Project Compassion, Inc.

St. Scholastica Retreat Center
1205 South Albert Pike Ave.
Fort Smith, AR 72903

P: (479) 783-2273 F: (479) 783-1849
Email: director@projectcompassioninc.com
www.projectcompassioninc.com

Volunteer Application

Last Name: _____First Name: _____ Middle: _____

Other Name(s)*(maiden, etc)*: _____ Social Security Number: ___-__-____

Address: _____

City: _____ State: _____ _ Zip: _____ Birthday: ___/___/____

Phone: Main: (___) ___-____ Cell: (___) ___-____ Email: _____

Employer: _____ Position: _____

Emergency Contact: _____ Relation: _____

Phone: Home: (___) ___-____ Cell: (___) ___-____ Work: (___) ___-____ Email: _____

How did you hear about Project Compassion? _____

References:

Name: _____ Relation: _____ Phone: (___) ___-____

Name: _____ Relation: _____ Phone: (___) ___-____

Areas of Interest *(check all that apply):*

☐ Visiting a Resident in the Nursing Home
☐ Events *(Luncheons, Tennis Tournament, etc.)*
☐ Hearts of Gold Campaign *(Nov-Dec)*
☐ Office or Administrative Work
☐ Other: _____

What activities do you enjoy? _____

What do you hope to get out of your volunteering? _____

Please list your availability: _____

Do you authorize Project Compassion, Inc. to perform a background check? *(check one)* ☐ Yes ☐ No

Do you authorize Project Compassion, Inc. to use your name and photo for publicity in print/TV/online regarding your volunteer work at Project Compassion? *(check one)* ☐ Yes ☐ No

Signature: _____ Date: _____
(By typing your name you are agreeing to terms)

For Office Use Only:

Name Pin Ordered: ___ Date Given to Volunteer: _____ Nursing Home Preference: _____

Key Volunteer Notified: ___ Orientation Date: _____ By: _____RSVP app:_____

Project Compassion, Inc. is a 501 (c)(3) organization and proud United Way Community Partner.

Community Partner LIVE UNITED United Way

CONFIDENTIALITY PLEDGE FOR PROJECT COMPASSION VOLUNTEERS

I understand that while I am visiting in this capacity, I may be exposed to "protected health information," as that term is defined and used in the nursing home policies and in the federal HIPAA privacy regulations (the "Privacy Regulations"), and other information deemed to be confidential by other laws. Protected health information is information about a person's health or treatment that identifies the person. I also understand that while I am visiting in this capacity I may be treated as a temporary member of the nursing home's "workforce" for purposes of the Privacy Regulations only.

I pledge and agree not to use or disclose any of this protected health information, and any other confidential information.

I understand that I may direct to the nursing home Privacy Officer any questions I have about my obligations under this Confidentiality Pledge or under any of the nursing home policies and procedures and applicable laws and regulations related to confidentiality.

_____

Printed Name of Project Compassion Volunteer

_____

Address of Volunteer (Street, City, St, Zip)

_____ _____

Telephone of Volunteer

Email Address of Volunteer

_____ _____

Signature of Volunteer
(By typing your name you are agreeing to terms)

Date

For Office Use Only

I, as sponsor of the above-named Volunteer, have reviewed this pledge with the volunteer and certify that the volunteer is in the nursing home for one-to-one visitation with the residents only.

_____

Printed Name of Party at Project Compassion Responsible for Volunteer

_____ _____

Responsible Party Signature ***Date***