

Application for Volunteer Chaplain

Sampson Regional Medical Center

Thank you for your interest in becoming a Volunteer Chaplain in our Spiritual Care Program at Sampson Regional Medical Center. Enclosed you will find the following:

1. Mission Statement
2. Basic Requirements
3. On Call Service Description
4. Application

The Volunteer Services Department of Sampson Regional Medical Center continues to expand and grow. If you are interested in becoming a Volunteer Chaplain, please fill out the application and mail it to the attention of volunteer services department. The volunteer services director will review your application and call you to set up an interview if you meet the basic requirements for the position.

SPIRITUAL CARE PROGRAM of VOLUNTEER SERVICES

MISSION STATEMENT

The Spiritual Care program of Volunteer Services complete focus is to demonstrate through compassionate care our concern for the patient as a whole person, encompassing not just the body, but the soul, mind, spirit, emotions, and human relationships important to the patient. The mission of Spiritual Care is to facilitate opportunities for healing through response to the spiritual needs of the patient and family, while also providing a spiritual presence and support for the patient care team and hospital staff.

SAMPSON REGIONAL VOLUNTEER CHAPLAIN PROGRAM

BASIC REQUIREMENTS FOR APPLICATION

Persons serving the Volunteer Chaplain Program shall have Ordination / License or Ecclesiastical Endorsement by their Faith Group or be enrolled in Religious or Theological Studies in an accredited college or school of Theological Studies, have life experience in ministry setting and/or specialized training for ministry. Those who have previous CPE (Clinical Pastoral Education) training are desired for this position and will receive the most consideration.

All background checks must be satisfactorily completed and cleared before appointment. After appointment, all Volunteer Chaplains are required to attend a Hospital orientation as well as a specific orientation related to Chaplaincy, conducted by the Director of Volunteer Services at the time of application approval. Each year served thereafter, Volunteer Chaplains will reaffirm their application and credentials. Must attend a minimum of (2) Spiritual Care/ Volunteer Departmental meetings per year and participate in Spiritual Care training opportunities, unless there are special circumstances that have been discussed with the Director. They must also serve at least one time per month and go no longer than three consecutive months without serving, unless there has been a previous arrangement with the Volunteer Services Director. All Volunteer Chaplains are required to have necessary vaccinations initially and annually and meet any other requirements of the hospital for volunteer service workers.

Anyone who fails to meet the above requirements may be asked to resign and return their Volunteer Chaplain's badge to the Volunteer Services Department Director.

RESPONSIBILITIES

Responsibilities are found under specific **service descriptions**.

SAMPSON REGIONAL MEDICAL CENTER

SPIRITUAL CARE PROGRAM

VOLUNTEER ON-CALL CHAPLAIN

SERVICE DESCRIPTION

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|-----------------------------|--|
| Summary Description: | Provide 24 Hour on-call Volunteer Chaplaincy coverage for emergency needs and a request for Volunteer Chaplain by patients and/or hospital staff. Visit new admit referrals and make rounds per Volunteer Director's instructions. |
| Hours: | One to two days per month at a minimum or more per arrangements made with Volunteer Service Director. Schedule will be posted outside the volunteer office. Shift begins 9:00 a.m. and ends the following day at 9:00 a.m., unless assigned consecutive days. Weekend duty does not require routine visitation. |
| Qualifications: | Ordination/ License or endorsement by Faith Group. Life experience in ministry setting and/ or specialized training for ministry. CPE training preferred but not required. A personal understanding and self-acceptance of his/her professional strengths and weaknesses as a Volunteer Chaplain. Interview with Director of Volunteer Services. Required Hospital orientation as well as annual specialized Pastoral Care training with the Director of Volunteer Services. Annual PPD, flu shot, and T dap as required. |
| Working Conditions: | Contact with inpatients, staff, and general public. Carry a cell phone and remain within a 60 minutes arrival time to hospital when on-call. |
| Training: | Hospital orientation, annual in-service, department orientation, continuous educational in- service, educational material and departmental staff meetings. |
| Responsibilities: | Round as able while on call. Respond to calls requesting Volunteer Chaplaincy services. Provide listening, prayer, support, scripture, ritual and rites, as requested and appropriate. Be a supportive presence for hospital staff asking for referrals while in hospital. Make appropriate referrals to the Director of Volunteer Services. No breach of confidentiality. No over proselytizing. |

SAMPSON REGIONAL MEDICAL CENTER
SPIRITUAL CARE PROGRAM / VOLUNTEER SERVICES

VOLUNTEER CHAPLAINCY APPLICATION

NAME: _____

Mailing Address: _____

Email address _____

Phone (Home) _____ Phone (Cell) _____

Work phone # _____ Fax # _____

Chaplains and local faith leaders / ministers who volunteer their time must provide the following information.

Name of Church (es) you are currently serving/attending.

Please supply the name of church, street address, city, state, zip code, and phone number.

1. Name of church _____

Address _____

Phone number _____

How many resident members are in your church (es) / faith group meetings? _____

2. Name of Church _____

Address _____

Phone number _____

How many resident members are in your church (es) / faith group meetings? _____

Are you a resident pastor and (live within 25-mile radius of the hospital)? _____

Have you applied for a clergy identification badge at SRMC before? If so when? _____

Are you a full-time pastor/clergy person? Yes _____ No _____

Are you replacing another minister? _____ if yes, please complete the following:

His /Her Name: _____

Has he/she moved away? Yes _____ No _____ Has he/she been assigned another church/faith group in the area? _____

Complete name of Your Denomination/Faith Group: _____

Denominational / Faith Group Headquarters Address: _____

Denominational/Faith Group Executive Leader: _____

Phone: _____

I have received and will abide by the rules and regulations for privileges of clergy visitation at Sampson Regional Medical Center {see attached document, Regulations, Rights, and Rules}

Signature of Minister Applying for Privileges _____

CERTIFICATION: To be completed by your Official Board Chairperson or Lay Denominational Leader.

This is to certify that _____ is an Ordained Minister and serves
(Pastor/ Clergyperson's Name)

at (Name of Church/Faith Group) _____

and is hereby authorized by this church / faith group to participate in privileges extended to pastors/clergypersons at Sampson Regional Medical Center.

Signature of Official Board Chairperson or Lay Denominational Leader:

Print Name: _____

Signature _____ Date _____

Address _____

Phone: _____ Cell Phone _____

EDUCATION

School - College, Seminary, and/or Graduate Studies

Degree _____

Year _____

Denominational Affiliation _____

Ordination Date _____

Licensure Date _____

PREVIOUS CHAPLAINCY EXPERIENCE

List previous volunteer chaplain experience below:

Year

CLINICAL PASTORAL EDUCATION

CPE CENTER

Dates Units

PASTORAL COUNSELING EXPERIENCE (Years) _____ (Where) _____

List other credentials, workshops, etc. below:

Please tell us about your gifts of ministry that you will bring to Sampson Regional and our Chaplaincy Program.

Give at least two references. One of the two may be a personal reference:

Name _____ Ph. _____

Name _____ Ph. _____

Upon approval by the Director of Volunteer Services or Designee, I agree to uphold and abide by the standards, policies, and procedures of Sampson Regional Medical Center and the Pastoral Care Program/ Volunteer Services.

Applicant's Signature _____ **Date** _____

Signature of **Director of Volunteer Services** signifying approval as Volunteer Chaplain.

_____ **Date** _____

****Please attach a copy of your resume' or your licensure**

Mail to:
Sampson Regional Medical Center
Attention: Director of Volunteer Services
PO Box 260
Clinton, NC 28329