Providence SWEDISH

Dear Prospective Volunteer:

Our volunteers are the heart of Swedish Edmonds. Whether you are looking to volunteer to explore an interest in the medical field, brush up on your work skills, keep active after retirement, or take a break from a fast-paced career, volunteering at Swedish Edmonds is a great choice.

Opportunities are available throughout the hospital. Here are just a few areas in which volunteers contribute to the success of Swedish Edmonds:

- Information Desk
- Baby Cuddling
- Cancer Resource Center
- Emergency Room
- Therapy Pups Program
- Recovery/PACU
- Bereavement
- Companionship Care
- Patient Care Areas

To become a volunteer you must:

- Be able to volunteer for at least 100 hours of your time. This can be approximately 6 months.
- Be able to commit to at least one 4-hour shift each week.
- Provide two recommendations using the two forms or providing letters.
- Complete all the required paperwork.
- Pass a background check.
- Interview with the Volunteer Services Staff.
- Complete orientation and training for your role.
- Complete a health screening and provide proof of immunizations upon request.

If you are interested in joining our team of volunteers, please return your completed application forms along with your immunization records and two reference forms to:

Swedish Edmonds
Volunteer Services Office
21601 -76th Avenue West
Edmonds, WA 98026
Or via email to raegan.fisher@swedish.org

If you have questions or need more information, please email raegan.fisher@swedish.org
or call the Volunteer Services Office at 425-640-4340
Our office hours are Monday through Friday, 8:00am to 5:00PM

Please note for some volunteer positions there can be an extensive wait list. Once accepted you will receive an email and have two weeks to respond before we move on to the next applicant in line.

Thank you for your interest in volunteering at Swedish Edmonds!

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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 IN PEN LEGIBLY or TYPE

Identification Information

Last Name	First Name	Full Middle Name	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
7am–11:00	Morning							
11:00–3pm	Afternoon							
3pm-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+
- ☐ Recovery/PACU Volunteer – Students 17+

(greeting, reception, escort)

(liaison between OR, Recovery, and patient families)

- ☐ Bereavement Volunteer (Requires approval from Bereavement program coordinator)
- ☐ Rehab Center – Patient Support (Restocking and turning rooms)
- ☐ Patient Care Area Volunteer – students 17+ (Support staff, stock rooms, answer call lights
- ☐ Cancer Resource Center Volunteer –students 18+
- ☐ Magazine and Book Cart
- ☐ Baby Cuddling (must be 18 and graduated from high school)
- ☐ Nutrition and Food Services
- ☐ Eucharistic Ministers – Spiritual Care
- ☐ Emergency Department – Clinical =Pre-Nursing & Pre Med-Students Only (support staff, stock rooms, answer call lights)
- ☐ Therapy Pups -Must be registered

Have you volunteered in the past? ☐ 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, or computer skills)

____

How did you hear about our volunteer program? ___________________________________

Emergency Contact Information

Name	Relationship
Home Phone ( )	Other phone (work, cell) ( )
Physician	Phone ( )

I agree to adhere to the hospital's policies, procedures, and rules to the best of my ability. I agree to participate in the hospital's orientations. I understand that the Manager of Volunteer Services may terminate my work as a volunteer at any time. I will provide 2 weeks' notice prior to a vacation or resignation. I will complete the minimum hour commitment to receive verification of hours. If I do not complete those hours or am dismissed, I understand those hours will not be verified or provided to me. 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 any time.

______________________________ ____________________

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

Providence SWEDISH

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 computer systems to access confidential information on myself, my family, or any other person except when necessary for 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 asked to be 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.

<u>Please return this form to:</u>
Volunteer Services
Swedish Edmonds
21601 76th Avenue West
Edmonds, WA 98026
Or via email – raegan.fisher@swedish.org

Name of applicant: ____

How long have you known the 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:____

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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: ____

Providence SWEDISH

PURSUANT TO THE REQUIREMENTS OF RCW 43.43.830, WE MUST ASK YOU TO COMPLETE THE FOLLOWING DISCLOSURE STATEMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL.

Have you ever been convicted of any of the following crimes against persons?

Yes	No	
☐	☐	Aggravated Murder
☐	☐	First or Second Degree Murder
☐	☐	First or Second Degree Kidnapping
☐	☐	First, Second, or Third Degree Assault
☐	☐	First, Second, or Third Degree Assault of a Child
☐	☐	First, Second, or Third Degree Rape
☐	☐	First, Second, or Third Degree Rape of a Child
☐	☐	First or Second Degree Robbery
☐	☐	First or Second Degree Manslaughter
☐	☐	First or Second Degree Extortion
☐	☐	First or Second Degree Criminal Mistreatment
☐	☐	Child Abuse or Neglect as defined in RCW 26.44.020
☐	☐	Selling or distributing erotic material to a minor
☐	☐	Endangerment with a controlled substance
☐	☐	Custodial Assault
☐	☐	Child buying or selling
☐	☐	First Degree promoting prostitution
☐	☐	Communications with a minor
☐	☐	First Degree Arson

Yes	No	
☐	☐	First Degree Burglary
☐	☐	Indecent Liberties
☐	☐	Incest
☐	☐	Vehicular Homicide
☐	☐	Unlawful Imprisonment
☐	☐	Simple Assault
☐	☐	Sexual Exploitation of Minors
☐	☐	First or Second Degree Custodial Sexual Misconduct
☐	☐	First or Second Degree custodial interference
☐	☐	Felony Indecent Exposure
☐	☐	Criminal Abandonment
☐	☐	Malicious Harassment
☐	☐	First, Second, or Third Degree Child Molestation
☐	☐	First or Second or Third Degree Sexual misconduct with a minor
☐	☐	Patronizing a Juvenile Prostitute
☐	☐	Child abandonment
☐	☐	Promoting Pornography
☐	☐	Violation of Child Abuse Restraining Order
☐	☐	Prostitution
☐	☐	Or any of these crimes as they may have been rename

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

____
____
____
____
____

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has functional, mental, or physical inability to care for him or herself or is a patient in a state hospital?

Yes	No		Yes	No	
☐	☐	First, Second, or Third Degree Extortion	☐	☐	Forgery
☐	☐	First or Second Degree Robbery	☐	☐	or any of these crimes as they may
☐	☐	First, Second or Third Degree Theft			have been renamed

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

____
____
____

1. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor? ☐ Yes ☐ No

2. Have you ever been found in a court in domestic relations proceeding to have physically abused or exploited any minor or to have physically abused any minor? ☐ Yes ☐ No

3. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person? ☐ Yes ☐ No

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited any person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital? ☐ Yes ☐ No

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital? ☐ Yes ☐ No

If your answer is "yes" to any of questions 1 through 5 above, please describe and provide the date(s) of the finding(s) and penalty (ies) imposed.

____

____

____

____

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudication of child abuse, and disciplinary board final decisions. YOUR AFFILIATION WILL BE CONDITIONED UPON THE SATISFACTORY OUTCOME OF BACKGROUND CHECKS AS DESCRIBED BELOW.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am accepted into a clinical internship, I can be discharged for any misrepresentation or omission in the above statement. I also understand that any employment or internship is conditioned on the successful completion of the following: professional references, background investigations including but not limited to: Licensure, Criminal History, Social Security Verification, Governmental Sanction Checks and required drug screens.

Signature ________________________________ Date ______________________________
Name (print) ____

WASHINGTON STATE PATROL
Identification and Criminal History Section

PLEASE COMPLETE THE FORM BELOW.

REQUEST FOR **CONVICTION CRIMINAL HISTORY RECORD** INFORMATION FROM THE WSP. **(RCW 10.97)**

SUBJECT INFORMATION: Please print clearly

Applicants Name:

____

Last First Middle

Alias/Maiden Name:

____

Date of Birth: Month / Day / Year_______________________________Sex:____________________

Race: _____________________