

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

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

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

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: Emergency Department Patient Liaison Volunteer

Location: Emergency Department

Days Needed: Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday

Timeframe/Shift/Hours: AM Shift: 11 a.m. - 3 p.m.
PM Shift: 3 p.m. - 5 p.m., 5 p.m. - 8 p.m.

Responsibilities: Provide non-medical support to patients, families, visitors, and staff by offering comfort, guidance, and assistance while helping maintain a welcoming, safe, and organized environment. Greeting and escorting patients and visitors, providing wheelchair assistance, responding to patient needs, stocking and organizing supplies and equipment, assisting with clerical and logistical tasks, delivering items between departments, and supporting staff with other duties. Demonstrate professionalism, communication effectively with the ED team, maintain confidentiality and cultural sensitivity, as well as adhering to all organizational policies, safety standards, and infection control procedures.



Dear Parents/Guardians,

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 Mason Cole, Volunteer Supervisor at 360.299.1397 or email mason.cole@islandhospital.org.

Thank you for considering volunteering at Island Health.

Sincerely,

Laura Moroney, MS
Director of Marketing & Communications



For Office Use Only:
Date Rec'd _____

Applicant Information

YOUTH VOLUNTEER APPLICATION

Legal Name: _____
Last First MI

Preferred First Name: _____ Preferred Pronouns: _____
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 national 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 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.



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 _____

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		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	aggravated murder	<input type="checkbox"/>	<input type="checkbox"/>	first or second degree custodial interference
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree murder	<input type="checkbox"/>	<input type="checkbox"/>	first or second degree custodial sexual misconduct
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree kidnapping	<input type="checkbox"/>	<input type="checkbox"/>	malicious harassment
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree assault	<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree child molestation
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree assault of a child	<input type="checkbox"/>	<input type="checkbox"/>	first or second degree sexual misconduct with a minor
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree rape	<input type="checkbox"/>	<input type="checkbox"/>	patronizing a juvenile prostitute
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree rape of a child	<input type="checkbox"/>	<input type="checkbox"/>	child abandonment
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree robbery	<input type="checkbox"/>	<input type="checkbox"/>	promoting pornography
<input type="checkbox"/>	<input type="checkbox"/>	first degree arson	<input type="checkbox"/>	<input type="checkbox"/>	selling or distributing erotic material to a minor
<input type="checkbox"/>	<input type="checkbox"/>	first degree burglary	<input type="checkbox"/>	<input type="checkbox"/>	custodial assault
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree manslaughter	<input type="checkbox"/>	<input type="checkbox"/>	violation of child abuse restraining order
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree extortion	<input type="checkbox"/>	<input type="checkbox"/>	child buying or selling
<input type="checkbox"/>	<input type="checkbox"/>	indecent liberties	<input type="checkbox"/>	<input type="checkbox"/>	prostitution
<input type="checkbox"/>	<input type="checkbox"/>	incest	<input type="checkbox"/>	<input type="checkbox"/>	felony indecent exposure
<input type="checkbox"/>	<input type="checkbox"/>	vehicular homicide	<input type="checkbox"/>	<input type="checkbox"/>	criminal abandonment
<input type="checkbox"/>	<input type="checkbox"/>	first degree promoting prostitution	<input type="checkbox"/>	<input type="checkbox"/>	manufacturing a controlled substance
<input type="checkbox"/>	<input type="checkbox"/>	communication with a minor	<input type="checkbox"/>	<input type="checkbox"/>	delivery of a controlled substance
<input type="checkbox"/>	<input type="checkbox"/>	unlawful imprisonment	<input type="checkbox"/>	<input type="checkbox"/>	possession of a controlled substance with intent to manufacture or deliver
<input type="checkbox"/>	<input type="checkbox"/>	simple or fourth degree assault	<input type="checkbox"/>	<input type="checkbox"/>	or any of these crimes as they may have been renamed
<input type="checkbox"/>	<input type="checkbox"/>	sexual exploitation of minors			
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree criminal mistreatment			
<input type="checkbox"/>	<input type="checkbox"/>	endangerment with a controlled substance			
<input type="checkbox"/>	<input type="checkbox"/>	child abuse or neglect (RCW 26.44.02)			

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		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree extortion	<input type="checkbox"/>	<input type="checkbox"/>	forgery
<input type="checkbox"/>	<input type="checkbox"/>	first, second or third degree theft	<input type="checkbox"/>	<input type="checkbox"/>	any of these crimes as they may have been renamed
<input type="checkbox"/>	<input type="checkbox"/>	first or second degree robbery			

Disclosure Statement

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

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