



Lakeland Advocate Program – Volunteer Personal Reference Request

_____ has applied to become an Advocate Volunteer for the Sexual Assault Nurse Examiner program at Lakeland Health. Your name has been submitted as a personal reference. Please respond to the following questions. *Answers will remain confidential.*

How long have you known the applicant and in what capacity do you know them? What is your relationship to them?

Please rate the applicant on the following criteria by writing "Yes," "No," or "N/A (Not Applicable):"

- _____ 1. Is the applicant dependable and reliable?
- _____ 2. Is the applicant punctual?
- _____ 3. Does the applicant work well with others?
- _____ 4. Is the applicant able to work independently?
- _____ 5. Is the applicant honest and trustworthy?
- _____ 6. Do you think this applicant would perform well and be an asset to Lakeland Health in assisting sexual assault survivors?

What do you think about the applicant providing support to sexual assault survivors by helping them emotionally cope with the trauma they've endured while undergoing an invasive forensic examination?

Volunteers play a vital role to patients, staff, and visitors at Lakeland Health. Thank you for your assistance in the screening process. Please return this completed form in the enclosed business reply envelope. The screening process for this applicant won't resume until your completed "Personal Reference Request" has been received.

Your Full Legal Name: _____

Date: _____

Telephone: (_____) _____ E-Mail: _____

Your honest and sincere feedback is important to us. Please feel free to include a separate letter that provides more insight into the aforementioned Advocate Volunteer. For example, share a story that demonstrates the applicant's character.



Statement of Commitment: Lakeland Advocate Program

I understand that as an Advocate Volunteer, I must fulfill a minimum of 24 hours of service per month. I also understand that when I'm on-call, I will be available during the entire shift to assist with any crises that may arise. I will make the appropriate lifestyle and/or schedule changes to support my commitment to the Sexual Assault Nurse Examiner program at Lakeland Health. If scheduling conflicts arise that are unavoidable, it is my responsibility to find a replacement Advocate Volunteer who can cover my shift.

I know that serving as an Advocate Volunteer will impact my life, as I'll be assisting real-life sexual assault survivors of all ages who have endured a traumatic event.

As an Advocate Volunteer, I promise to be caring, compassionate, and friendly; performing my Advocate Volunteer duties to the best of my abilities.

I know that what I do here at Lakeland matters, and that I am valued, and will make a difference in the lives of others.

By signing this document I agree to the aforementioned terms as presented.

Print First and Last Legal Name

Sign First and Last Legal Name

Date (Month/Day/Year)

**Berrien County Justice System – Public Access Defendant History Report
Criminal Background Check**

TOP PORTION TO BE COMPLETED BY VOLUNTEER

Name (Last, First):	
Social Security Number:	
Street Address:	
City:	
State:	
Zip Code:	
Date of Birth:	
Lakeland Site (Please Circle):	Lakeland Hospital, Niles Lakeland Hospital, Watervliet Lakeland Medical Center, St. Joseph

STAFF USE ONLY

NO RECORD	
Drug Court Record (<i>See Attached</i>)	
Signature:	
Job Title:	
Date:	

Fax to: Berrien County Sheriff's Office; Attention: Gail Hindu
 Fax Number: (269) 982-8650 Date Faxed: _____ Initials: _____
 Date Background Check Received: _____

Fax Results To:
 Lakeland Advocate Program, Attention Meg Gallert, (269) 683-2337



Lakeland Health Volunteer Requirements

As a Lakeland Health volunteer, I agree to the following conditions and terms:

1. I am 18 years of age or older, with no prior criminal background or history.
2. I've been a resident of Berrien County for at least six months or longer, with no plans of moving or re-locating to a different area within the next year.
3. I own or have access to a reliable car or method of transportation.
4. I own or have access to a phone so I will be reachable at any point in time during my shifts.
5. I shall hold, as absolutely confidential, all information that I obtain directly or indirectly concerning patients, physicians, and hospital personnel.
6. My services are voluntarily donated to the hospital without expectation of compensation or future employment.
7. I understand that it is a violation of hospital policy to solicit business of any kind, including acting as an agent for an outside business, or soliciting business from patients and/or staff. I understand that violation of this policy may result in my termination as a volunteer.
8. I shall not sell or attempt to sell goods and/or services, request contributions and/or donations, or solicit people to sign and/or distribute political materials on hospital grounds, unless I receive prior authorization from the Manager of Volunteer Services to engage in these activities.
9. I shall submit to health requirements, which may include tuberculin (TB) skin tests and/or immunizations that may be necessary as part of my volunteer service.
10. I authorize Lakeland Health to photograph me and use such photographs for charitable activities, education, marketing, and other such purposes it may deem appropriate.
11. I shall make my best effort to fulfill my commitment to Lakeland Health by completing all assignments that I accept.
12. I shall be conscientious, courteous, and punctual; conducting myself with dignity and striving to achieve professional-quality work.
13. I agree to commit to at least one year of service as an Advocate Volunteer. I understand that my commitment is automatically extended beyond the stated minimum requirement, unless termination is requested.
14. I understand that Volunteer Services reserves the right to terminate my volunteer status as a result of:
 - Failure to comply with hospital policy, regulations, and/or rules
 - Four consecutive absences without prior notification
 - Unsatisfactory appearance, attitude, and/or work
 - Any other circumstance that, in the opinion of the Manager of Volunteer Services, would make my continued service as an Advocate Volunteer contrary to the best interests of Lakeland Health
15. I agree to inform the Supervisor of Volunteer Services if I decide to resign my volunteer position and agree to an exit survey. I also agree to return my badge and uniform upon resignation.

By signing this document, you understand and agree to all of the terms stated within this agreement.

Print First and Last Legal Name

Sign First and Last Legal Name

Date (Month/Day/Year)

Your signature serves as your acknowledgement of the requirements of the Volunteer Program at Lakeland Health. If you have any questions or concerns, please call the main Volunteer Office at Lakeland Medical Center, St. Joseph at (269) 983-8102. We anticipate that you'll have a positive and rewarding experience at Lakeland Health.