Dear Potential Volunteer in Action:

Thank you for your interest in joining Volunteers in Action (VIA). Here is some information about how to become a VIA volunteer. As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through compassionate service. VIA seeks volunteers to help vulnerable adults pursue wellness through social and practical support.

The gift of your volunteer time helps people living in Hood River and Klickitat Counties get food, health care, transportation, and social connections which are critical to living well at any stage of life. VIA serves in the community, not in the hospital. The relationships you can build through your VIA service will bring you joy, laughter, and (at times) frustration. If you are volunteering in order to connect with others and help them enjoy life, you have found the right program.

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

Providence Hood River Memorial Hospital
Volunteers in Action – Anna Williams
Mail: PO Box 149  Physical: 810 12th St.
Hood River, OR 97031
541-387-6404

Volunteer applicants will be called to schedule training. Bilingual (Spanish/English) volunteers are especially appreciated.

Volunteers in Action Onboarding Process

As a potential volunteer you must:

- Complete and sign your volunteer application and background disclosure form. Mail or bring them to the VIA office, second floor, Providence Administration Building
- Complete Volunteer Training (3 hours)
- Pass background check (social security number required, must be 18 or older)
- Make a minimum commitment of six months of service, if there is a match for placement
- Obtain a TB blood test provided by Providence Health & Services
- Provide driver’s license and insurance information (if you wish to provide transportation services to clients)
- Obtain an ID badge

VIA will:

- Interview potential volunteers to determine if you are a good fit for the program
- Complete a background check on all volunteers
- Provide volunteer orientation and training
- Issue a volunteer ID badge

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

Sincerely,

Anna K. Williams, MSW
VOLUNTEER APPLICATION

PERSONAL INFORMATION

Name  ___________________________________________  DOB ______________________
      First  MI  Last

Address ___________________________ City _________________ State ____ Zip ________

Home Phone _______________  Cell Phone _______________  E-Mail ____________________

How long have you lived at this address? ___________  Previous address:__________________

__________________________  Where did you hear about us?_____________________________

EDUCATION / TRAINING

Present Occupation/Employer ________________________________________________________

Position/Years of Service ____________________________________________________________

Other Skills/Responsibilities ________________________________________________________

Education/Course Study ________________________  Current Student:  Full Time  Part Time
(please circle)

High School Name ___________________________ Year ___________

College Name ___________________________ Year ___________

Special Training/Other Certification __________________________________________________

What is Your Primary Language?____________________________________________________

Do You Speak Other Languages? _____________________________________________________

Have You Volunteered Before? _______________ Where? In what capacity__________________
**VOLUNTEER PREFERENCES**

Day(s) Available:  
- Mon  
- Tues  
- Wed  
- Thurs  
- Fri  
- Sat  
- Sun  

(Please Circle) Morning  
Afternoon  
Evening  

Areas of Interest: (See attachments "Volunteer Opportunities & Skill Bank")

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**

Reference (Personal)  
Name ____________________________  Phone ____________________________  Relationship ____________________________

Reference (Business)  
Company Name ____________________________  Phone ____________________________  Contact person ____________________________

Emergency Contact  
Name ____________________________  Phone ____________________________  Relationship ____________________________

Will you consent to a mandatory Background Check? ____________________________

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I hereby agree to abide by the Volunteer Policies, hospital rules and regulations, and to uphold patient/client confidentiality as I fulfill my role as a volunteer. I understand and confirm my willingness and availability to meet the 6 month commitment requirement for my volunteer service. I certify that the above information is true, correct and complete.

Print Name ____________________________  Signature ____________________________

Date ____________________________

If applicant under 18 years of age:

I understand my child has made a commitment of 6 months to Volunteers in Action Providence Community Caregivers. I give permission for my child to be given a Tuberculin skin test, which is provided by Providence Hood River Memorial Hospital. 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.

Print Name ____________________________  Signature ____________________________

Date ____________________________  Relationship ____________________________