KADLEC | REGIONAL MEDICAL CENTER

WELCOME TO VOLUNTEER SERVICES AT KADLEC!

Thank you for your interest in becoming a Volunteer at Kadlec Regional Medical Center!

New volunteers are always needed at Kadlec Regional Medical Center, and the rules and regulations of hospital procedure are easily learned. Since supervision of all volunteers is mandatory, you will receive understanding guidance and whatever training you may need. You are expected to commit to serving for at least six months and giving at least 100 hours of service.

The first procedure is to complete the attached application, and return it Carly Larkin, Manager, Volunteer Services. You will be notified of the next orientation before you begin your volunteer duties. **You must attend an orientation, fill out a health screening form and your titers drawn before you can volunteer. You will also have a health screening appointment with Caregiver Health.**

YOU WILL BE EXPECTED TO

1. Make a firm commitment on specific services for a specific number of hours, and at specified times
2. Attend Kadlec Volunteer orientation.
3. Have training in your assigned area/department.
4. Attend a Health Screening appointment.
5. Respect the rules of the hospital and support them.
6. Accept the direction and suggestions from those who will supervise you.
7. Maintain professional standards in matters of patient and staff confidentiality.
8. Take complaints to the Volunteer Coordinator for resolution.

The main function of the Adult Volunteer is to help. You won't be asked to perform tasks that are normally performed by paid staff members. You will perform extra services that employees do not always have time for. These services add to the welfare of patients and often help the hospital to function better by freeing employees to take care of essential services.

Thank you for considering Kadlec Regional Medical Center in your search for volunteer service.

Carly Larkin,
Manager, Volunteer Services
Kadlec Regional Medical Center
888 Swift Blvd, Richland WA 99352
(509)942-2949
Carly.larkin@kadlec.org

Date Received _____
For office use only

KADLEC | REGIONAL MEDICAL CENTER

ADULT VOLUNTEER APPLICATION

_____

Date

_____ _____ _____

Last name First name Middle I.

_____

Date of Birth

_____ _____ ____ _____

Address City State ZIP

_____

Home Phone # Cell # Email Address

_____

Emergency Contact Name and Phone #

Special Skills

_____

Hobbies

_____

What type of volunteering are you interested in?

_____

Do you speak a language other than English?

_____

Best Days to Volunteer_____**AM/PM**_____

REFERENCES (Must be signed)

1._____

Name & Address

_____

Telephone # Signature

2._____

Name & Address

_____

Telephone # Signature

KADLEC REGIONAL MEDICAL CENTER VOLUNTEER AGREEMENT

Kadlec Regional Medical Center has made a provision in our facility to provide volunteer service within the community. As a volunteer at Kadlec Regional Medical Center you are expected to act professionally at all times. Part of this expectation is that you will keep confidential all information pertaining to patients and others within the facility

CONFIDENTIALITY STATEMENT

During the course of your activities at Kadlec Regional Medical Center you may have access to information which is confidential. The Law does not permit disclosure of confidential information.

Confidential Information includes, but is not limited to:

- Medical and certain other personal information about patients.
- Medical personnel and certain other information about employees.
- Medical Staff records and committee proceedings.
- Medical Center financial and operating data.
- Reports, policies and procedures, marketing or financial information, business & strategic plans, corporate minutes, electronic mail and other private or sensitive information related to the business or services of Kadlec Medical Center.

If you have any questions concerning the confidentiality or disclosure of information, you should contact the Volunteer Coordinator at 942-2949.

By my signature, I _____ (**PRINT NAME**) certify that I have been informed of and understand my responsibility in maintaining the confidentiality of all patients, personnel, and hospital information. I have read and agree to be bound by the conditions contained in this agreement. I understand that failure to comply may subject me to disciplinary action including legal action.

_____

Signature Date

VOLUNTEER AGREEMENT

My services are donated to Kadlec Regional Medical Center without contemplation of compensation or future employment, and given for humanitarian, religious and/or charitable reasons, and with the expectation that I serve for at least six months.

I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others. I will endeavor to make my work professional in quality.

I shall attempt to resolve any problems related to my volunteer activities with my supervisor. If that is unsuccessful, I will attempt to resolve any such problems with the Volunteer Coordinator.

I shall make my best effort to fulfill my commitment to KRMC by completing all assignments that I accept.

I shall at all times uphold the philosophy and standards of Kadlec Regional Medical Center.

I agree to attend continuing education courses so that I can carry out my assignments more effectively.

I understand that the Volunteer Services department of KRMC reserves the right to terminate my volunteer status as a result of, a) failure to comply with KRMC policies, rules and regulations; b) absences without prior notification; c) unsatisfactory attitude, work or appearance; d) any other circumstances which would make my continued service as a volunteer contrary to the best interests of the hospital.

As a volunteer at Kadlec Regional Medical Center I have read each of the above conditions and I agree to be bound by them.

Signature Date

FAILURE TO SIGN THIS DOCUMENT IN BOTH PLACES WILL RESULT IN YOUR APPLICATION FOR VOLUNTEER SERVICE AT KADLEC REGIONAL MEDICAL CENTER TO BE DECLINED.

KADLEC

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.

Have you ever been convicted of any of the following crimes against persons?

Yes	No		Yes	No	
☐	☐	Aggravated Murder	☐	☐	First Degree Burglary
☐	☐	First or Second Degree Murder	☐	☐	Indecent Liberties
☐	☐	First or Second Degree Kidnapping	☐	☐	Incest
☐	☐	First, Second, or Third Degree Assault	☐	☐	Vehicular Homicide
☐	☐	First, Second, or Third Degree Assault of a Child	☐	☐	Unlawful Imprisonment
			☐	☐	Simple Assault
☐	☐	First, Second, or Third Degree Rape	☐	☐	Sexual Exploitation of Minors
☐	☐	First, Second, or Third Degree Rape of a Child	☐	☐	First or Second Degree Custodial Sexual Misconduct
☐	☐	First or Second Degree Robbery			
☐	☐	First or Second Degree Manslaughter	☐	☐	First or Second Degree custodial interference
☐	☐	First or Second Degree Extortion			
☐	☐	First or Second Degree Criminal Mistreatment	☐	☐	Felony Indecent Exposure
			☐	☐	Criminal Abandonment
☐	☐	Child Abuse or Neglect as defined in RCW 26.44.020	☐	☐	Malicious Harassment
			☐	☐	First, Second, or Third Degree Child Molestation
☐	☐	Selling or distributing erotic material to a minor	☐	☐	First or Second or Third Degree Sexual misconduct with a minor
☐	☐	Endangerment with a controlled substance			
☐	☐	Custodial Assault	☐	☐	Patronizing a Juvenile Prostitute
☐	☐	Child buying or selling	☐	☐	Child abandonment
☐	☐	First Degree promoting prostitution	☐	☐	Promoting Pornography
☐	☐	Communications with a minor	☐	☐	Violation of Child Abuse Restraining Order
☐	☐	First Degree Arson	☐	☐	Prostitution
			☐	☐	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.

_____

_____

_____

_____

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has functional, mental, or physical inability to care for himself or herself or is a patient in a state hospital?

Yes	No		Yes	No	
☐	☐	First, Second, or Third Degree Extortion	☐	☐	Forgery
☐	☐	First or Second Degree Robbery	☐	☐	Or any of these crimes as they may have been renamed
☐	☐	First, Second or Third Degree Theft			

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.

_____

_____

_____

1. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor? ☐ Yes ☐ No

2. Have you ever been found in a court in a domestic relations proceeding to have physically abused or exploited any minor or to have physically abused any minor? ☐ Yes ☐ No

3. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person? ☐ Yes ☐ No

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited any person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital? ☐ Yes ☐ No

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital? ☐ Yes ☐ No

If your answer is "yes" to any of questions 1 through 5 above, please describe and provide the date(s) of the finding(s) and penalty(ies) imposed.

_____

_____

_____

_____

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 adjudication of child abuse, and disciplinary board final decisions. YOUR AFFILIATION WILL BE CONDITIONED UPON THE SATISFACTORY OUTCOME OF BACKGROUND CHECKS AS DESCRIBED BELOW.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am accepted into a clinical internship, I can be discharged for any misrepresentation or omission in the above statement. I also understand that any employment or internship is conditioned on the successful completion of the following: professional references, background investigations including but not limited to: Licensure, Criminal History, Social Security Verification, Governmental Sanction Checks and required drug screens.

Signature _____ Date _____

Name (print) _____

WASHINGTON STATE PATROL

Identification and Criminal History Section

PLEASE COMPLETE THE FORM BELOW.

REQUEST FOR **CONVICTION CRIMINAL HISTORY RECORD** INFORMATION FROM THE WSP. **(RCW 10.97)**

SUBJECT INFORMATION: Please print clearly

Applicants Name:_____

Last First Middle

Alias/Maiden Name:_____

Date of Birth:_____ Sex:_____ Race:_____

Month/Day/Year

KADLEC

Kadlec Volunteer Services - New Volunteer Health Screening

Welcome to Kadlec!

To protect you and our vulnerable patients, certain health requirements must be met before you start volunteering. Complete this packet and return it to Volunteer Services along with your application. You will be required to attend a health screening appointment to review you immunization records.

Immunization and Titer records

Please provide as much documentation as possible regarding the tests and immunizations listed below. This will prevent the duplication of testing and/or vaccinations. If you do not have documentation, **the tests or vaccines can be provided free of charge.**

- **Tuberculosis testing –** Interferon Gamma Release Assay (IGRA), which is a blood test for TB, that is current within the last 30 days. Quantiferon Gold or T-spot is acceptable. If there is a history of positive TST (TB skin test) or IGRA, please bring copies of chest x-rays (within the last 12-months), medical provider documentation, and previous positive test results.
- **Measles, mumps, and rubella (MMR) –** Documentation of two MMR vaccines and/or positive titers
- **Chickenpox (varicella) –** Documentation of two varicella vaccines and/or positive titer
- **Tetanus, diphtheria and pertussis (Tdap)** – Documentation of vaccination
- **Annual influenza vaccine –** Documentation of acceptance or declination of the vaccine

If you need help obtaining your immunization records, check with your physician, previous employers, or schools or contact the health department where you grew up.

You may also call the immunization information system helpline for the state in which you received your vaccinations:

- Alaska 888-430-4321
- California 800-578-7889
- Montana 406-444-5924
- Oregon 800-980-9431
- Washington 866-397-0337

We strongly encourage you to gather your records as soon as possible.

It may take several weeks to obtain your records.

Please bring all your records to your health screening appointment.

Thank you

KADLEC

Caregiver Health Services - Volunteer Screening Form

Name:_____
Last First Middle

Date of Birth: _____Gender: _____

Address:_____

City:_____State:_____Zip:___

Email address: _____

Phone number:_____Alternate phone number: _____

Best time to call:_____

Please complete the following to the best of your knowledge. This will become a part of your Caregiver Health Services (CHS) file. All medical information is confidential. If you have any questions or need to reschedule your appointment, please call Caregiver Health Services at 946-4611 ext. 4179 or 942-4179.

I understand the following:

❑ **Yes**	I understand, if applicable, I am willing and able to wear required safety equipment such as gloves, glasses, respirators, masks or ear protection on the job? If no, please explain:_____
❑ **Yes**	I understand, if I have ever had any reaction to any latex product (e.g., rash, swelling, anaphylaxis, burning after contact) that I would inform my Caregiver Health Services professional.
❑ **Yes**	I understand that titers will be drawn and I will be notified of my immune status and that if I am not immune I may be vaccinated in Caregiver Health Services.

Applicant signature:_____ Date: _____

Caregiver Health signature:_____ Date: _____

KADLEC

Tuberculosis Screening Questionnaire

Name:_____ Date of Birth: _____
Last First Middle

Do you currently have:		If yes, please explain:
Productive cough for more than three weeks?	❑ Yes ☐ No	
Fever associated with cough for more than one week?	❑ Yes ☐ No	
Blood present in sputum?	❑ Yes ☐ No	
Night sweats?	❑ Yes ☐ No	
Unusual fatigue for more than two weeks?	❑ Yes ☐ No	
Loss of appetite for more than two weeks?	❑ Yes ☐ No	
Unexplained weight loss (of five pounds or more)?	❑ Yes ☐ No	
Current health status:		**If yes, please explain:**
Do you have an acute viral infection or febrile illness?	❑ Yes ☐ No	
Have you had a live-virus vaccine in the past six weeks?	❑ Yes ☐ No	
Are you currently taking steroids (cortisone or prednisolone)?	❑ Yes ☐ No	
Are you currently undergoing radiation therapy, chemotherapy or immunosuppressive therapy?	❑ Yes ☐ No	
History:		**If yes, please explain:**
Where you born outside of the U.S.?	❑ Yes ☐ No	Country:
Have you been out of the country within the last six months?	❑ Yes ☐ No	Country:
Have you ever had a TB skin or blood test?	❑ Yes ☐ No	
Have you ever had a positive reaction?	❑ Yes ☐ No	Date:
Have you had a recent chest x-ray?	❑ Yes ☐ No	Date:
Is there anyone in your family with TB?	❑ Yes ☐ No	Relationship:
Have you ever had close contact with active TB (including health care exposure)?	❑ Yes ☐ No	
Have you ever been treated with TB medications?	❑ Yes ☐ No	
Have you received the BCG vaccination?	❑ Yes ☐ No	
Do you have diabetes?	❑ Yes ☐ No	

To my knowledge, the above information is correct. I consent for a TST (TB skin test) or IGRA blood test.

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease, if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

Applicant signature:_____ Date: _____

CHS Representative Signature:_____ Date: _____

KADLEC

Consent and Release of Medical Information

Name:_____ Date of Birth: _____
Last First Middle

I authorize the Kadlec designee(s) to administer immunization(s), TB skin testing/TB blood testing, and other preventative, or diagnostic treatments for illness or injury sustained during the course of my work. This Authorization also includes treatment for minor non-industrial injuries/illnesses.

This authorization does not prevent me refusing treatment at a later date. It remains in effect during my service at any Providence Health & Services and Kadlec facility. Commonly administered injections include TST, tetanus & diphtheria, tetanus, diphtheria & pertussis, Hep B, MMR (measles, mumps & rubella), varicella and influenza. Additional testing may be ordered, such as chest x-rays or lab testing. This is to rule out Tuberculosis and test for immunity status.

All individually identifiable information in the Caregiver Health Service (CHS) record is maintained in said department in accordance with state and federal statutes and regulations. Information will be disclosed if that information is deemed relative regarding suitability for volunteering, ability to perform essential job functions or significant job change or transfer.

In the event of a work related injury/illness sustained while volunteering at Kadlec Regional Medical Center, information may be provided to those involved through Volunteer Services.

- **Work related incidents/injuries need be reported to Volunteer Services immediately.**
- **Communicable disease related illnesses/exposures should be reported to Caregiver Health Services.**

Findings of initial health screen and any other examinations will be reviewed by the CHS nurse or designee. I have read this document and I have been given an opportunity to ask questions.

Applicant Signature:_____ Date: _____

CHS Representative:_____ Date:_____