disclose:
   (a) photographs, video images, and/or digital images of me; and
   (b)sound recordings of my voice, for publication in the media. The media in which my information may be published includes, but is not limited to, newspapers, magazines, billboards, brochures, web sites, radio advertisements, or television broadcasts.

2. I understand that the information described above will be used to keep the public informed about services offered at the Health System, for fundraising efforts, marketing campaigns, and/or for educational purposes (such as conferences for health care professionals). I have no rights in the images or recordings, and no right to inspect or approve advertisements or other documents in which my image or recording may be used. However, I understand that any such use will be in good taste.

3. I understand that I may refuse to sign this Authorization. The Health System and its related entities will not refuse to treat me based on my refusal to sign the Authorization.

VOLUNTEER

_____ _____ _____

PRINTED NAME *SIGNATURE (Handwritten)* *DATE*

PARENT/GUARDIAN (APPLICANT UNDER THE AGE OF 18)

_____ _____ _____

PRINTED NAME *SIGNATURE (Handwritten)* *DATE*

INTERVIEWER: _____ **CHOICE: [ ] IN PERSON [ ] PHONE**

AREA OF ASSIGNMENT: _____ **DATE START:** _____

HR APPROVAL DATE: _____ **ORIENTATION DATE:** _____

Lake Charles Memorial Health System
VOLUNTEERS

LCMHS VOLUNTEERS PROGRAM

REFERENCE FORM #1

APPLICATION REQUIREMENT- 2 REFERENCES

References should be scanned and emailed to **volunteerservices@lcmh.com** or returned to applicant in a sealed envelope. **This is an application requirement and must be submitted before acceptance**. Call 337-494-2493 with any questions.

Please Print-DO NOT USE RELATIVES FOR REFERENCE

VOLUNTEER FIRST NAME:	**VOLUNTEER LAST NAME:**
REFERENCE FIRST NAME:	**REFERENCE LAST NAME:**
REFERENCE CONTACT **EMAIL:** **PHONE:**	**YEARS YOU HAVE KNOWN APPLICANT**
PLEASE CANDIDLY DESCRIBE THE FOLLOWING CHARACTERISTICS OF THE APPLICANT	
MATURITY	
ABILITY TO WORK WITH OTHERS	
ATTITUDE TOWARD TAKING INSTRUCTIONS	
SENSE OF RESPONSIBILITY	
DEPENDABILITY	
ADDITIONAL COMMENTS	

REFERENCE SIGNATURE_____**DATE:** _____

Lake Charles Memorial Health System
VOLUNTEERS

LCMH VOLUNTEERS PROGRAM
REFERENCE FORM #2
APPLICATION REQUIREMENT- 2 REFERENCES

References should be scanned and emailed to **volunteerservices@lcmh.com** or returned to applicants in a sealed envelope. **This is an application requirement and must be submitted before acceptance.** Call 337-494-2493 with any questions.

Please Print – DO NOT USE RELATIVES FOR REFERENCE

VOLUNTEER FIRST NAME:	**VOLUNTEER LAST NAME:**
REFERENCE FIRST NAME:	**REFERENCE LAST NAME:**
REFERENCE CONTACT **EMAIL:** **PHONE:**	**YEARS YOU HAVE KNOWN APPLICANT**
PLEASE CANDIDLY DESCRIBE THE FOLLOWING CHARACTERISTICS OF THE APPLICANT	
MATURITY	
ABILITY TO WORK WITH OTHERS	
ATTITUDE TOWARD TAKING INSTRUCTIONS	
SENSE OF RESPONSIBILITY	
DEPENDABILITY	
ADDITIONAL COMMENTS	

REFERENCE SIGNATURE_____**DATE:** _____