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. ______________

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EMERGENCY INFORMATION

Emergency Contact ____

Relationship to you _____________________________ Home Phone _________________

Work Phone ___________________________________ Cell Phone ____________________

QUESTIONNAIRE

1. Why are you interested in volunteering? ___________________________________

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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 ____

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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** ________________

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

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5. Do you have any physical, visual or hearing needs we need to consider?

No [ ] Yes [ ] – **If yes, please explain:** ______________________________

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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
[ ] Emergency Department
[ ] Eucharistic Minister
[ ] Finance
[ ] Gift Shop
[ ] Guest Services
[ ] ICU Intensive Care Desk
[ ] Lab
[ ] Mother Baby
[ ] Patient Care Floors
[ ] Pediatrics
[ ] Pharmacy (Level B licensure is required)
[ ] Radiology(College students only, must be enrolled in Radiology program)
[ ] Safety Management
[ ] Short Stay
[ ] Surgery Center Pre/Post Op
[ ] Surgery Center Registration
[ ] Surgery Center Waiting Rooms
[ ] Volunteer Services Office Support
[ ] Other: ____________________

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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.

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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.

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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? _______________________

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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.				
2. Able to work with diverse populations.				
3. Is dependable and punctual.				
4. Accepts responsibility and commitment.				
5. Accepts supervision in a positive way.				
6. Able to accept change.				

ADDITIONAL COMMENTS: ____

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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