Chaplain Staff Information/Application Form

Name: _____ Date of Birth: _____
Professional Title/Position: _____ Full Time:_____ Part Time: _____
Church Name: _____ Home Address: _____
Address: _____ City, State, Zip:_____
City, State, Zip: _____ Home Phone: ( ) _____
Church Phone: ( ) _____ Cell Phone: ( ) _____
Email: _____
Spouse's name (if married):_____ Number of children_____

_____Ordained _____Licensed _____Certified _____Other (specify) _____
Ordaining/certifying/licensing body: _____
(Please attach copy of certificate)

MINISTRY EXPERIENCE: (Listing most recent first)

Church/Institution:_____
Address_____ City, State, Zip: _____
Inclusive dates of service:_____ Position:_____

Church/Institution:_____
Address:_____City State, Zip:_____
Inclusive dates of service:_____ Position:_____

Hospital ministry-related experience and/or chaplaincy involvement:_____
_____
_____
_____

It is helpful to us to know of education, special training, and areas of professional and civic interest as we attempt to utilize each members' gifts and abilities within the chaplaincy ministry at Blessing Hospital.

EDUCATION: (Circle the highest educational status you have attained)
High School **College:** 1 2 3 4 years **Seminary** **Other graduate degree program**
Other: _____

CLINICAL EXPERIENCE:
Have you completed Clinical Pastoral Education? ___ Yes ___ No Number of units completed: 1 2 3 4 _____
Other clinical training or experience: _____
_____

MEMBERSHIPS: List civic and religious organizations in which you hold membership:

_____

_____

_____

CHOICE OF AREAS OF SERVICE:

Required Primary Service (check one or more):

__Afternoon Shift (Noon-5 pm) __Evening Shift (5-10 pm) __Night Shift (10 pm-8 am) __Priest On Call (24 hrs.)

Optional Secondary Service in specialized areas (check as you have interest)

_____Hospice	_____Support Group Facilitator	_____Outpatient Referral
_____Oncology	_____Renal Dialysis	_____Disaster Team
_____Meditation Line	_____Chapel Services	_____ Other Interests (list on line below)

_____

REFERENCES: At least two of your listed references should be experienced, ordained or professional clergy/pastoral caregivers. Someone aware of your involvement in hospital ministry would be helpful. The Chaplain's Executive Committee may contact any or all references listed:

Name:_____ Name: _____
Address:_____ Address : _____
Phone: ( )_____ __ Phone: ( ) _____

Name:_____ Name: _____
Address:_____ Address:_____
Phone: ( ):_____ __ Phone: ( ) _____

Who referred you to the Chaplains Program? _____

Please take a few moments to consider and respond to the following five questions:

1. How did you learn about the Chaplain Program? _____

_____

2. Please share two or three brief thoughts on what you believe chaplaincy ministry is like:

_____

_____

_____

3. Why do you want to become a volunteer chaplain at Blessing Hospital?

_____

_____

_____

4. If you are accepted into this program, what do you feel your role as a chaplain would be?

_____

_____

_____

5. In your opinion, what qualities would you bring that qualify you for service as a volunteer chaplain at Blessing Hospital?

_____

_____

_____

~~We appreciate the efforts of pastors who make up the Chaplain Staff of Blessing Hospital. Recommendation~~ by the pastor's local faith community indicates the community's support of this added commitment on their pastor's time. **The signature and title of the chairperson of the governing board, council, deacons, etc., of the faith community is required for membership. It indicates support for the pastor's volunteer commitment.**

Recommended to the Chaplain Staff by the _____ faith community.
(Your Church)

_____ _____
Signature of Church Leader Title

_____

~~"I hereby request membership on the Blessing Hospital Chaplain Staff and will attend an orientation session. I~~ agree to conduct myself in accordance with the By-Laws, regulations and Code of Ethics adopted by the Blessing Hospital Chaplain Staff. **I will keep all patient information confidential.**"

Date:_____ Signature:_____

Executive Committee Action:
_____ Accepted as Provisional Member Date _____
_____ Approved as Active Status Chaplain Date _____
_____ Other Action Taken (Specify) Date _____

Rev. 2/95,. 6/97, 2/98, 7/00, 1/09

Volunteer Health Questionnaire

1. Do you have any limitations which would affect the kind of volunteer services assignment we would agree upon? _____ yes _____ no

2. Please provide information which would help us make an appropriate assignment:

_____

_____

_____

3. In case of emergency, list the name of a doctor we can notify:

_____

4. **Applies to volunteers working in the following areas: Blessed Beginnings, Child Care, Hospice, and Pediatrics, as well as those who participate in the following volunteer groups: Chaplain, Eucharistic Minister and Patient Representative.**

Have you had a TB test within the last year? _____ yes _____ no

TB test results: _____

5. **Applies to volunteers working in Blessed Beginnings, Pediatrics and Child Care.**

Have you had measles? _____ yes _____ no
If no, please provide proof of measle immunity through evidence of having a titre or measle shot.

MMR test results: _____

Authorization for Release of Information

I _____ authorize and request all persons acting in my behalf to furnish Blessing Hospital information for a reference check, background check, or specific medical information identified on the attached Volunteer Health Questionnaire. I release them and Blessing Hospital from any and all liability for any damages whatsoever that may occur as a result of this exchange of information.

(Name of volunteer)

_____ _____
(Signature of volunteer) *(Date)*

_____ _____
(Signature of Volunteer Services Staff) *(Date)*