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*
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:**

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| Morning | Afternoon | Evening

**SECOND CHOICE:**

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**THIRD CHOICE:**

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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:

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Business:

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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?

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Have you completed the following immunizations?

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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.

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SIGNATURE:

Print: ____________________________ Date: ____________________________

Sign: ____________________________ Date: ____________________________
CONFIDENTIALITY & COMMITMENT

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: _____________________________________________________________

_____________________

A D D I T I O N A L  Q U E S T I O N S

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:

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