



1813 Laurel Street Columbia, SC 29201 | Phone: 803.254.6644 | Fax: 803.254.2209
www.schivaidscouncil.org

Volunteer/Intern Application

Please print. Thank you.

Name: _____ Date: _____
Address: _____ City/Zip: _____
County: _____ Birthday: _____
Employer: _____ Position: _____
Phone (Cell): _____ Phone (Work): _____
Phone (Home): _____ Date available to Start: _____
Is it okay to leave messages at your home or work or on your cell? Yes No _____
Email Address: _____

EDUCATION

Name of School	Graduation Date	Diploma/Major
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_____	_____	_____
_____	_____	_____
_____	_____	_____

What area of Volunteer Service are you interested in?

Education/Outreach Advocacy/Policy PR/Marketing Communication Fund Raising Grant Writing
 Girls' & Women's Issues GLBT Issues HIV/AIDS Ministry Administrative Information Technology (IT)
 As Assigned Internship Other (please explain below)



Describe the skills you bring that you feel would be beneficial to the organization?

What other organizations have you volunteered with and what was your position?

What did you like best about your last volunteer position?

What did you like least about your last volunteer position?

How did you hear about our volunteer program? Web Newspaper Mail Friend Family Presentation/Event School House of Worship Other: _____

Have you ever been convicted of a misdemeanor or felony offense to include crimes against children? Yes No If yes, please explain:

Are you willing to submit to a background check? Yes No

Do you have any physical limitations that would prevent you from performing volunteer assignments? Yes No

If yes, please explain:

When are you currently available to volunteer? Please specify the days of the week and hours during which you are potentially available each day (see page 3):



Monday _____ am/pm (until _____ am/pm Tuesday _____ am/pm (until) _____ am/pm
Wednesday _____ am/pm (until) _____ am/pm Thursday _____ am/pm (until) _____ am/pm
Friday _____ am/pm (until) _____ am/pm Saturday _____ am/pm (until) _____ am/pm

Can you commit to a minimum of five volunteer hours per month? ___ Yes ___ No

How long do you anticipate being a volunteer with the SC HIV/AIDS Council (SCHAC)?

PLEASE ATTACH A CURRENT RESUME, IF AVAILABLE.

Emergency Contact Information:

Physician's Name: _____ Phone: _____
Address, City, Zip: _____

Whom should we contact in the event of an emergency?

Name: _____ Phone: _____
Relationship: _____ Alternate Phone: _____

Release of Liability

This is to certify that I wish to participate by volunteering my services at the South Carolina HIV/AIDS Council. I hereby release the South Carolina HIV/AIDS Council, its agents, and employees from any liability or any consequences of my request to participate in this service. I make this release entirely of my own free will, without any threats, coercion or encouragement from any employee of the South Carolina HIV/AIDS Council.

Volunteer Signature

Date

OFFICE USE ONLY	
Date Application Received: _____	Date of Interview: _____
Date of SCHAC Orientation: _____	<input type="checkbox"/> Scheduled <input type="checkbox"/> Complete



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ALL SCHAC VOLUNTEERS, SERVICE LEARNING STUDENTS & INTERNS AGREE TO:

1. Commit to a minimum of five (5) volunteer hours per month, for as long as you are available. Should you choose to discontinue your service as a volunteer, you agree to notify the Volunteer Coordinator or Human Resources Representative.
2. Maintain **CONFIDENTIALITY** at all times.
3. Attend any training that may be required.
4. Return all phone calls in a timely manner.
5. Follow all policy and procedures outlined during initial orientation.
6. Notify the Volunteer Coordinator or Human Resources Representative of any problems or concerns regarding a volunteer assignment.
7. Follow through on all accepted assignments
8. Follow all procedures as presented with regard to: buddy support, office assistance, or any volunteer assignments.
9. Provide feedback in an appropriate manner to staff, clients and other volunteers.
10. Carry yourself in an appropriate/professional manner when representing SCHAC in any meetings or training.

VOLUNTEERS WILL BE TERMINATED FOR ANY OF THE FOLLOWING:

1. Breaching **CONFIDENTIALITY** in any way.
2. Rudeness to a client, any member of client's support network, other volunteers, staff, or anyone for whom such rudeness might reflect negatively on SCHAC.
3. Intentional negligence
4. Failure to drive safely, failure to obey posted traffic speeds, failure to use seat belts, failure to ensure client uses seat belts.
5. Being under the influence of a controlled substance or alcohol while serving as a representative of SCHAC.
6. Drinking alcohol or doing drugs while with a client or around a client.
7. Buying alcohol or drugs for a client.
8. Selling alcohol or drugs to a client.
9. Engaging in any behavior which could be considered illegal.
10. Having sex with a client.
11. Giving or lending money to a client
12. Borrowing or taking money from a client.

I AGREE THAT I HAVE READ AND UNDERSTAND ALL OF THE ABOVE, AND AGREE TO ADHERE.

Printed Name

Signature

Date



TO: All Employees, Contracted Individuals and Volunteers

FROM: Dr. Bambi Gaddist, Executive Director

Subject: Breach of Confidentiality

I agree to use the information obtained from the patient's records for continuing education, medical review, and study, and will preserve and protect privileged contents of the records and any other confidential information obtained. In addition, I acknowledge that any results obtained through this study/review are the sole use of South Carolina HIV/AIDS Council. Further, it's understood that this material is subject to Section 40-70-20 of the Code of Laws of the State of South Carolina concerning the confidentiality of materials and information acquired by the Quality Assurance Committee.

I understand that under Section 1166(b) of the Social Security Act, penalties may be fined of not more than \$1,000.00 and/or imprisonment for not more than six months for breach of confidentiality of medical, identifying data, patterns of care, etc., on Medicare, Medicaid, and Champus patients.

Employee/Contracted Individual/Volunteer

Date



Media Release Form

The South Carolina HIV/AIDS Council (SCHAC), its designees, and affiliates will be using various individual, and/or group photographic, video images or personal information to document projects, and events using different types of media publication.

I irrevocably and absolutely consent to the unrestricted use of and waive any right to inspect or approve the finished images, copy, text, or other printed matter that may be used in conjunction therewith, and the eventual use to which the images may be applied.

By signing this form I, _____, am granting permission to SCHAC, its designees, and affiliates to use my photo, video images, or personal information for different types of media publication.

E-mail Address _____

Printed Name _____

Signature _____

Date _____