160 East Erie Avenue
Philadelphia, PA 19134-1095
Tel: (215) 427-5000

Dear Applicant:

Thank you for your interest in St. Christopher's Hospital for Children. Please review the information below that lists the prerequisites for participating in activities at the hospital. NOTE: All steps must be completed and required documentation received before you begin the requested activity.

1. Please access the appropriate application and information sheets by clicking on the links located on the volunteering page of the St. Christopher's website: http://www.stchristophershospital.com/volunteering

2. Make note of the criteria and information required for your activity of interest.

3. Complete required steps and gather all required documentation.

4. Please send completed volunteer application forms to:
   Email: SCH-Volunteer@AmericanAcademic.com (Please put your name and "Volunteer Application" in the subject line.)
   Mail: Volunteers Department St. Christopher's Hospital for Children 160 East Erie Avenue Philadelphia, PA 19134-1095

5. For questions or assistance with the application process, please contact Barbara A. Liccio, Director of Volunteer Services at (215) 427-5398.

When all of the required information and documentation has been submitted, a representative from Volunteer Services will contact you to discuss next steps.

Thank you for your interest.

VOLUNTEER ON-BOARDING PROCESS
INFORMATION SHEET

A volunteer is defined as anyone who provides a service without pay for personal gratification not required for academic purposes, contractual agreement or monetary gain.

On-boarding of volunteers will be handled by the Department of Volunteer Services. The point of contact for Volunteer Services is: Barbara A. Liccio, Director of Volunteer Services, 215-427-5398

Initiation of on-boarding process:

- Interested applicants who contact Volunteer Services Department expressing interest in volunteering will be directed to the St. Christopher's Hospital for Children's website for completion of application packet: http://www.stchristophershospital.com/volunteering

- Completed application packet is returned to Volunteer Services Department (Department Director and/or designee) for review of required documents. ***On-boarding may take 30-45 days to complete.***

    - Application
    - Consent documentation for "serving without pay" (minors, ages 15-17)
    - Application Agreement
    - Personal Statement of Intent
    - Skillbank
    - Parental Release Form (minors, ages 15-17)
    - Authorization for Release of Medical Information
    - Tuberculin (TB) Test Consent Form
    - Pre-Volunteer Drug Testing Consent Form
    - Criminal Background Check Form
    - FBI IdentoGO Application Registration Form (Fingerprinting)
    - Child Abuse History Clearance Information (Will be facilitated by volunteer candidate. For Child Abuse Clearance, free of charge, please go to: www.compass.state.pa.us/cwis/public/home

Required documents:

- Must provide current immunization records or documentation of having immunity for the following infectious diseases: Measles, Mumps, Rubella, Varicella (Chicken Pox), Hepatitis B, Tetanus, Diphtheria, proof of PPD (Tuberculosis) testing twice during the past twelve months or QuantiFERON and Influenza vaccine during the present Flu season (September through April) is also required. Documentation of immunity will expedite the process.

St. Christopher's Hospital for Children

VOLUNTEER ON-BOARDING PROCESS
INFORMATION SHEET

- Criminal background check within the past six months. This must include a seven year detailed summary inclusive of OIG (Office of Inspector General), GSA (General Service Administration) with State Patch and Offender Sex Registry, Department of Public WelfarePennsylvania Child Abuse History Clearance within the past six months, FBI IdentoGo Fingerprinting Clearance within six months and/or agree for St. Christopher's Hospital for Children to conduct all of the above screenings.

- Complete Reference Forms: 1 personal and 1 professional

Students (minors, ages 15-17):

- Consent documentation for "serving without pay"

- Parental Release Form

- Letter of Reference from School

- Completed application packet should be returned to Volunteer Services Department for in-processing and on-boarding process. Volunteer Services will evaluate the completion of the submitted application packet. Volunteer applicant will be notified by staff member of Volunteer Services Department if there are any files with missing documentation.

- Volunteer Services will schedule an interview with applicant

- Volunteer Services will work with departments in the development of the volunteer service descriptions for assigned volunteers

- Volunteer Services approved applicants will then be scheduled by Volunteer staff for appointment with Employee Health for drug screening and physical

- Volunteer Services will schedule volunteer applicant for hospital orientation

- Volunteer services will communicate with volunteer applicant days, hours and start date

- Volunteer Services will provide document for issuing hospital I.D. badge (Hospital Security will not accept any I.D. badge request form for volunteers without the prior consent of the Department of Volunteer Services via a formally signed document).

St. Christopher's Hospital for Children

VOLUNTEER ON-BOARDING PROCESS
INFORMATION SHEET

Termination Process:

- Volunteer Services Director or designee will collect hospital I.D. badge from volunteer on their last day and maintain in archive file.

- Volunteer Services Director or designee will notify security of termination of volunteer status.

- Volunteer Services Director or designee will notify Human Resources of termination of volunteer who has had computer or system access and will follow the employment termination process.

St. Christopher's Hospital for Children

VOLUNTEER APPLICANT

Categories Include:
Adult Volunteer
Student Volunteer
Pet Therapy Volunteer
Shadowing

Summary of Necessary Application Steps:

Complete application packet

Provide criminal background check within the past six months. This must include a seven year detailed summary inclusive of OIG (Office of Inspector General), GSA (General Service Administration) with State Patch and Sex Offender Registry, Department of Public Welfare Pennsylvania Child Abuse History Clearance within the past six months, FBI IdentoGo Fingerprinting within the past six months and/or agree for St. Christopher's Hospital for Children to conduct all of the above screenings.

Provide current immunization records or documentation of having immunity for the following infectious diseases: Measles, Mumps, Rubella, Varicella (Chicken Pox), Hepatitis B, Tetanus, Diphtheria. Proof of PPD (Tuberculosis) testing twice during the past twelve months and Influenza Vaccine during the present Flu season (September through April) is also required. Documentation of immunity will expedite the process.

Agree to be screened by St. Christopher's Hospital for Children Employee Health Services. Screening to include: Physical, Drug Screening, 2 PPD's (Tuberculosis) or QuantiFERON and Influenza vaccine. If applicant can provide documentation of 1 PPD then only 1 PPD will be required to be administered by Employee Health Services.

Provide 2 references

Attend Hospital Volunteer Orientation

For additional information please contact:

Barbara A. Liccio, Director of Volunteer Services at (215) 427-5398.

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION PACKET

Volunteer Services
160 East Erie Avenue
Philadelphia, PA 19134-1095
(215) 427-5398

We take pride in the diversity provided in our workplace and provide equal employment opportunity for all qualified applicants.

St. Christopher's Hospital for Children is a tobacco-free workplace.

Please note this application does not apply to Shadowers. Individuals interested in Shadowing should refer to the Shadowing Application.

St. Christopher's Hospital for Children

Please Check one:
☐ **Adult**
☐ **Student (minor, age 15-17)**
☐ **Pet Therapy**
Date Received: _____
Application:_____ Complete____ Incomplete
Date Interviewed: _____

VOLUNTEER APPLICATION

PLEASE PRINT

Date: _____ Date of Birth: _____

Name: _____
(Last) (First) (Middle)

Present Address: _____
(Street) (City) (State) (Zip)

Telephone: Home ( ) _____ Work ( ) _____

E-mail address: _____ Cell ( ) _____

If minor, Name of Parent or Guardian _____

IN CASE OF EMERGENCY, NOTIFY:

_____
Name Address City, State, Zip

_____
Relationship Telephone Number Cell Phone Number

_____ Email address

SERVICE AREA AND TIME PREFERENCE:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Hrs: _____ Hrs: _____ Hrs:_____ Hrs:_____ Hrs:_____ Hrs: _____ Hrs:_____

When do you prefer to volunteer? (Check all that apply): ☐ Morning ☐ Afternoon ☐ Evening

Please specify preference:

☐ No patient contact ☐ Limited patient contact ☐ Clerical
☐ Patient contact ☐ Children's Services ☐ Pet Therapy

Are there any work activities or conditions that you must avoid? Yes ☐ No ☐ Please list: _____

_____
Is there any reason you will not be able to carry out in a safe manner all assignments associated with this role?
Yes ☐ No ☐

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

EDUCATION:

Education (Please Circle) Grades 1 2 3 4 6 7 8 9 10 11 12 College Degrees Obtained or In Progress:

_____

School presently attending:_____

Education program or special training (describe):

_____

If minor, please provide name of school_____Grade _____

EMPLOYMENT/VOLUNTEER HISTORY: Starting with your most recent, list all positions and activities including self-employment, volunteer work, and all significant experience.

Employer	Street	City	State	Zip Code
Job Title	Supervisor Name & Telephone Number			
Date Employed (mo/yr)	Date separated (mo/yr)			
Duties				
Reason for leaving				

Employer	Street	City	State	Zip Code
Job Title	Supervisor Name & Telephone Number			
Date Employed (mo/yr)	Date separated (mo/yr)			

Duties
Reason for leaving

Employed_____ **Unemployed_____** **Retired_____**

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

PERSONAL REFERENCE (Other than relatives) – Please provide full mailing address.

NAME	STREET/CITY/STATE/ZIP	PHONE
		Home: Work: E-mail:
		Home: Work: E-mail:

PET THERAPY PROGRAM VOLUNTEERS

PET INFORMATION:

Name of Dog: _____ Date of Birth: _____

Dog Breed: _____ Gender: ☐ Male ☐ Female

PET CERTIFICATION:

Has dog been certified? Yes ☐ No ☐ Date of Certification: _____

Certifying Agency (please check appropriate box): ☐ Pet Partners ☐ Therapy Dog International

☐ Other _____

Has dog been a part of a Pet Therapy Program Previously? Yes ☐ No ☐

If yes, please provide information to include, Agency/Hospital name, contact information and length of involvement

Name of Agency:_____ Contact Person: _____

Phone #: _____ Email Address:_____

Length of Involvement: _____ Start Date: _____ End Date: _____

IF USING A HARD COPY OF THIS APPLICATION, PLEASE RETURN TO:

ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN DEPARTMENT OF VOLUNTEER SERVICES 160 EAST ERIE AVENUE PHILADELPHIA, PA 19134-1095

St. Christopher's Hospital for Children

Student Volunteer

(minors, ages 15-17)

Student volunteers minors, ages 15-17 must complete this application him or herself. All volunteers serve without pay. Students must show proof of age, photo identification and immunization records. Parental permission is required.

_____

Print Name Date

_____

Signature of Student Date

Consent for minors ages 15-17 (to be completed by parent or person responsible)

I hereby give my consent for _____ to serve as a volunteer at St. Christopher's Hospital for Children.

_____

Print Name Date

_____

Signature of Parent or Guardian Date

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

APPLICANT AGREEMENT:

- I certify that the information contained in this application is correct and complete to the best of my knowledge.

- Acceptance as a Traditional Volunteer at St. Christopher's Hospital for Children is contingent upon satisfactory completion of all pre-placement procedures which includes, but is not limited to, an interview, verification of references, criminal background, FBI IdentoGo Fingerprinting, Child Abuse investigation, drug screening, orientation, health screening, tuberculosis screening, and Flu shot.

- I realize that misrepresentation of facts will be cause for rejection of this application. In the event of placement in the volunteer program, falsification of any information on this application will be cause for dismissal.

- I authorize St. Christopher's Hospital for Children to investigate the information provided on this application and to conduct a Drug Screening, Criminal Background Investigation, Child Abuse investigation, and FBI IdentoGOFingerprinting. I will hold no person liable for giving or receiving information with regard to these investigations.

- I agree to abide by the policies of St. Christopher's Hospital for Children and the Standards of Conduct which will be discussed and distributed during hospital volunteer orientation.

- I authorize St. Christopher's Hospital for Children to use photographs of me taken at hospital for marketing, public relations, recruitment, and/or educational purposes, and waive any rights to compensation for these uses. The term photograph shall mean modern pictures or still photography in any format and as well as videotape, video disc, digital, electronic, or other mechanical means of recording and reproducing images.

- I, _____, understand and acknowledge that, upon both my successful completion of the volunteer placement process required by St. Christopher's Hospital for Children and the receipt of approval for service by Volunteer Services management, I will become a "volunteer". As a volunteer, I acknowledge that I will not receive compensation for services. I acknowledge that I will receive a volunteer service description to specify the department(s) that I will be volunteering in prior to my placement(s). A signed copy of that (those) volunteer service description(s) will be in my volunteer file.

_____

PRINT NAME **DATE**

_____

SIGNATURE OF APPLICANT **DATE**

_____

SIGNATURE OF VOLUNTEER SERVICES DIRECTOR **DATE**

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

PERSONAL STATEMENT OF INTENT

1. Why did you select St. Christopher's Hospital for Children for your volunteer work?

_____
_____
_____

2. What would you like to gain from this experience?

_____
_____
_____

3. In what way will St. Christopher's Hospital for Children benefit from your volunteering?

_____
_____
_____

4. Describe any special skills and languages that you feel will be helpful as a volunteer:

_____
_____
_____

5. What area would you like to volunteer in? Why?

_____
_____
_____

6. Are there any special considerations that you would like us to keep in mind when reviewing your volunteer application?

_____
_____
_____

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

SKILLBANK (Please check all that apply)

BUSINESS PROFESSIONALS

- ☐ CERTIFIED PUBLIC ACCOUNTANT
- ☐ CUSTOMER SERVICE
- ☐ HUMAN RESOURCES SPECIALIST
- ☐ RETAIL SALES
- ☐ LAWYER
- ☐ OTHER_____

SKILLED TRADES

- ☐ HAIR STYLIST
- ☐ LANDSCAPING
- ☐ MAKEUP ARTIST
- ☐ MANICURIST
- ☐ MAINTENANCE

ARTS AND ENTERTAINMENT

- ☐ ACTING
- ☐ BALLOON ART
- ☐ BAND
- ☐ FACE PAINTING
- ☐ JUGGLING
- ☐ MUSIC INSTRUMENT TYPE: _____
- ☐ SINGING
- ☐ STORY TELLER
- ☐ OTHER:_____

ADMINISTRATIVE SUPPORT

- ☐ COMPUTER PROGRAMS (ACCESS, EXCEL, POWER POINT, AND WORD) SPECIFY TYPES:_____
- ☐ DATA ENTRY
- ☐ FILING
- ☐ GENERAL OFFICE ASSISTANCE
- ☐ MAILING
- ☐ RECEPTIONIST
- ☐ TELEMARKETING
- ☐ OTHER:_____

HEALTH AND MEDICAL SERVICES

- ☐ NURSE
- ☐ NUTRITIONIST
- ☐ PHYSICAL THERAPY
- ☐ PHYSICIAN TYPE:_____
- ☐ OTHER :_____

NATURAL RESOURCES

- ☐ ENVIRONMENTAL EDUCATION
- ☐ GARDENING / HORTICULTURE
- ☐ LANDSCAPE ARCHITECT
- ☐ RECYCLING
- ☐ OTHER:_____

GENERAL ASSISTANCE

- ☐ TELEPHONE
- ☐ TRANSPORTATION/DRIVER
- ☐ OTHER:_____

COMMUNICATION

- ☐ CALLIGRAPHY
- ☐ FOREIGN LANGUAGE:_____
- ☐ GRAPHIC DESIGN
- ☐ MARKETING/PROMOTION
- ☐ MULTIMEDIA PRODUCTION
- ☐ NEWSLETTER/BROCHURE
- ☐ PUBLISHING
- ☐ PHOTOGRAPHY
- ☐ PUBLIC RELATIONS
- ☐ SIGN LANGUAGE
- ☐ TOUR GUIDES
- ☐ VIDEO PRODUCTION
- ☐ WRITING
- ☐ OTHER:_____

EDUCATION

- ☐ DAY CARE AIDE
- ☐ ELEMENTARY SCHOOL TEACHER
- ☐ EXC INSTRUCTOR
- ☐ HIGH SCHOOL TUTOR
- ☐ GED INSTRUCTOR
- ☐ LIBRARIAN
- ☐ LIFE SKILLS INSTRUCTOR
- ☐ LITERACY INSTRUCTOR
- ☐ MIDDLE SCHOOL TEACHER
- ☐ SPECIAL EDUCATION
- ☐ OTHER:_____

NON-PROFIT ADMINISTRATION

- ☐ FUNDRAISING
- ☐ GRANT WRITING
- ☐ SPECIAL EVENT PLANNING
- ☐ VOLUNTEER RECRUITMENT AND TRAINING
- ☐ OTHER:_____

HAND CRAFT SKILLS

- ☐ ARTS AND CRAFTS
- ☐ CERAMICS/POTTERY
- ☐ NEEDLE CRAFT
- ☐ WOOD WORKING
- ☐ OTHER:_____

CORPORATE TRAINING

- ☐ CULTURAL SENSITIVITY
- ☐ CUSTOMER SERVICE
- ☐ FACILITATE
- ☐ LEADERSHIP DEVELOPMENT
- ☐ MANAGEMENT SKILLS
- ☐ MOTIVATIONAL
- ☐ STRESS MANAGEMENT
- ☐ TEAM BUILDING
- ☐ TIME MANAGEMENT
- ☐ OTHER:_____

St. Christopher's Hospital for Children

Student Volunteer
(minors, ages 15-17)

PARENTAL RELEASE FORM

Parents of Prospective Student Volunteers (minor)

St. Christopher's Hospital for Children, a for-profit, nonsectarian medical center, treats thousands of children each year. Because we specialize in the care of children, it is important that those who assist staff in the delivery of care are of the highest quality. For this reason, we are requesting that the school which your child attends supply a "Letter of Reference," which is designed to assist in the screening process. We will take both the character of the individual and academic standing into consideration.

Please sign the form below giving your child's guidance counselor permission to supply us with the letter of reference. If you have any questions, please feel free to contact me at (215) 427-5398. Your assistance and cooperation is greatly appreciated.

- I hereby give my consent for a "Letter of Reference" to be sent to St. Christopher's Hospital for Children.

_____
Print Name

_____ _____
Parents' Signature Date

_____ _____
Child's Name Name of School and Grade

St. Christopher's Hospital for Children

Student Volunteer

(minors, ages 15-17)

LETTER OF REFERENCE

_____, a student at your school is interested in becoming a volunteer at St. Christopher's Hospital for Children. The form below represents a minimal record of your student's abilities. After filling in the rating scale, please feel free to make additional comments.

Please be prompt in returning this letter of reference as the student's application will not be processed until we have received this information from you.

Your cooperation is greatly appreciated. If you have any questions, please feel free to contact the Volunteer Services Department at 215- 427-5398.

_____
(Print Student's Name)

	Superior	Above Average	Average	Below Average	Poor	Don't know
Student attendance						
Quality of academic work						
Ability to work with peers						
Ability to work with faculty						
Dependability						
Leadership qualities						
Resourcefulness						
General effectiveness						

Additional Comments:

_____

_____

_____ _____
Counselor's Name Date

_____
Counselor's Signature

_____ _____
School Phone number

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete this form and return it, along with your application to the Volunteer Services Department. We must have this completed form in order to process your application.

I hereby authorize this office to release immunization records to St. Christopher's Hospital for Children. I understand that I may cancel this authorization at any time except when the above information has already been released in accordance with this authorization. This authorization is void within sixty (60) days from the date of signature. Further, I certify that I understand the nature of this release.

Print Name _____ Date_____

Signature _____ Date of Birth _____

Parent/Legal Guardian Signature _____
(Required if age 15 to 17)

TO BE COMPLETED BY MEDICAL CARE PROVIDER

Immunization History – Please attach immunization records indicating proof and date of immunizations for the infectious diseases listed below. If over age 18, proof of titers must be provided.

Measles (Rubeola)
Immunity required
2 Vaccine doses (dates)
or
Titer results
(date required)

Rubella
Immunity required
2 Vaccine doses (dates)
or
Titer results
(date required)

Varicella (Chicken Pox)
Immunity required
2 Vaccines (dates)
or
Titer results
(date required)

Hepatitis B
Immunity required
3 Vaccines doses (dates)
or
Titer results
(date required)

Mumps
Immunity required
2 Vaccine doses (dates)
or
Titer results
(date required)

Tdap (Tetanus-Diphtheria)
Proof of Tdap is required
(date)

Flu Shot
During Flu Season
(September through April)
(date)

Tuberculosis History

Most recent TB skin test (2PPD's) Date _____ Result _____mm induration
If PPD result – 10 mm induration CXR Date _____ Result _____
Yes
History of Tuberculosis Disease? _____ No _____
Treatment of TB infection or Disease? Medication _____ Dates _____ to _____

Must have letter regarding treatment

_____
Medical Care Provider's Signature

Provider's Office Stamp with Address

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

EMPLOYEE HEALTH SCREENING

I give permission for St. Christopher's Hospital for Children to administer a QuantiFERON Blood test for tuberculin screening:

If applicant can provide documentation of 2 PPD's within the past 12 months QuantiFERON will not be required.

- My child _____
  (Print Name)
- Myself _____
  (Print Name)

_____ _____
Signature of Volunteer Date

_____ _____
Signature of Parent/Guardian Date

****

I give permission for St. Christopher's Hospital for Children to administer a Flu shot during Flu season (September through April)

If applicant can provide documentation of Flu shot being administered during the time period of September through April of present year, a Flu shot will not be required.

- My child _____
  (Print Name)
- Myself _____
  (Print Name)

_____ _____
Signature of Volunteer Date

_____ _____
Signature of Parent/Guardian Date

St. Christopher's Hospital for Children

VOLUNTEER APPLICATION

EMPLOYEE HEALTH SCREENING

Please bring with you a recent photo I.D. and SS# for in-processing of drug screening.

PRE-VOLUNTEER DRUG TESTING CONSENT FORM

I consent freely and voluntarily to the testing of (my/my child's) urine specimen for the presence of illegal or unauthorized drugs. I hereby release and hold harmless American Academic Health System and its agents from any liability arising as a result of this testing. I further understand that passing the pre-volunteering drug test is a requirement for volunteering.

_____
Volunteer Name (Please Print)

_____
Volunteer Telephone Number

_____
Volunteer Signature Date

_____
Parent Signature Date

****

To be signed day of drug screening by applicant:

I certify that this urine sample was provided by me, was not altered, and was placed in a container, sealed and labeled in my presence.

_____
Volunteer Name (Please Print)

_____
Volunteer Signature Date

****THIS CLEARANCE WILL BE MAILED TO THE ADDRESS THAT YOU LIST BELOW. PLEASE BE SURE TO WRITE YOUR ADDRESS DOWN CORRECTLY AND BRING COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.**

St. Christopher's Hospital for Children

BACKGROUND CHECK AUTHORIZATION FORM

First Name (PLEASE PRINT): _____Middle: _____ Last: _____

List any other names used (nickname, maiden/married last names): _____

Social Security Number: _____ Date of Birth: _____ Sex M □ F □

Street Address: _____

City: _____ State: _____ Zip: _____

To the extent permitted by applicable state law, I hereby consent to this investigation and authorize a St. Christopher's Hospital for Children Healthcare facility, and/or their respective parents, subsidiaries, affiliates, other related entities, successors, and/or assigns (the "Company"), as applicable, to procure consumer report(s), criminal background check(s), consumer credit report(s), and/or investigative consumer report(s) (as defined by applicable California state law), on my background from a consumer reporting agency ("CRA") or from an investigative consumer reporting agency ("ICRA"), as described in the **Background Check Disclosures**, the **Additional Disclosures**, and the **California State Law Disclosures** (all of which I have received separately from the Company). I have reviewed and understand the information, statements, and notices in the **Background Check Disclosures**, the **Additional Disclosures**, and the **California State Law Disclosures**, as well as this **Background Check Authorization**. My authorization remains valid throughout my employment with the Company, such that, to the extent permitted by applicable law, I agree Company can procure additional consumer report(s), criminal background check(s), and/or consumer credit report(s) during my employment without providing additional disclosures or obtaining additional authorizations. Except as otherwise prohibited by state law, I consent to and authorize the Company to share this information with Company's current or prospective clients, customers, others with a need to know, and/or their agents (including but not limited to staffing/placement company clients and vendor credentialing companies) for business reasons (e.g., to place me in certain employment positions, jobs, work sites, etc.).

A background check is a type of consumer report in which information (which may include, but is not limited to, creditworthiness, credit standing, credit capacity, criminal background, driving background, character, general reputation, personal characteristics, and mode of living) about you is gathered and communicated by a consumer reporting agency ("CRA") to a St. Christopher's Hospital for Children Healthcare facility, and/or their respective parents, subsidiaries, affiliates, other related entities, successors, and/or assigns (the "Company"), as applicable.

Company may obtain a consumer report on you to be used for employment purposes, including your application for employment.

Signature: _____ Date: _____

St. Christopher's Hospital for Children

*****THIS CLEARANCE WILL BE MAILED TO THE ADDRESS THAT YOU LIST BELOW. PLEASE BE SURE TO WRITE YOUR LEGAL NAME AND ADDRESS CORRECTLY – ONCE YOU RECEIVE THIS CLEARANCE, YOU ARE REQUIRED TO BRING IT TO THE VOLUNTEER SERVICES DEPARTMENT .***

FBI IdentoGO Applicant Registration Form

Last Name* _____

First Name* _____

Middle Name _____

Date of Birth (MMDDYYYY)* _____

Place of Birth City* _____

Place of Birth State* _____

SSN* _____

Sex* _____

Race* _____

Eye Color* _____

Hair Color* _____

Height* _____

Weight* _____

Country of Citizenship* _____

Address* _____

City* _____

State* _____

Zip code* _____

Phone* _____

Email* _____