Requirements and Benefits for Island Health Volunteers

Volunteer Requirements – **Adult Program**

- Be at least 18 years old
- Commit to volunteering for at least six months, serving a minimum of 100 hours
- Pass a background check
- Pass a health screening and provide vaccination records
- Attend a two-hour orientation
- Complete annual NetLearning modules

Volunteer Requirements – **Youth Program**

- Be at least 16 years old
- Commit to volunteering a minimum of 8- 10 weeks
- Commit to at least one 2- 4 hour shift each week
- Pass a background check
- Pass a health screening and provide vaccination records
- Attend a two-hour orientation
- Complete NetLearning modules

Benefits of Volunteering

- Complimentary meal at the Island Bistro
- Always complimentary coffee, tea and water available in the Bistro
- Free influenza vaccination (per season, when available)
- Job shadowing with a seasoned volunteer
- Annual Volunteer Recognition Celebration (April) –come celebrate all volunteers
- New friendships

Youth Volunteer Positions

Position Title: Greeter Volunteer Assistant
Location: Island Health Main Entrance
Dates Needed: Monday, Tuesday, Wednesday, Thursday and Friday
Timeframe/Shift/Hours: AM Shift 8:00 a.m.-12:00 p.m.
PM Shift 12:00 p.m.-4:00 p.m.
Responsibilities: Volunteers greet patients, visitors and staff as they arrive at the hospital. They may provide assistance with wayfinding and escort patients and/or visitors to their destination. Volunteers in this role may also provide support for Patient Access employees with projects and other duties as needed.

Position Title: Lab Reception Volunteer Assistant
Location: Island Health Lab Phlebotomy Department
Dates Needed: Monday, Tuesday, Wednesday, Thursday and Friday
Timeframe/Shift/Hours: AM Shift 8:00 a.m.-12:00 p.m.
PM Shift 12:00 p.m.-4:00 p.m.
Responsibilities: Greet patients, visitors and staff as they arrive to their appointment; communicate wait time, answer wayfinding questions, help with patient escort and phone messaging.

Position Title: Surgery Desk Volunteer Assistant
Location: Island Health Surgery Desk
Dates Needed: Monday, Tuesday, Wednesday, Thursday and Friday
Timeframe/Shift/Hours: AM Shift 7:30 a.m-11:00 a.m.
PM Shift 11:00 a.m.-3:00 p.m.
Responsibilities: Volunteers assigned to work in a patient care area will assist with providing an informative and comfortable visit for the patient and/or family member. This may include retrieving warm blankets, escorting patients and families through the Outpatient Surgery area to the nursing team, providing instructions on how to read the surgery tracker board, assisting with wheelchairs upon discharge, and other duties that support the patient care experience and are within the scope of the volunteer role.

Position Title: Clinic Volunteer
Location: Clinics - Anacortes
Days Needed: Monday, Tuesday, Wednesday, Thursday and Friday
Timeframe/Shift/Hours: AM Shift: 8 a.m.-12 p.m.
PM Shift: 1 p.m.-4:30 p.m.
Duties/Project Description: Assist limited mobility patients in getting to-and-from the building for physician appointments; also getting patient who need assistance to get to Diagnostic Imaging or to the Emergency Room; when not helping patients with limited mobility, greet patients and offer them water. Chat with patients to see if they need health information on any particular topics (exercise, sleep habits, mental health topics, etc.).
Total Number of Volunteers needed: 10

ISLAND HEALTH
Care Courageously™

Dear Parents,

We are delighted that your teen has decided to become a member of the healthcare community at Island Health as a volunteer. Volunteering is a way that all of us can offer gifts of time and skill to the community at large, but we recognize that volunteering is a two-way exchange. Although it will have its fun moments, becoming a hospital volunteer is a serious endeavor. As an Island Health volunteer your teen will gain new skills, new friends, opportunities to observe careers in action, experience that will certainly be valuable in other settings, and the chance to grow in responsibility and maturity.

I want to take this time to tell you about the Island Health Volunteer Program your teen is inquiring about, the responsibilities of our volunteers, and the expectations we have for them.

Our volunteers are essential to the workings of the hospital, and the staff will come to depend on your teen's services for support. Scheduling will be done in concert with your teen's other activities to the best of our abilities, but they must make a commitment to be here at their appointed times. Please go over the page 'Requirements & Benefits of Island Health Volunteers' with your teen. For a current list of available volunteer positions, have your teen go to our website at https://islandhealth.org/volunteer-services/. This is to be done prior to their appointment with the Volunteer Supervisor or New Volunteer Orientation (NVO).

Your teen's volunteer experience, while a great gift to the community as well as the patients and hospital staff, will be very valuable to them as they consider career options, educational plans, and goals for adult life. We are honored to have your teen with us and will be pleased to recommend them in other areas of their life as we come to know them and their abilities.

We recognize that your teen's desire to serve and care for others reflects the care they have received at home and throughout their life. If you have any questions about our Volunteer Department or the application process, please call Jordy Pratt, Volunteer Supervisor at 360.299.1397 or email Jordyn.pratt@islandhospital.org.

Thank you for considering volunteering at Island Health.

Sincerely,

Laura Moroney

Laura Moroney, MS
Director of Marketing & Communications

ISLAND HEALTH
Care Courageously™

For Office Use Only:

Date Rec'd_____

WSP _____

Applicant Information

YOUTH VOLUNTEER APPLICATION

Legal Name:_____

Last *First* *MI*

Preferred First Name: _____

only if different from legal name

Mailing Address:_____

Street Address *Apt. /Unit #*

_____

City *State* *Zip Code*

Phone Number: (_____) _____ - _____ (_____) _____ - _____

Primary *Secondary*

Email Address:_____

Emergency Contact

Parent/Guardian: _____

Last *First* *Relationship*

Phone Number: (_____) _____ - _____ (_____) _____ - _____

Primary *Secondary*

General Questions & Availability

Do you have any physical limitations or are you under any course of treatment that might limit your ability to perform certain types of work/tasks? (i.e. lifting boxes, pushing wheelchairs, etc.) ?

☐ Yes ☐ No

Please explain: _____

Medication(s) allergies: _____

Food allergies (to accommodate at luncheons): _____

All day shift hours are between 6:00 a.m. – 5:00 p.m.; dependent on position.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Hours preferred: _____

Please list two non-family references and provide a recommendation letter from each:

1. _____ Phone: _____
2. _____ Phone: _____

How did you learn about our program?

☐ Neighbor/Volunteer ☐ Advertisement ☐ Social Media

☐ Website ☐ Agency/School

☐ Other _____

Are you volunteering for school community service? Yes No

Name of school _____ Hours needed _____

Volunteer Skills

As a volunteer you will have the opportunity to offer many of your skills and work in areas of interest to you. To better place you, and to know just what wonderful gifts you have to offer we would like you to fill out this inventory of skills. This information will assist us in placing you in just the right volunteer position.

Skills you have that you would like to share:

_____

_____

_____

_____

Other volunteer activities:

_____

_____

_____

Educational/occupational background:

_____

Any other information that may help us to know you and your abilities?

_____

_____

_____

Area/s you are interested in volunteering in:

_____

_____

_____

Professional Licensure

Active Certifications (BLS, ACLS, etc.):

_____

Have you been previously employed by Island Health?

☐ Yes ☐ No If yes, indicate position held and dates of employment:

_____

Read & Sign Acknowledgment

I certify the information set forth in this application to volunteer is true and complete to the best of my knowledge. I understand that falsified statements on this application or failure to furnish all requested information shall be considered cause for my dismissal.

Affiliation with Island Health is voluntary and may be discontinued at the organization's discretion with or without notice by Island Health.

I understand to volunteer with Island Health that I will be required to complete a disclosure statement and a background check through the Washington State Patrol's criminal identification system. I will also be required to satisfy Island Health's immunization requirements, complete volunteer orientation, and abide by established organization policies and procedures.

Signature:_____

Name *(print)*: _____

Date: _____

Signature of parent/guardian:_____

Date: _____

For Internal Processing Only

Date Approved: _____

Volunteer Role/Job: _____

_____ License Verification Completed (If Applicable)
_____ Background Check Completed
_____ Confidentiality Statement Signed
_____ Immunizations Verified
_____ Orientation Acknowledgement Signed

Orientation Completed Date: _____
Verified By (IH Employee): _____

ISLAND HEALTH
Care Courageously™

AUTHORIZATION FOR QUANTIFERON GOLD TB SCREEN TEST OF A MINOR

A Quantiferon Gold TB test (blood draw) is required as a condition of volunteer work at Island Health to determine if there was an exposure to tuberculosis (TB). The test is done by the hospital lab and is free of charge. The Employee Health Nurse will write the lab order during the scheduled New Volunteer Employee Health visit. It is the responsibility of the volunteer to follow through and ensure this is completed on the same day as their Employee Health visit. Results will take approximately one week to get back to the Employee Health Nurse.

If the test shows a positive result, a chest X-ray will be ordered at Island Health. There is no charge for the X-ray. It is the responsibility of the volunteer and parent/legal guardian to schedule a follow up visit(s) with their healthcare provider regarding these test results and any further care/treatment determined by the provider. Island Health does not cover the care/treatment of the provider visits.

Please reach out to Employee Health at 360-299-4955 with any questions or concerns.

My (our) child, _____, has my (our), _____,

_____ consent to have a Quantiferon Gold TB test drawn at Island Health.

_____

Date Parent/Legal Guardian Signature

_____

Date Parent/Legal Guardian Signature

ISLAND HEALTH
Care Courageously™

Island Health Youth Volunteer Program
Recommendation Form

As part of your application, we require written recommendation from two adults, other than family members. You may want to ask a teacher, counselor, minister, employer or family friend (over 18) who knows you well. Please have them use the form below. They may return the recommendation to us at the volunteer office, or it can be mailed to:

Island Health
Volunteer Services
1211 24th Street
Anacortes, WA 98221

Applicant Name: _____ **Date:** _____

The applicant named above is interested in becoming a volunteer with the Island Health Youth Volunteer Program. Please share with us your knowledge of this young person, and your reasons for recommending his/her placement in our program.

I recommend that _____ be accepted in the Island Health Youth Volunteer Program because:

Name: _____

Signature: _____

Relationship to Applicant: _____

Phone Number: _____

Thank you for your thoughtful input.

ISLAND HEALTH
Care Courageously™

YOUTH VOLUNTEER
PARENTAL CONSENT AND MEDICAL RELEASE FORM

Dear Parents,

Your son/daughter is interested in becoming a Youth Volunteer at Island Health. We look forward to providing a meaningful and educational experience for your child. It is important that you recognize the commitment and responsibility that will be involved in your child's participation in the Island Health Youth Volunteer Program.

Youth volunteers will serve in a variety of areas within the hospital, always under close supervision and with the necessary training. The hospital will depend on their services and will count on them coming in on their appointed days. Typically, youth volunteers will be on duty, two to four hours a week on weekdays; there may be occasional special projects involving other times and they must commit a minimum of eight weeks of volunteer time. Please sign below to indicate your consent to the time commitment and transportation needs of your child.

My (our) child _____ has my (our) permission to serve as a youth volunteer at Island Health. I (we) understand that transportation to and from the hospital will be arranged by me (us). I (we) approve of the regular volunteer service hours of two to four hours a week on weekdays, or special assignment times and his/her minimum commitment to volunteer at least eight weeks.

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Signature

Emergency/Work Phone _____ Emergency/Work Phone _____

Home Phone _____

MEDICAL RELEASE

In the event of a medical emergency, I give permission to the Island Health Volunteer Services Department to seek and procure medical treatment for my child _____.

_____

Parent/Legal Guardian Name (please print)

Signature _____ Date _____

Disclosure Statement

Island Hospital has a long standing commitment to the safety and security of our patients, employees and affiliates and as such, we will be conducting a background check that may include the Washington State Patrol's criminal identification system, national background check and/or the Office of the Inspector General's excluded individual / entity database checks.

Pursuant to the requirements of RCW 43.43.830, we must ask you to complete the following disclosure statement. This information will be kept confidential.

1. Have you ever been convicted of any of the following crimes against children or other persons, or crimes relating to drugs?

YES	NO	
____	____	aggravated murder
____	____	first or second degree murder
____	____	first or second degree kidnapping
____	____	first, second or third degree assault
____	____	first, second or third degree assault of a child
____	____	first, second or third degree rape
____	____	first, second or third degree rape of a child
____	____	first or second degree robbery
____	____	first degree arson
____	____	first degree burglary
____	____	first or second degree manslaughter
____	____	first or second degree extortion
____	____	indecent liberties
____	____	incest
____	____	vehicular homicide
____	____	first degree promoting prostitution
____	____	communication with a minor
____	____	unlawful imprisonment
____	____	simple or fourth degree assault
____	____	sexual exploitation of minors
____	____	first or second degree criminal mistreatment
____	____	endangerment with a controlled substance
____	____	child abuse or neglect *(RCW 26.44.02)*

YES	NO	
____	____	first or second degree custodial interference
____	____	first or second degree custodial sexual misconduct
____	____	malicious harassment
____	____	first, second or third degree child molestation
____	____	first or second degree sexual misconduct with a minor
____	____	patronizing a juvenile prostitute
____	____	child abandonment
____	____	promoting pornography
____	____	selling or distributing erotic material to a minor
____	____	custodial assault
____	____	violation of child abuse restraining order
____	____	child buying or selling prostitution
____	____	felony indecent exposure
____	____	criminal abandonment
____	____	manufacturing a controlled substance
____	____	delivery of a controlled substance
____	____	possession of a controlled substance with intent to manufacture or deliver
____	____	or any of these crimes as they may have been renamed

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction (s) and the sentence(s) imposed:

2. Have you ever been convicted of any of the following crimes relating to financial exploitation if the victim was a vulnerable adult:

Per RCW 43.43.830, a vulnerable adult is defined as an adult: (a) of any age who lacks the functional, mental, or physical ability to care for themselves, or (b) found incapacitated under chapter 11.88 RCW; or (c) who has developmental disability as defined under RCW 71A.10.020; or (d) admitted to any facility as defined under RCW 74.34.020; or (e) receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127RCW.

YES	NO	
____	____	first, second or third degree extortion
____	____	first, second or third degree theft
____	____	first or second degree robbery

YES	NO	
____	____	forgery
____	____	any of these crimes as they may have been renamed

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction (s) and the sentence(s) imposed:

3. **Have you ever been convicted of any crime relating to obstruction of an investigation, fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? YES ____ NO ____**

If your answer is "yes", please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed:

4. **Have you ever had an agency or a court make a finding against you in a civil adjudication proceeding that you committed any of the following acts against a child or vulnerable adult?**

YES	NO		YES	NO	
____	____	domestic abuse	____	____	abuse
____	____	sexual abuse	____	____	neglect
____	____	exploitation	____	____	financial exploitation

If your answer is "yes" to any of the questions about civil adjudications, provide the type of proceeding, the names of the parties involved, the date(s) of the finding (s), and explain the details of any findings and penalties/restrictions imposed. Attach additional pages if necessary.

5. **Have you ever been convicted of any other crimes in addition to the ones listed above? YES ____ NO ____**

If "yes", indicate the crime and provide the city, state and court where you were convicted, the date(s) of the conviction(s), the sentence (s) imposed, and if you served time in prison or jail, the date of your release. Attach additional pages if necessary.

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. YOUR AFFILIATION WILL BE CONDITIONED UPON THE SATISFACTORY OUTCOME OF BACKGROUND CHECKS AS DESCRIBED.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am accepted into an affiliation, I can be discharged for any misrepresentation or omission in the above statement.

_____ _____

Signature Date

_____ _____ _____

Name *(Please Print)* Maiden Name / Other Names Used Date of Birth