ISLAND HOSPITAL

Dear Parents,

We are delighted that your teen has decided to become a member of the health care community at Island Hospital 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 Hospital 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 Hospital 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 teens 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 Hospital Volunteers' with your teen. For a current list of Available Volunteer Positions have your teen go to our web site at www.islandhospital.org. This is to be done prior to their appointment with the Volunteer Coordinator or New Volunteer Orientation (NVO).

Your teen's volunteer experience, while a great gift to the community as well as 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. Please don't hesitate to contact me if you have any questions about the Volunteer Program and your teen's participation with us.

Very sincerely,

Jennifer Van Dyke
Volunteer Coordinator
360-299-1371
jvandyke@islandhospital.org

ISLAND HOSPITAL

For Office Use Only:
Date Rec'd_____
WSP_____
Interview_____
TB_____
Orientation_____

YOUTH VOLUNTEER APPLICATION

Name: _____ Ph: Hm:_____

Address: _____ Cell:_____ □ text ok

_____ Date of Birth _____

E-mail address:_____

Emergency Contact: _____ Ph: _____
Name Relationship □ Hm. □ Cell □ Wk.

School _____ Present Grade _____ Overall GPA_____

School Counselor:_____ Ph:_____

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)?

If so, please explain _____

Medication(s) allergies:_____

Food allergies (to accommodate at luncheons):_____

Availability:
All day shift hours are between 6am – 5pm; dependent on position.

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Hours Preferred: _____

Please list the name(s) and number(s) of the two non-family references who filled out the recommendation forms:

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

How did you learn about our program?

□ Neighbor/Volunteer □ Saw Advertisement □ Volunteer Center
□ Website □ School/Agency □ Other_____

I certify that the information provided herein is true and correct to the best of my knowledge, and I agree to update this information in the event that anything changes.

_____ _____
Volunteer Signature Date

ISLAND HOSPITAL

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/Club/Sport Activities:_____

_____

_____

_____

What skills would you like to learn or obtain from volunteering?_____

_____

_____

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

_____

_____

_____

ISLAND HOSPITAL

YOUTH VOLUNTEER
PARENTAL CONSENT AND MEDICAL RELEASE FORM

Dear Parents,

Your son/daughter is interested in becoming a Youth Volunteer at Island Hospital. 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 Hospital 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 need to 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 three months of volunteer time. Please sign below to indicate your consent to the time commitment and transportation needs of your child.

My (our) son/daughter _____ has my (our) permission to serve as a youth volunteer at Island Hospital. 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 three months.

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Signature

Emergency/work phone _____ Home Phone _____

MEDICAL RELEASE

In the event of a medical emergency I give permission to the Island Hospital Volunteer Services Department to seek and procure medical treatment for my son/daughter _____.

_____

Parent/Legal Guardian Name (Please Print)

Signature_____ Date_____

ISLAND HOSPITAL

AUTHORIZATION FOR QUANTIFERON GOLD TB SCREEN TEST AND INFLUENZA VACCINATION OF A MINOR

A Quantiferon Gold TB screen test (blood draw) is required as a condition of volunteer work at Island Hospital. The test is done by the hospital lab and is free of charge. The Employee Health Nurse will write the lab order during your sons/daughters chosen New Volunteer – Health Clinic day. It is the responsibility of the youth volunteer to follow through and ensure this is completed on the same day as their Health Clinic day. Results will take approximately a week to get back to the Employee Health Nurse. If the test shows a positive result, a chest X-ray may be ordered. Unless otherwise directed, chest X-rays, when indicated, are taken at Island Hospital.

My (our) son/daughter, _____, has my (our), _____, _____ consent to have a Quantiferon Gold TB screen test (blood draw) administered at Island Hospital.

An Influenza (Flu) Vaccination is required as a condition of volunteer work at Island Hospital. If you do not provide a copy of proof that your son/daughter has received the current Flu Season vaccination they will receive one during their chosen New Volunteer – Health Clinic day (provided it is within the Flu Season and Island Hospital has vaccinations available). If your son/daughter has not had the most current Flu Season vaccination and they are not available during the Health Clinic they may not volunteer until their Flu vaccinations are up to date.

My (our) son/daughter, _____, has my (our), _____, _____ consent to receive the Flu Vaccination administered at Island Hospital if available and if proof cannot be given.

_____ _____

Date Parent/Legal Guardian Signature

_____ _____

Date Parent/Legal Guardian Signature

ISLAND HOSPITAL

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, you are privileged to become a member of the Island Hospital family. Once you become a member of the Volunteer staff, you become a representative of the institution, and as such, your behavior at all times reflects upon the institution. It is expected that you will be worthy of the trust given to you, and that you will perform your duties to the best of your ability with intelligence, courtesy, tact and cheerfulness.

The hospital assumes an obligation to keep in strict confidence ALL information about patients. Each person who works here in any capacity shares this responsibility. Discretion cannot be too strongly emphasized. Keep confidential any information acquired through volunteer service in the hospital. **NEVER REFER TO THE IDENTITY OF A PATIENT, HIS/HER DIAGNOSIS, CONDITION OR TREATMENT.** It is the obligation of each and every volunteer to respect a patient's privacy. **DO NOT DISCUSS ANY INFORMATION REGARDING A PATIENT WITH ANY INDIVIDUAL, IN OR OUT OF THE HOSPITAL.** Do not seek information regarding a patient. It is well to forget even a patient's name when you leave the hospital or while you are on your breaks.

Being a volunteer places upon you the responsibility of loyalty to the hospital, its administration and its staff.

REMEMBER:

What you see here,

What you hear here,

Must remain here,

When you leave here.

I have read and understand the “Code of Ethics for Volunteers.”

_____ _____

Volunteer Print Name Date

_____

Volunteer Signature

10/29/2018

ISLAND HOSPITAL

VOLUNTEER SERVICES
NON-DISCLOSURE/CONFIDENTIALITY AGREEMENT

I, _____, understand and agree that I must hold patient information/records, employee personnel records, hospital financial and operating data, computer information (including my password, if applicable) and ANY OTHER information of a private or sensitive nature, in the strictest confidence.

I also understand that if I am found to have violated this policy, I will be subject to disciplinary action up to and including discharge.

_____
Volunteer Signature

_____
Print Name

_____
Date

ISLAND HOSPITAL

CONFIDENTIALITY

POLICY:

One of the primary responsibilities of every employee, physician and staff person is confidentiality. This is defined as "any information, written or spoken or computer-generated, that its unauthorized or indiscreet disclosure may be harmful to the interest of a patient, an employee or the hospital district".

All patient Protected Health Information (PHI – which includes patient medical and financial information), employee personnel records, hospital financial and operating data, computer information (including an individual's access password) and any other information of a private or sensitive nature is considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members.
- Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility - without the patient's consent - to an unauthorized party who has no legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

Inquiries regarding patients are to be directed to a Supervisor or Nurse in charge.
Responses to requests for information from outsiders (such as the press) about a patient, an employee, the hospital district or any hospital district-related activities are to be given only by authorized personnel. Such inquiries are to be referred to the District Administrator or his/her designee.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the organization to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

ISLAND HOSPITAL

GENERAL COMPUTER INFORMATION:

1. The Information Systems Department is responsible for assigning unique computer access codes to those who are employed or contracted by Island Hospital. Passwords cannot be shared by or delegated for use to anyone but the authorized individual.

2. If you are assigned an access code *(computer password)* it is for your use only. You will be held accountable for any computer use *and misuse* on your personal user code. Violations will be addressed using the "Island Hospital Unauthorized Access of Medical Records Form."

3. All patient information in the computer system is confidential. You are only authorized to access computer information if it is in a secure area, directly related to your "need to know in the due course of business", and relative to your job. (i.e. you may only access computer information on your own patients, not that of other patients). For example, you do not have the right to review records of family members without a properly authorized consent.

4. Since all computer information is confidential, you must exercise discretion and caution by exiting the system when you leave the terminal or PC, even if for a short time.

5. *Any special audit requests (those other than random audits) must be requested by department Directors of the Information Systems Director specifically, not of Information Systems on-line staff members.*

6. All employees, physicians, office staff and others requesting computer access are required to sign either the attached Employee Confidentiality Agreement or the Non-Employee Confidentiality Agreement, as appropriate. Any person found to have violated the policy on confidentiality of information will be subject to disciplinary action up to and including discharge.

_____ _____

Employee/Volunteer Signature Date

ISLAND HOSPITAL

EMPLOYEE/VOLUNTEER CONFIDENTIALITY AGREEMENT

I hereby acknowledge, by my signature below, that I understand that Protected Health Information (PHI), other confidential records, and data to which I have knowledge and access in the course of my employment with Island Hospital is to be kept confidential, and this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at Island Hospital pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Island Hospital is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Island Hospital is grounds for punitive action such as computer access denial, and/or disciplinary action, up to and including immediate dismissal.

_____
Date

_____
Employee/Volunteer Signature

_____
Print Name

Volunteer/Volunteer Services
_____
Job Title/Department

MEMORANDUM

To: New Volunteers

Fr: Director of Volunteer Services

Re: Child and Adult Abuse Information Act

In 1987, the Washington State Legislature passed the Child and Adult Abuse Information Act. This law requires that employees and volunteers hired on or after January 1, 1988, who will or may have unsupervised access to and who will or may be directly responsible for the care, supervision or treatment of children or developmentally disabled persons, must make a written disclosure of certain civil adjudications, convictions, records of crimes against persons and, for licensed personnel, disciplinary board final decisions. Background inquires on these matters will be made to the appropriate state or federal law enforcement agencies. In compliance with this law, we are required to obtain disclosure statements from newly hired employees and volunteers as outlined above. We keep all information received in the strictest confidence.

Have you ever been convicted of a crime against persons? (A crime against persons includes any of the following offenses: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second or third degree statutory rape; first or second degree robbery; first or second degree arson; first or second degree manslaughter; first degree burglary; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; or any of these crimes as they may be renamed in the future.)

□ Yes □ No

Have you ever been found in (a) disciplinary action, (b) domestic proceeding, or (c) disciplinary board final decision to have sexually assaulted or exploited a minor or to have sexually abused a minor?

□ Yes □ No

If you answered “YES”, please describe and provide the date(s) of the finding(s) and the penalty (penalties) imposed.

_____

_____

We require your legal name (first, full middle and last), alias/maiden name(s) (if applicable) and date of birth, to obtain from the Washington State Patrol Criminal Identification System a report of your record and criminal convictions for offenses against persons, civil adjudications of child/adult abuse, and disciplinary board final decisions.

We will be notified of the State Patrol's response within 5 – 7 business days after they receive the report. We will make a copy of the report available to you upon request. All information will be confidential.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that I can be discharged from volunteering for any misrepresentation or omission in the above statement. I also understand that my volunteer status is conditioned on your receipt of a satisfactory report from the Washington State Patrol.

Signature: _____

Print Name: _____

Date: _____

***Please fill out the **WASHINGTON STATE PATROL Identification and Background Check Section (WSP)** form. If this application does not have the WSP form you can find it on the hospital web site at www.islandhospital.org, under Careers, Volunteers, Volunteer Application Process and Forms on the right side of the screen (third one down).

ONLY fill out the **top box** please – which is **highlighted** for you.

ISLAND HOSPITAL 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 Hospital - Volunteer Services – c/o Jennifer Van Dyke - 1211 24th Street – Anacortes – WA - 98221

Applicant Name:_____ Date:_____

The applicant named above is interested in becoming a volunteer with the Island Hospital 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 Hospital Youth Volunteer Program because:

Name: _____

Signature: _____

Relationship to Applicant: _____

Phone: _____

Thank you for your thoughtful input.

10/29/2018

ISLAND HOSPITAL 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 Hospital - Volunteer Services – c/o Jennifer Van Dyke - 1211 24th Street – Anacortes - WA - 98221

Applicant Name:_____ Date:_____

The applicant named above is interested in becoming a volunteer with the Island Hospital 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 Hospital Youth Volunteer Program because:

Name: _____

Signature: _____

Relationship to Applicant: _____

Phone: _____

Thank you for your thoughtful input.

10/29/2018