

**ADULT and
COLLEGE 18 & OLDER**



VOLUNTEER SERVICES APPLICATION

CONFIDENTIAL

PERSONAL INFORMATION

First _____ Middle _____ Last _____

Date of Birth _____ Social Security # _____

Driver's License # _____

Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____

Do you speak any foreign languages? [] No [] Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

2. Are you currently seeking volunteer experience to fulfill a community service obligation (i.e. church, school)? No [] Yes [] – If yes, please describe the service requirements _____

Service Organization & Contact _____

Phone Number _____

3. Is there anything that may adversely affect your ability to perform volunteer work? No [] Yes [] – **If yes, please describe in detail** _____

4. Are there any accommodations needed in order for you to safely and competently perform volunteer work as requested? _____

5. Do you have any physical, visual or hearing needs we need to consider? No [] Yes [] – **If yes, please explain:** _____

6. Are you physically able to transport patients? Yes [] No []

7. Please check all areas that you are interested in working in the hospital:

- American Cancer Society Resource Center at Deaconess Medical Center
- Cardiac Intensive Care Desk
- Education
- Emergency Department
- Eucharistic Minister
- Finance
- Gift Shop
- Guest Services
- ICU Intensive Care Desk
- Laboratory (Must be ambulatory)
- Mother Baby
- Patient Care Floors (Cardiac, Orthopedic, Respiratory Surgical floors)
- Pediatrics
- Pharmacy (Level B licensure is required. Applicant will be interviewed by volunteer services and the pharmacy volunteer selection committee)

- Operating Room (OR) (Must be 16 or older pursuing a healthcare career. Applicant will be interviewed by volunteer services and the OR volunteer selection committee.)
- Radiology (College students only, must be enrolled in a Radiology program. Observation only for required 10 hours, other required hours are completed in a supplementary department)
- Safety Management
- Short Stay
- Surgery Center Pre/Post Op
- Surgery Center Registration
- Surgery Center Waiting Rooms
- Volunteer Services Office Support
- Other: _____

1. Have you ever been convicted of a felony? Yes [] No []

2. Have you ever been convicted of a misdemeanor? Yes [] No []
If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

EDUCATION & WORK EXPERIENCE

Education: Check highest level

High School: 9 [] 10 [] 11 [] 12 [] GED []

Name & State _____

If a college student, please list your School, primary interest of study and career goals.

College: 1 [] 2 [] 3 [] 4 [] Graduate School 1 [] 2 [] 3 [] 4 []

Employment Experience:

Have you ever worked at a hospital? Yes [] No []

Last Place of Work – if any: _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor's Name: _____

3. How did you hear about this volunteer program? _____

5. When can you start volunteering? _____

6. Check when you are available to volunteer. Each shift is 4 hours**

[] Monday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Tuesday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Wednesday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Thursday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Friday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Saturday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm
[] Sunday	___ 8:00 am – 12:00 pm	___ 12:00 pm – 4:00 pm	___ 4:00 pm – 8:00 pm

****Please note times may vary depending on your department placement**

Certification and Authorization

PLEASE READ THE FOLLOWING BEFORE SIGNING:

Your placement as a volunteer with Deaconess Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with a criminal background screening and drug screening. The purpose of these screenings is for the protection of patients, staff, physicians and volunteers.

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer.

I authorize the Hospital to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I further understand that my volunteering is contingent upon checking of references furnished. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

I understand I will not be paid for my volunteer services and if accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital.

COLLEGE STUDENTS ONLY: INCLUDE WITH YOUR APPLICATION

- **A letter of reference from a COLLEGE PROFESSOR/TA with your completed application.**
- **An UNOFFICIAL copy of your college transcripts.**
- **A COPY of your immunization records.**

Name: _____

Date: _____

PLEASE MAIL OR FAX YOUR COMPLETED APPLICATION TO:

Deaconess Medical Center
VOLUNTEER OFFICE
800 West Fifth Ave.
Spokane WA. 99210-0248

FAX NUMBER – 509-473-3148
Office – 509-473-3767



**VOLUNTEER SERVICES
REFERENCE FORM**

APPLICANT'S NAME: _____

NAME OF PERSON GIVING REFERENCE: _____

RELATIONSHIP TO APPLICANT: _____

HOW LONG HAVE YOU KNOWN THIS APPLICANT? _____

Please evaluate the applicant in the following areas:

	OUTSTANDING	GOOD	FAIR	NEEDS IMPROVEMENT
1. Displays tact, patience and respect for others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Able to work with diverse populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is dependable and punctual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Accepts responsibility and commitment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Accepts supervision in a positive way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Able to accept change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL COMMENTS: _____

Signature: _____ **DATE:** _____

PRINT NAME: _____ **PHONE:** _____

MAY WE CONTACT YOU FOR ADDITIONAL COMMENTS? YES NO

PERSON GIVING REFERENCE - PLEASE RETURN TO THE APPLICANT THE COMPLETED REFERENCE FORM IN A "SEALED" ENVELOPE TO BE INCLUDED IN HIS/HER APPLICATION PACKET or you may send the completed reference by email or fax to:

Ms. Joey Frost
frostj@empirehealth.org
Fax – 509-473-3148