SWEDISH
Edmonds

**Dear Prospective Junior Volunteer:**

We are so excited that you have chosen to volunteer at Swedish Edmonds. We hope that you will find your experience interesting, educational and FUN!

**<u>This program will allow you to:</u>**

- Assist in the care and comfort of patients at the hospital
- Learn about and experience possible careers in the healthcare field
- Meet new people and make new friends
- Fulfill community service requirements for school

**<u>To become a volunteer you must:</u>**

- Be at least 14 years old
- Be able to volunteer for at least 48 hours or 3 months of your time
- Be able to commit to at least one 4 hour shift each week
- Provide two letters of recommendation; at least one of which is from a school staff member
- Complete the all required paperwork
- Interview with the Volunteer Services Staff
- Provide proof of immunizations
- Attend a Volunteer Orientation and complete the required accompanying tests

**<u>We have volunteer opportunities in the following areas:</u>**

- Admitting / Information Desk
- Magazine and Book Cart
- Gift Shop
- Patient Care Areas
- Food Services
- Special Events/Projects
- ACV Program

If you have questions or need more information please call the Volunteer Services Office at 425-640-4341
Our office hours are Monday through Friday, 8:00am to 5:00PM

***Thank you for your interest in volunteering at Swedish/Edmonds!***

SWEDISH
Edmonds

# Application for Volunteer Services

**Instructions**: Please complete all sections of this application in detail so we may consider you for volunteering. If a question or blank does not apply to you, write N/A in the space. Upon completion, sign your name in the space provided and return all documents to Swedish Edmonds Volunteer Services

**PLEASE PRINT LEGIBLY IN PEN**

## Identification Information

| Last Name | First Name | Middle Initial | Maiden Name | Last 4 # Security Number |
|---|---|---|---|---|
| Address (Street) (City) (State) (Zip) | | | | Date of Birth |
| Mailing Address (if different from above) | | | | Telephone ( ) |
| Email Address | | | | Cell phone ( ) |

## Education/Employment Information – Check All That Apply

Education
- Junior High
- High School
- Some College
- Undergrad Degree
- Graduate Degree

Employment
- Student
- Employed
- Retired
- Unemployed
- Other

Your occupation ___________________________________________

Are you volunteering for school community service? yes no

Name of school _______________________________ Hours needed ________

## Availability – Check All That Apply

| Hours | | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|---|
| 8am–noon | Morning | | | | | | | |
| Noon–4pm | Afternoon | | | | | | | |
| 4pm-7pm | Evening | | | | | | | |
| Other | | | | | | | | |

**References** Business / School / Community (other than a relative)

| *Name/Relationship* | *Address* | *Telephone* |
|---|---|---|
| | | ( ) |
| | | ( ) |

*Please provide the Volunteer Services Office with a reference letter from each of the above.*

**Interests – please check all that apply**

Hospitality- Front Desk ACC - students 17+
(greeting, reception, escort)

Administrative Support Volunteer
(clerical, education, computer)

Gift Shop Volunteer
(sales, clerical, customer service)

Patient Care Area Volunteer – students 17+
(support staff, stock rooms, answer call lights

Surgery Liaison Volunteer – Students 17+
(liaison between OR, Recovery, and patient families)

Cancer Resource Center Volunteer –students 17+

Magazine and Book Cart

Special Events / On Call Volunteer
(on call for event support or fill in)

Nutrition and Food Services

Have you ever volunteered before? yes no If yes, where? And what did you do?
__________________________________________________________________

Why did you leave? ____________________________________________________

Why did you choose Swedish Edmonds for your volunteering?
__________________________________________________________________

What is most important to you in a volunteer assignment?
__________________________________________________________________

Do you have any restrictions that might limit your ability to perform certain volunteer assignments? (lifting, pushing, and standing)
__________________________________________________________________

How did you hear about our volunteer program? ________________________________________

## Emergency Contact Information

| Name | Relationship |
|---|---|
| Home Phone<br>( ) | Other phone (work, cell)<br>( ) |
| Physician | Phone<br>( ) |

I agree to adhere to the hospital's Volunteer Services policies, procedures, and rules to the best of my ability. I agree to participate in the hospital's orientations. I understand that the Director of Volunteer Services or the hospital's Executive Director may terminate my work as a volunteer at any time, and that I may also terminate my work. I also understand all information regarding patients with whom I work is strictly confidential and I shall maintain that confidentiality. Volunteers 14-18 years old- Parents or Legal Guardians may request information from the volunteer services staff about my volunteer status and or schedule at anytime.

____________________________________ ______________________
Volunteer Signature Date

*All volunteers 14 through 18 years of age must have the consent of a parent or legal guardian.*

____________________________________ ______________________
Signature of Legal Guardian Relationship

# CONFIDENTIALITY AGREEMENT

Swedish/Edmonds Healthcare employees, volunteers, medical providers, and vendors must make every effort to prevent unauthorized use and disclosure of medical, personal, or other data pertaining to patients, employees, and proprietary hospital operations ("confidential information"). Under no circumstances should confidential information be released or discussed with anyone unless it is in the performance of legitimate job related duties or medical staff functions ("job duties"). To ensure that all Swedish/Edmonds Healthcare employees, volunteers, medical providers and vendors acknowledge their responsibility to protect the privacy and confidentiality of confidential information, please read and sign the following:

1. I acknowledge that all confidential information is confidential and protected against unauthorized viewing, discussion, use and disclosure regardless of format: electronic, written, overheard or observed.
2. I understand that I may view, use, disclose, or copy information only as it relates to the performance of my job duties. Any unauthorized viewing, discussion, use or disclosure of confidential information is a violation of Swedish/Edmonds Healthcare policy and may be a violation of state and federal law. Any such violation may lead to immediate disciplinary action, including termination (or as appropriate to my affiliation with Swedish/Edmonds Healthcare), and possible civil liability and/or criminal charges.
3. I agree not to change, delete or destroy confidential information unless part of my job duties and, if part of my job duties, I agree to follow all established policies in relation to changing, deleting, or destroying confidential information in any form.
4. I agree to use Swedish/Edmonds Healthcare computer based information systems (the "computer systems") for the sole purpose of performing my legitimate job duties.
5. I agree not to use the computer systems to access confidential information on myself, my family, or any other person except when necessary to the performance of my job duties.
6. I understand that the passwords assigned to me to access the computer systems are confidential, and not to be shared with anyone under any circumstances.
7. I agree to use only my assigned password to access the computer systems and that I am responsible for any access to the computer systems using my password as a result of my own negligence or password sharing.
8. I understand that any actions I take in the Computer Systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me.
9. I agree to report any real or potential breach of confidentiality immediately to the administrator on call.
10. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand, and am committed to its principles.
11. I understand that this signed and dated document will become part of Swedish/Edmonds Healthcare records.

| ______________________ | ______________________________ | _______________ |
|---|---|---|
| Print Name | Signature | Date |

# VOLUNTEER SERVICES REFERENCE FORM

You have been given as a reference by this applicant. Volunteers play an important role in working with hospital patients and visitors in a sensitive manner. Volunteers must be able to maintain confidentiality, communicate effectively, and follow through with commitments. We appreciate your honesty in responding and if you wish to keep the content of your reply confidential please let us know. Your prompt reply is appreciated.

Please return this form to:
***Volunteer Services***
***Swedish/Edmonds***
***21601 76th Avenue West***
***Edmonds, WA 98026***

Name of applicant: ______________________________________________

How long have you known applicant? ____________________________

In what capacity have you known the applicant?______________________________

Ratings:
1. Needs Improvement
2. Fair
3. Very Good
4. Outstanding

| | | | | | |
|---|---|---|---|---|---|
| 1. | Displays courtesy, tact, patience. | 1 | 2 | 3 | 4 |
| 2. | Works well with a diverse population. | 1 | 2 | 3 | 4 |
| 3. | Exhibits interest and enthusiasm for a volunteer position. | 1 | 2 | 3 | 4 |
| 4. | Accepts supervision in a positive way. | 1 | 2 | 3 | 4 |
| 5. | Seeks opportunity to improve and advance. | 1 | 2 | 3 | 4 |
| 6. | Accepts responsibility and commitment. | 1 | 2 | 3 | 4 |
| 7. | Is dependable and punctual. | 1 | 2 | 3 | 4 |

Comments:_______________________________________________________________

________________________________________________________________________

____________________________________________

Date: ___________________________________________

Signature: _______________________________________

Printed Name: ____________________________________

Address: _________________________________________

Phone Number: ____________________________________

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| 7. | Is dependable and punctual. | 1 | 2 | 3 | 4 |

Comments:______________________________________________________________

________________________________________________________________________

__________________________________________

Date: ________________________________________

Signature: ____________________________________

Printed Name: _________________________________

Address: _____________________________________

Phone Number: _________________________________

## CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

Hospitals may be reluctant to treat or care for children without consent from parents or legal guardians. This can cause problems if the child has a medical emergency when parents or guardians are not readily available to consent.

Complete this form and leave it with the person who is responsible for your child in your absence. In case of a medical emergency, this form should be brought with the child to the hospital.

I, ______________________________ (PLEASE PRINT), the natural parent/legal

guardian of ______________________________ (PLEASE PRINT), authorize and consent

to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment and procedures are immediately necessary or advisable in the interest of my child's health and well-being, and it is not advisable to take the time to contact me in advance.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results, possible alternatives, and the risks, complications and anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

______________________________
Date

______________________________
Signature of Parent/Guardian

______________________________
Witness

*Please provide the information requested on the reverse side of this form.*

Swedish/Edmonds 21601 76th Avenue West • Edmonds, WA 98026 • (425) 640-4000



LEG 048 07/97

LE0030

**Consent To Medical Care and Treatment Of Minor Children**

## INFORMATION ON THE CHILD

Child's Name ______________________________________________

Date of Birth ______________________________________________

Allergies and Drug Reactions ________________________________

______________________________________________________

Chronic Illnesses ___________________________________________

______________________________________________________

Regular Medications _________________________________________

______________________________________________________

Blood Type _______________________________________________

Date of Last Tetanus Immunization____________________________

Other Pertinent Data ________________________________________

______________________________________________________

______________________________________________________

Child's Physician ___________________________________________

Physician's Phone Number ____________________________________

Parent's or Guardian's Address_________________________________

Parent's or Guardian's Home Phone Number______________________

Parent's or Guardian's Work Phone Number_______________________

Insurance Coverage _________________________________________

Group Number _____________________________________________

Membership Number _________________________________________

Employer _________________________________________________

LE0030

SWEDISH
Edmonds

**Consent To Medical Care and Treatment Of Minor Children**

SWEDISH EDMONDS
EDMONDS, WA

A two step TB skin test is required as a condition of volunteer work at Swedish Edmonds. The tests, which are spaced one to three weeks apart, are given by the hospital free of charge by the employee health nurse. It is the responsibility of the teenage volunteer to have the results read by one of our Employee Health nurses 48 – 72 hours after the test is given. (She looks at the site of the injection on the inside of the arm to determine a positive or negative reaction.) If the skin test is positive or has previously been positive, a chest x-ray is required. If the junior volunteer fails to have it read, he/she would need to have another TB test at the Health department.

Lab work may also be required if you do not have immunization records. If you have questions, call Bobbi or Ruth at (425) 640-4133.

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**Authorization for TB Testing of a Minor**

My son or daughter ________________________________ has my consent to have a TB (tuberculin skin test) and/or lab tests administered at Swedish Edmonds.

___________ ________________________________

Date Parent / Guardian signature

Name: ___________________________________

DOB: ____________ Emp#/SS#_____________

Dept: ___________ Job Title: ______________

Phone: _____________ Cell: _______________

Date: _______________

**EH Use Only**
**Compliant** HBV MMR Vari
TB#1 or doc TB#2 or doc
Hx of Positive
CXR doc or given quest.
Titers needed:
HBV Meas Rub Mum Vari
TB List EH Comp

## Infectious Disease/Latex Evaluation

This evaluation will help ensure that you are protected from infectious isease that would pose undue risk to you, other employees, patients or visitors. This information will be placed in your confidential file.

**Circle if you have had the following diseases?**

Chickenpox (Varicella) yes no Date: _____________

**TB Screenings**

Have you ever had a positive TB Skin Test/PPD yes* no Date: _____________

*Documentation of the positive skin test date, any prophylactic treatment and a chest x-ray dates after the positive skin test required.

**Circle if you have had any of the following immunizations?**

*Documentation is incomplete without official immunization records

Required Immunizations*:

Two-step Initial TB Skin Test yes no 1.________ 2. ________

Annual TB yes no 1.________

Hepatitis B Vaccine yes no 1.________ 2._________ 3._______

Or Hepatitis B antibody (HBSAB) Titer Date_________

MMR(Measles/Mumps/Rubella) 2 Needed yes no 1.________ 2. ________

Or positive titers for Rubeola, Rubella and Mumps

Date of Rubeola titer ____________ Date of Rubella titer_________ Date of Mumps titer __________

**Other Immunization (Not Required)**

Varicella Vaccine yes no 1.________ 2. ________

Tetanus/Diphtheria or Tdap yes no Last date ___________ Please circle Td or Tdap

Flu annually yes no Last date___________

Are you latex sensitive or do you have a latex allergy. Please explain:_________________________________

_____________________________________________________________________________________

Do you have any other allergies or medical condition that we should be aware of? ______________________

_____________________________________________________________________________________

_______________________________________ ___________________

**Volunteer Signature** **Date**