Chaplain Staff Assistant 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_____

_____Licensed _____Certified _____Other (specify) _____
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:

_____

_____

_____

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 Volunteer Chaplain's Assistant 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's Assistant at Blessing Hospital?

_____

_____

_____

_____

_____

_____

4. If you are accepted into this program, what do you feel your role as a Volunteers Chaplain's Assistant would be?

_____

_____

_____

5. In your opinion, what qualities would you bring that qualify you for service as a Volunteer Chaplain's Assistant at Blessing Hospital?

_____

_____

_____

The signature and title of the chairperson of the governing board, council, deacons, etc., of the faith community and Pastor of your congregation is required for membership. It indicates support for the Volunteer Chaplain's Assistants commitment to the Chaplaincy program of Blessing Hospital.

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

_____ _____

Signature of Church Leader Title

_____

Signature of Pastor

_____

"I hereby request membership to the Volunteer Chaplain's Assistant 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 Chaplain's Assistant Member

Date _____

_____ Accepted as Active Chaplain's Assistant Member

Date _____

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
(Name of volunteer)
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.

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

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