Ambassador Program Application Packet

Thank you for your interest in becoming an Ambassador at Centinela Hospital Medical Center. Please complete the attached forms and then contact the Centinela Hospital Ambassador Program office to schedule an interview. Please be advised that your application needs to be complete and ready for review at the time of your interview.

Centinela Hospital Medical Center
Ambassador Program Office
555 E. Hardy St.
Inglewood, CA 90301

FAX: (310) 673-0251
E-Mail: jbracamontes@primehealthcare.com

In addition to this application packet, all applicants will need to complete a TB test, drug screening and background check. Once an applicant has been accepted into the program, they will need to attend an 8 hour orientation session at the hospital. If you have any questions, please contact Jackie Bracamontes, Volunteer Services Supervisor at (310) 680-8869.

Thank you

Jackie Bracamontes
Volunteer Services Supervisor
Centinela Hospital Medical Center

Centinela Hospital Medical Center
Ambassador of Patient Care Application

Personal Information:

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone (Home): _____ (Office/Cell): _____ Gender: M F (Circle)

Social Security Number: _____ E-Mail: _____

Date of Birth (minimum age requirement is 16) (month/day/year): _____

Driver's License Number: _____ State: _____

Car –Make, Model, & Year: _____ License Number: _____

Name & Phone Number of your personal physician: _____

_____

Name & Phone Number of someone to contact in case of emergency: _____

_____

Have you ever been employed by Centinela Hospital Medical Center?

Yes / No (Circle) If yes, when? _____

Skills and Interests:

Educational Background: _____

Are you currently in college/vocational school? _____ Year? _____

Where: _____

CENTINELA HOSPITAL MEDICAL CENTER

TRUVEN HEALTHANALYTICS 100 TOP HOSPITALS 2013

Current Occupation: _____

Past work experience: _____

Do you speak/write/read another language fluently? _____

Previous Volunteer experience: _____

Do you have any physical limitations that require accommodation?

_____

_____

References:

List two (2) personal references with phone numbers:

Name:_____ Date:_____

Name:_____ Date:_____

I authorize the references listed above to provide Centinela Hospital Medical Center with information relevant to volunteering.

_____ _____

Signature **Date**

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Ambassador Uniform Guidelines

VOLUNTEERS MUST BE IN UNIFORM TO SIGN-IN

Identification: Every Ambassador is issued an identification badge once they are accepted into the program. This **MUST** be worn at all times while on duty at the hospital. It should be prominently displayed on your uniform jacket. Your I.D. badge not only identifies you, but is also used to clock in to keep track of your hours of service at the hospital.

Personal Hygiene: Please avoid the use of perfume, cologne or any skin care product with a strong scent as it may cause breathing difficulty for patients or visitors. Nails should be kept at a moderate length which will not interfere with your duties. All body art (tattoos) must be covered. No face, lip, nose or tongue jewelry.

Foot Apparel: White closed toed shoes are a required part of the ambassador uniform. Open toed shoes are a safety hazard and are not allowed.

Ambassador Uniform: Ambassadors will be provided with one gray uniform jacket with identifying Ambassador patch. In addition, Ambassadors need to be attired in white pants and white closed toed shoes. Jeans and t-shirts are not acceptable. In order to maintain a professional appearance, your uniform should be clean and wrinkle free.

I (print name) _____ *have read, understand and will abide by the Ambassador Program dress code. I understand that I must be in uniform to sign in and that I may be sent home if I am not in uniform.*

Signed: _____ Date: _____

Youth Volunteer Parental / Guardian Consent Form

(Required for all youth volunteers under 18 years of age)

In order for your child to become a volunteer at Centinela Hospital Medical Center, we need your consent and your involvement in helping them have a meaningful experience. Please read and sign this parental consent form. Should you have any questions about the nature of our program, now or at any time in the future, please do not hesitate to contact Jackie Bracamontes at (310) 680-8869 or by e-mail at jbracamontes@primehealthcare.com.

I, the undersigned parent/guardian of _____, who is at least age sixteen but not yet age eighteen, do hereby authorize my child to participate in such volunteer activities in Centinela Hospital Medical Center's Volunteer Program. I understand that he/she will be provided with orientation and training necessary for the safe and responsible performance of his/her duties and that he/she will be expected to meet all the requirements of the position, including regular attendance and adherence to Hospital policies and procedures. I understand that he/she will not receive monetary compensation for the services contributed.

I release and agree to indemnify and hold harmless Centinela Hospital Medical Center from any and all liabilities related to or arising from my son/daughter's service as a volunteer, even if arising from the Hospital's negligence, to the fullest extent permitted by law. I also agree that I will assume all costs and expenses (including medical care costs) associated with any injury related to or arising from my son/daughter's service as a volunteer.

In case of injury, I give permission for my son/daughter to be treated in the Emergency Department at Centinela Hospital Medical Center. I understand that all efforts will be made to contact me before treatment occurs, and that it will only proceed without my verbal consent in case of extreme emergency.

This parental consent form shall remain effective for the period of time my son/daughter is a volunteer at Centinela Hospital Medical Center.

I have read, understand, and accept these terms.

Signature: _____ Date: _____

Printed Name: _____

Nature of Relationship: _____

CONSENT TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

In connection with, and for the duration of, my employment (including contract for services) with you, I understand that you may obtain consumer reports for employment purposes that relate to my credit, criminal, driving, employment or education history. This information will, in whole or in part, be obtained from Insight Investigations, Inc. ("Insight") PO Box 891571, Temecula, CA 92589 (800) 615-8111. These reports may include information as to my general reputation, character, personal characteristics, mode of living, work habits, job performance and experience along with reasons for termination of past employment from previous employers. I understand that you may be requesting information from various federal, state and other agencies or institutions, which maintain public and non-public records concerning my past activities relating to my driving, credit, civil, education and other experiences.

I authorize, without reservation, any party, institution, or agency contacted by Insight or this employer to furnish the above mentioned information:

Applicant Name	Date of Birth	Social Security Number
	____/____/____	____-____-____

Alias/Previous Name(s) _____ Email address: _____

Current Address	City & State	Zip Code

Driver's License #	State	Position Applied For

☐ **California, Minnesota & Oklahoma Applicants Only:** Please check here to have a copy of your consumer report sent directly to you. Minnesota and Oklahoma applicants will receive a copy directly from Insight. California applicants may receive a copy from either the prospective employer or Insight.

☐ **Do not contact Current Employer**

Notice to CALIFORNIA Applicants

Under Section 1786.22 of the California Civil Code, you have the right to request from Insight, upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you, which Insight has previously furnished within the two-year period preceding your request. You may view the file maintained on you by Insight during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services. Upon making a written request, you may receive a summary of your report via telephone.

Under Section 1786.16(a)(2)(B)(vi) of the California Civil Code, you are notified that Insight privacy practices can be found at http://www.insightscreening.com/privacy.htm

Under Section 1785.20.5 of the California Civil Code and Section 1024.5 of the California Labor Code, you are notified that a credit report may be ordered if you are applying for a position involving access to confidential or proprietary information.

Notice to NEW YORK Applicants

Under Article 25 Section 380-g of the New York General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

APPLICANT SIGNATURE_____ DATE _____

CENTINELA HOSPITAL MEDICAL CENTER

TRUVEN HEALTHANALYTICS 100 TOP HOSPITALS 2013

Ambassador Health Questionnaire

Today's Date _____

Last Name _____ First Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

☐ Male
☐ Female Date of Birth _____ Phone Number _____ E-Mail _____

Physician Name _____ Physician's Address _____

Describe your present health in your own words _____ Height _____ Weight _____ Age _____

NURSE USE ONLY

Drug Screen _____ Smoker: ☐ Yes ☐ No

Recommendations _____

Allergies _____

RN Signature _____ Date _____

PPD: Date _____ Dose _____ Site _____ By _____

Read: Date _____ Erythema _____mm Induration _____mm By _____

Chest X-Ray _____ Referred PMD: ☐ Yes ☐ No

PPD HISTORY: Please place a check mark next to any which apply to you

☐ Had a measles or polio vaccine in the past 2 months
☐ Currently taking cortisone or steroids
☐ Ever received BCG
☐ Had a positive or reactive PPD
If yes, was follow up chest x-ray done? Date: _____
If no, why not? _____
☐ Had a chest x-ray positive for tuberculosis
If yes, were you treated and how: _____
If no, why not? _____

If you have a history of a positive PPD and a negative chest x-ray, do you currently have any of the following?

☐ Night Sweats
☐ Cough / Hoarseness
☐ Fever / Fatigue
☐ Unexplained weight loss
☐ Chest Pain / Cough up blood
☐ None of above

CURRENT HISTORY

Drugs and Medications

List any drugs or medications you take regularly or frequently

_____ _____ _____ _____

_____ _____ _____ _____

Immunizations / Injections

Date of last tetanus: _____

Have you ever had any of the following vaccinations?

- ☐ Measles _____ date
- ☐ Mumps _____ date
- ☐ Rubella (German Measles) _____ date
- ☐ Hepatitis B Immune Globulin _____ date
- ☐ Gamma Globulin _____ date
- ☐ Hepatitis B Vaccine _____ date
  # of injections received _____ date
- ☐ Are you currently on steroids _____ date

List Current Medical Problems

_____ _____ _____ _____

_____ _____ _____ _____

- Please check the appropriate answer for each condition listed
- Insert dates and treatment details for each "YES" answer in the space provided

Yes	No		Yes	No	
☐	☐	Allergies _____	☐	☐	Amputation _____
☐	☐	Anemia _____	☐	☐	Asthma _____
☐	☐	Arthritis _____	☐	☐	Shortness of Breath _____
☐	☐	Back Injury _____	☐	☐	Bleeding Tendencies _____
☐	☐	Blind (Vision Problems) _____	☐	☐	Cancer / Tumor _____
☐	☐	Wear Glasses _____	☐	☐	Diabetes _____
☐	☐	Deaf (Hearing Loss) _____	☐	☐	Heart Trouble / Chest Pains _____
☐	☐	Use Hearing Aid _____	☐	☐	Hernia _____
☐	☐	Dizziness / Fainting _____	☐	☐	Joint Problems _____
☐	☐	Emphysema _____	☐	☐	Mental / Emotional Problems _____
☐	☐	Headaches (Migraine) _____	☐	☐	Neck Injury _____
☐	☐	Hepatitis _____	☐	☐	Nerve Problems / Neuritis _____
☐	☐	High Blood Pressure _____	☐	☐	Seizures / Epilepsy / Convulsions _____
☐	☐	Multiple Sclerosis _____	☐	☐	Skin Disease / Rash _____
☐	☐	Muscle Weakness _____	☐	☐	Other _____
☐	☐	Polio _____			
☐	☐	Tuberculosis _____			

Illness or change in condition in the past year:

_____

_____

Do you use:
- ☐ Crutches
- ☐ Cane
- ☐ Prosthesis
- ☐ Brace

HOSPITALIZATIONS / SURGERIES

Please provide the following information concerning hospitalizations and surgeries

Type of Illness or Operation	Month & Year	Name of Hospital

Do you have any restrictions or things you are unable to do: _____

_____

_____

I, the undersigned, certify the above answers are true, and understand that any false statement may be ground for termination. I understand that this physical examination is not comprehensive, but only intended as an assessment of my ability to perform my work. I understand that the positive or negative finding pertaining to my ability to perform work shall be submitted to the hospital.

Signature: _____ Date: _____