Dear Prospective Volunteer:

Thank you for your interest in volunteering at Providence Hood River Memorial Hospital. Enclosed you will find information about how to become part of our volunteer program. As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service. Providence Health & Services is seeking volunteers willing to carry out our Mission with cooperation and enthusiasm. Your contribution as a volunteer can be significant in providing the quality care for which we are noted.

Attached is a volunteer application and background disclosure forms. Please complete all of the forms and return them to the address listed below.

Providence Hood River Memorial Hospital
Volunteer Services
81012th St.
Hood River, OR 97031
541-387-6242

Volunteer applicants will be called for interviews based on open positions, interest, qualifications and match of skills.

Providence Hood River Memorial Hospital Placement Process

As a potential volunteer you will need to:

- Submit a completed and signed volunteer application and background disclosure form to the volunteer office
- Attend an interview which will be scheduled by the volunteer office
- Make a minimum commitment of six months of service, if there is a match for placement
- Obtain a TB test provided by Providence Health & Services
- Provide proof of appropriate vaccinations (if applicable)
- Obtain an ID badge
- Attend a volunteer orientation

The Volunteer Services Department will:

- Interview all potential volunteers and determine if there is a match for a volunteer assignment
- Initiate a background check on all volunteers 18 years and older to include a criminal history and social security number verification
- Provide volunteer orientation and training for the specific volunteer placement
- Issue your volunteer ID badge and uniform

Providence Hood River Memorial Hospital values the dedication and many hours of service its volunteers give each year. Thank you again for your interest in being part of our committed team of volunteers.

Sincerely,

Brandi Sheppard
Director Volunteer Services

Providence Hood River Memorial Hospital
Volunteer Services
810 12th Street
Hood River, OR 97031
T: 541-387-6242; F: 541-387-8906
brandi.sheppard@providence.org

VOLUNTEER APPLICATION

Date: _____

❑ Adult Program ❑ Student Program

PERSONAL INFORMATION

Name: _____
Last *First* *MI*

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

SS#: _____ Birthdate: _____

Email: _____

Where did you hear about us? _____

EDUCATION / TRAINING

Present Occupation / Employer: _____

Position / Years of Service: _____

Other Skills / Responsibilities: _____

Education / Course of Study: _____ Current Student? ❑ Full time ❑ Part time

High School Name: _____ Yr: _____

College Name: _____ Yr: _____

Special Training / Other Certification: _____

What languages do you speak? _____

Have you volunteered before? _____ Where? _____

Position Experience: _____

VOLUNTEER PREFERENCES

Areas of interest within hospital: _____

DAY(S) AND TIME(S) AVAILABLE (circle):

FIRST CHOICE:
Mon Tues Wed Thurs Fri Sat Sun

Morning Afternoon Evening

SECOND CHOICE:
Mon Tues Wed Thurs Fri Sat Sun

Morning Afternoon Evening

THIRD CHOICE:
Mon Tues Wed Thurs Fri Sat Sun

Morning Afternoon Evening

Current Scheduling Obligations: _____

In addition to your usual weekly commitment, are you willing to be notified to assist with special projects on an "as needed" basis (4-6 hours)? _____

OTHER INFORMATION

References:

Personal: _____
Name *Phone* *Relationship*

Business: _____
Name *Phone* *Relationship*

Emergency Contact:

Name: _____

Relationship_____Phone _____

Criminal History:

Within the last seven years, have you ever been convicted of a criminal offense (other than a minor traffic violation) after your 18th birthday? *(Conviction will not necessarily disqualify an applicant; consideration will be given to the nature and timing of the crime in relation to the position.)* ❑ Yes ❑ No

If yes, please explain: _____

Are there any currently pending and/or unresolved criminal charges? ❑ Yes ❑ No

If yes, please explain: _____

HEALTH QUESTIONNAIRE

It is the policy of Providence Health & Services for each volunteer to have a health questionnaire on file with the volunteer department. The health record is kept in confidence by the department. Should you have any questions, please feel free to ask the director of Volunteer Services.

IMMUNIZATIONS & CHILDHOOD DISEASES

Please answer the following questions. Have you had the following diseases?

Yes	*No*	
❑	❑	Measles (rubeola / hard measles?)
❑	❑	Mumps
❑	❑	Rubella (3 day / German measles?)
❑	❑	Chicken Pox

Have you completed the following immunizations?

Yes	*No*	
❑	❑	Measles
❑	❑	Combined measles, mumps, rubella (MMR)
❑	❑	Diphtheria, tetanus & pertussis (DTaP)
❑	❑	Flu shot annually?
❑	❑	Hepatitis B: _____ Year completed: _____

TUBERCULOSIS SCREENING

Yes	*No*	
❑	❑	Have you had a TB test?
❑	❑	Have you ever had redness or swelling after a TB skin test?

SAFETY AND ACCOMMODATIONS

Please list any medications you are currently taking that may impact your ability to safely perform the functions of your volunteer position or pose a safety concern.

_____

Yes	*No*	
❑	❑	Are you willing to wear required safety equipment such as gloves and masks on duty?
❑	❑	Are you allergic to any substances, materials or medications? If yes, what?_____
❑	❑	Do you have any illnesses or infectious diseases which may be potentially transmitted to others in the hospital or health care setting?
❑	❑	Are there accommodations needed to assist you in being able to perform the essential functions of your job?
❑	❑	Are there accommodations needed for your safety or the safety of others at work?
❑	❑	Are you able to push patients in wheelchairs?
❑	❑	Are you able to walk the distance of the hospital several times a day?
❑	❑	Do you feel comfortable talking with different cultural and ethnic persons?
❑	❑	Can you take direction from staff in various areas of the hospital?

SIGNATURE:

Print:_____

Sign:_____ Date:_____

C O N F I D E N T I A L I L T Y & C O M M I T M E N T

I hereby agree to abide by the volunteer policies, hospital rules and regulations, and to uphold patient confidentiality as I fulfill my role as a volunteer. I understand and confirm my willingness and availability to meet the six month commitment requirement for my volunteer service. I certify that the above information is true, correct and complete.

APPLICANT SIGNATURE:

Print: _____

Sign: _____

If applicant under 18 years of age:

I understand my child has made a commitment of six months to the volunteer department at Providence Hood River Memorial Hospital. I give permission for my child to be given a TB test, which is required by state law and provided by Providence Health & Services.

In the event I cannot be reached, I give permission for necessary emergency treatment to be given to my child in case of illness or injury.

PARENT/LEGAL GUARDIAN SIGNATURE:

Print: _____

Relationship: _____

Sign: _____

ADDITIONAL QUESTIONS

Volunteer applicant name:_____

1. Why do you want to volunteer at Providence? (personal / professional goals, motivation, etc.)

2. If you could pick the ideal volunteer position, what would it look like?

3. List three things you would like us to know about you.

Send completed forms to:

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