

## PROCTOR HOSPITAL MEDICAL ESCORT APPLICATION

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_  
(Last) (First)

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ (optional) JACKET SIZE \_\_\_\_\_

CURRENT OCCUPATION OR PRIOR TO RETIREMENT \_\_\_\_\_

DO YOU HAVE TRANSPORTATION? \_\_\_ YES \_\_\_ NO

PREVIOUS EXPERIENCE AS A VOLUNTEER \_\_\_ YES \_\_\_ NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

COMMUNITY AFFILIATIONS (CHURCH, CLUBS, ETC.) \_\_\_\_\_

HEALTH PROBLEMS? \_\_\_ YES \_\_\_ NO PROBLEMS WALKING? \_\_\_ YES \_\_\_ NO

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WOULD PREVENT YOU FROM  
WORKING FOR 4 HOURS OR PUSHING A WHEELCHAIR THROUGHOUT THE HOSPITAL?

\_\_\_ YES \_\_\_ NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

NAME OF PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

\_\_\_\_\_  
(Name) (Address) (Relationship)  
CONTACT'S PHONE # \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

Name of a **reference** who may be contacted \_\_\_\_\_

REFERENCE'S PHONE # \_\_\_\_\_ in order to determine my suitability for this volunteer  
position.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Remit to:  
Proctor Hospital  
Attn: Anne Lockhart  
Volunteer Office  
5409 N. Knoxville Ave  
Peoria, IL 61614



# Health Care Worker Background Check

## Disclosure and Authorization for Criminal History Records Check

I hereby authorize the Illinois Department of Public Health, the Department's designee that trains or tests health care workers, a staffing agency, or the health care employer to request a criminal history records check and I further authorize the Illinois State Police (ISP) to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency that maintains records relating to me, including but not limited to the Federal Bureau of Investigation or a local unit of government, to provide same on request to the ISP or the Department. I certify that the ISP and any agency, including the Department, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or to retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment or, if discovered after employment begins, could result in discipline up to and including my termination of employment.

I understand that the information requested below regarding sex, race, height, eye color, and date of birth is for the sole purpose of identification and the gathering of the above-mentioned information about me accurately, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name \_\_\_\_\_ Full Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address if different \_\_\_\_\_

Other Names Used \_\_\_\_\_ Telephone \_\_\_\_\_ - \_\_\_\_\_

States Where You Have Lived? \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Eye Color \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_

- Race
- A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
  - B** Black or African American (Not Hispanic or Latino)
  - H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
  - I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
  - U** Of undeterminable race. Of Untold mixture.
  - W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft?  Yes  No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)?  Yes  No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

\_\_\_\_\_  
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

\_\_\_\_\_  
(Signature of Parent or Guardian when applicable) (Date)