Salem Hospital

665 Winter St. SE
Post Office Box 14001
Salem, Oregon 97309-5014

Student Volunteer Form Packet Instructions

1. Print off this Form Packet.

2. Review each form and complete it.

    a. **Exception:** If you are ***under*** 18 years old, you are ***not*** required to print off and complete the background check form.

3. If you are under 18 years old, a parent or guardian must sign with you on each form.

4. The recommendation forms must be completed by 2 separate adults who are not part of your family. These adults should be people who know you well and can provide a reference for us. We want to know if other people think you would make a good volunteer for our program.

5. Bring your completed Form Packet with you to your volunteer interview to turn in. All forms are required before you may begin volunteering, if accepted into the program (note exception under Step 2).

6. Contact Volunteer Services at 503-561-5277 with any questions.

Volunteer Services
Job Shadow/Practicum/Student Volunteer
Dress and Participation Standards

Purpose: To reflect the organization's commitment to professional excellence by establishing reasonable appearance expectations and guidelines for participation.

Policy: To ensure that Salem Hospital and West Valley Hospital's professional reputations are maintained in part by the image students and volunteers present to patients, families, medical staff, and the general public during their participation in Volunteer Services programs.

Procedure: It is both important and expected that all volunteers and students will do their part in projecting and promoting a positive, business-like image and atmosphere by adhering to the following:

STANDARDS

1. Good judgment and common sense should be practiced in determining dress and appearance, as well as personal grooming habits.
2. Uniforms, if required, and clothing shall meet a business-casual dress code, and will be clean, neat, and appropriate in size at all times.
3. Appropriate hospital identification is to be worn visibly at all times. Photo ID must be worn close to the face with your name and photo showing.
4. Conservative business clothing is recommended for both ladies and gentleman. Dresses, skirts, and skorts must be modest in length (no more than a few inches above the knee).
5. Shoes and socks or nylons must be worn at all times and must be clean and appropriate for the work area. Any part of the foot or leg not covered by shoes or clothing must be covered with nylons or socks.
6. Comfortable shoes are recommended, and clean tennis shoes are acceptable. Open-toed shoes are not allowed for safety reasons.
7. Baseball caps, tee shirts with logos, sleeveless dresses or blouses, tube tops, shorts, see-through, provocative, or revealing clothing, stirrup pants, jeans, denim of any color, and spandex are a few examples of unacceptable attire for the hospital environment.
8. Jewelry should not be excessive and should always be worn in good taste. Facial jewelry, including tongue jewelry, is prohibited.
9. Tattoos that are visible to the public must be covered.
10. Hair must be neat, clean, and appropriately secured if shoulder-length or longer. Beards and mustaches must be kept clean and neatly trimmed.
11. Fingernails are not to extend beyond the fingertip for safety and sanitary reasons. Artificial nails are prohibited for anyone with patient contact.
12. Cell phones and other personal electronic devices are not to be carried or used while participating in Volunteer Services programs.
13. Patient care will be performed by the trained and licensed healthcare professionals at Salem Hospital and West Valley Hospitals, not students or volunteers.
14. Students must maintain good academic standing for continued participation.

Non-compliance with Standards: Volunteers and students who are dressed and/or groomed inappropriately will be sent home. Volunteers and students who fail to adhere to dress and participation standards shall be subject to disciplinary action, up to and including dismissal from Volunteer Services programs.

By my signature below, I confirm that I have read, understand, and agree to adhere to the conditions of the above standards for continued participation in Salem Hospital and West Valley Hospital's Volunteer Services programs.

Name: ____ Date: ___________________________

Signature:____ Volunteer _______ Shadower ______

School/Organization (if applicable): ____

Parent/Guardian Signature (if student is under 18): ____

Volunteer Services
Job Shadow/Practicum/Student Volunteer
Consent Form

My son/daughter, ____, has my permission to participate in Salem Hospital and West Valley Hospital's Student Volunteer/Job Shadow/ Practicum/Internship program. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her.

I understand my child may be required to have a Tuberculin skin test prior to beginning his or her job shadow, practicum, internship, or volunteer work experience assignment and I give my permission for my child to have this test performed by Salem Hospital's Employee Health Department.

Participation in these programs will include observing patients in a healthcare setting and observing medical, laboratory, and/or business procedures. I do hereby release Salem Hospital/ West Valley Hospital and their staff and sponsors from any responsibilities of injury or accident as a result of the Volunteer Services Programs. Any medical expenses incurred as a result of injury or accident will be my responsibility.

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken.

However, this document is my consent as parent or guardian for emergency treatment and/or procedures necessary for my son/daughter by the professional staff at Salem Hospital/ West Valley Hospital.

I also understand that it is my responsibility to find or provide transportation for my child to and from his or her assignment if my child is unable to drive him or herself. I understand that my child is expected to notify the appropriate person, in advance, if they are unable to report at the prearranged time and that several absences or failure to comply with program standards may disqualify them from participating in Volunteer Services programs with Salem Hospital and/or West Valley Hospital in the future.

____
Printed Name of Parent/Guardian (if student is under 18)

____
Relationship

____
Signature of Parent/Guardian (if student is under 18)

____
Date

____
Address of Parent/Guardian

____
Daytime Phone # ☐ Home ☐ Work

____
Mailing Address (If Different)

____
Evening Phone # ☐ Home ☐ Work

Emergency Contact Information:

____
Name of Emergency Contact (If other than contact above)

____
Relationship

____
Phone Number

Confidentiality Statement

Pacific Health Horizons
Employee, Agency, Volunteer, or Other Non-Employee Personnel

Confidentiality means protecting a patient's privacy and sharing hospital business only with those who have a need to know. The "need to know" is defined as the need to have the information to perform your job. Confidential patient information includes, but is not limited to: patient's presence, medical, financial, quality assurance/quality improvement/ performance improvement, and risk management data.

I agree to maintain absolute confidentiality of all Pacific Health Horizons information. This expectation pertains to patient, physician, employee, as well as my own personal medical records and those of my family members (including children, parents, spouses, siblings) and other non-workforce or business arrangement information.

I understand that this means that I will not discuss confidential patient information with others or access information, including online, unless it is required in the performance of my job duties, is the minimum necessary, and as identified in the level indicator that is associated with my job and/or service.

I further agree that if I require computer access, the user ID and password that will be issued to me are my means of accessing the computer system. It is to be used solely in connection with the performance of my authorized job function. I will take all necessary steps to prevent anyone from gaining knowledge of my login and password and I will not use anyone else's login and password. The use of these unique codes by anyone other than the person to who they have been assigned is prohibited and will be reported to my supervisor when detected. I will sign-off each time I leave the terminal to ensure the security of my password and the information.

I agree that when it is necessary as part of my job duties or work assignment for me to discuss patient information with other employees that I will be certain the conversation is in a private area. I understand that I may not access my personal lab results, physician dictated reports, x-ray reports; in short, anything in my personal medical record is considered Protected Health Information (PHI). If I desire access to my medical record, I will sign an authorization form available in the HIM department and get such records from them. I further understand that I may not access my family members' (including children, parents, spouses, siblings) medical records, and that these are also considered Protected Health Information (PHI).

Any breach of confidentiality is grounds for immediate withdrawal of onsite privileges, termination of my service and/or indemnification afforded me by Pacific Health Horizons, or corrective action up to and including termination of my employment and/or service.

I have read the above confidentiality statement of policy. I understand it, and I agree to comply.

Name of School or Affiliation: ______________________________

Printed Name of Student or Vendor and Job Title: ______________________________

Signature of Student or Vendor: ______________________________ **Date:** __________

Signature of Parent/Guardian: ______________________________
(if student is under 18)

Direct Supervisor/Manager/Director: ______________________________ **Date:** __________

DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF BACKGROUND REPORTS

It is recognized and understood that the Fair Credit Reporting Act provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses" shall be fined not more than $2,500 or imprisoned not more than a year, or both.

Salem Health

In connection with my application for EMPLOYMENT (including contract for services) , I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle, and other reports. These reports may include information as to my character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further, I understand that you will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences.

I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from any liability and responsibility for doing so. I hereby consent to obtaining the above information from ChoicePoint WorkPlace Solutions Inc. and/or any of their licensed agents. This authorization and consent shall be valid in original, fax or copy form. I further authorize ongoing procurement of the above mentioned reports at any time during my employment (or contract).

Applicant Signature: ____ Date: ______________

Have you ever been convicted of a crime? Yes :_____ No :_____ If yes, please explain below :

____

____

____

If additional space is needed please attach explanation.

To your knowledge have you ever been disciplined, sanctioned, debarred, or excluded by a duly authorized regulatory agency are there any current restrictions or limits on your license or certification ? Yes :____ No :____ If yes please attach explanation

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Please PRINT clearly: Position applied for: ____

Name: ____ Maiden / AKA: _______________
First Middle Last

Soc. Sec. #: ______________________ *Sex: ______ *Date of Birth: _______________

List all address information for past 7 years (Use back of form for additional space)

Current Address: ____ County: ______________________

City: __________________________ State: ______ Zip: ____________ How long: _________ to _________

Previous Address: ____ County: ______________________

City: __________________________ State: ______ Zip: ____________ How long: _________ to _________

Previous Address:____ County:______________________

City:__________________________ State:______ Zip:____________ How long: _________ to _________

Professional License/Certification type:_____________________________ **Lic #**______________________________________

State Issued:________ **Issue Date:**_______ **Expiration Date:**________

Motor Vehicle Report **Fax to: (208)769-7282**

Name as it appears: ________________________ License #: _______________________ State held: _______

CA, MN & Oklahoma Residents please note: In connection with your application for employment, your consumer report may be obtained and reviewed. Under California, Minnesota and Oklahoma law, you have a right to receive a free copy of your consumer report by checking the appropriate box below.

___ Yes, I am a California resident and would like a free copy of my investigative consumer report.
___ Yes, I am a Minnesota resident and would like a free copy of my consumer report.
___ Yes, I am an Oklahoma resident and would like a free copy of my consumer report.

*Responses to these are completely voluntary. You need not respond to have your application considered. However, without this information, we may be unable to distinguish you from another in the event we discover adverse information during our background investigation. 03/06/01

Summary of Rights Under the FCRA

The federal **Fair Credit Reporting Act** (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every consumer reporting agency (CRA). You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commissions web site (http://www.ftc.gov). The FCRA gives you specific rights, as outlined below. You may have additional rights under the state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

1. You must be told if information in your file has been used against you. Anyone who uses information from a CRA to take action against you--such as denying an application for credit, insurance or employment must tell you and give you the name, address, and phone number of the CRA that provided the consumer report.

2. You can find out what is in your file. At your request, a CRA must give you the information in your file and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You are also entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.

3. You can dispute inaccurate information with the CRA. If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs--to which it has provided the data, of any error.) The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRAs investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.

4. Inaccurate information must be corrected or deleted. A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.

5. You can dispute inaccurate items with the source of the information. If you tell anyone--such as a creditor who reports to the
CRA--that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.

6. Outdated information may not be reported. In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.

7. Access to your file is limited. A CRA may provide information about you only to people with a need recognized by the FCRA, usually to consider an application with a creditor, insurer, employer, landlord, or other business.

8. Your consent is required for reports that are provided to employers or reports that contain medical information. A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.

9. You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers. Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.

10. You may seek damages from violators. If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA. For questions or concerns regarding:

CRAs, creditors and others not listed below, please contact:	Federal Trade Commission Bureau of Consumer Protection-FCRA, Washington, DC 20580 (202) 326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name).	Office of the Controller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 (800) 613-6743
Federal Reserve System member banks (except national banks and federal branches/agencies of foreign banks).	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 (202) 452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institutions name).	Office of Thrift Supervision Consumer Programs Washington, DC 20552 (800) 842-6929

Federal credit unions (words "Federal Credit Union" appear in institutions name).	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 (703) 518-6360
State-chartered banks that are not members of the Federal Reserve System.	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 (800) 934-FDIC
Air, surface or rail common carriers regulated by former Civil Aeronautics Board of Interstate Commerce Commission.	Department of Transportation Office of Financial Management Washington, DC 20590 (202) 366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator-GIPSA Washington, DC 20250 (202) 720-7051

rev 07/19/00

You are hereby notified that a consumer report or an investigative consumer report may be obtained from a consumer reporting agency, other agency or directly by this employer for the purpose of evaluating you for employment, promotion, reassignment or retention as an employee.

Reports may include consumer credit, criminal convictions, motor vehicle and other reports. These reports may include information as to character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further understand that we may be requesting information from various Federal, State and other agencies which maintain records concerning your past activities relating to your driving, credit, criminal, civil and other experiences.

QUESTIONS REGARDING REPORTS PLEASE CALL ChoicePoint WorkPlace Solutions, 1-800-845-6004

rev08/06/01

Volunteer Statement and Agreement

I certify that the information contained in this application is true, correct, and complete to the best of my knowledge. I understand that continuation of any subsequent volunteer placement depend upon true and accurate representation of the facts stated or implied herein. In addition, I hereby authorize Salem Health to make inquiries regarding my education, work experience and references, unless otherwise stated. I hereby release all parties and persons associated with any such inquiries from all claims, liabilities, and damages for whatever reason in connection with information they give.

I acknowledge and agree that I am not obligated if called upon to perform the volunteer services herein applied for, and that Salem Health is not obligated to assign or actively seek to assign me to a placement.

I understand this application is not a contract of employment. If I am accepted as a volunteer, I agree to abide by and conform to all policies and procedures of Salem Hospital and Volunteer Services.

I understand that my services are donated to the hospital without contemplation of compensation or future employment, and are given with humanitarian reasons.

____ ____________

Applicant's Signature Date

Salem Hospital

665 Winter St. SE
Post Office Box 14001
Salem, Oregon 97309-5014

Applicant Name: ____

SALEM HOSPITAL STUDENT VOLUNTEER RECOMMENDATION FORM

At Salem Hospital, we are committed to improving the health and well-being of the communities we serve. To help us meet our mission, we bring on service-oriented volunteers who want to provide support to the community. We look for individuals to join our student volunteer program who represent our commitment to excellent service, who are team players, and who are friendly and outgoing.

To help us determine if the applicant named above would be a good asset to our volunteer workforce, please answer the following questions. Use the back of this page, if needed.

- How do you know this student applicant?

- Why would this student be an excellent volunteer, based on our values?

- Knowing about the qualifications for our student volunteers, would you recommend this applicant to our program and why?

- How would you rate this student on the following values: (check one for each line)

Service	___ Excellent	___ Average	___ Poor
Ethics	___ Excellent	___ Average	___ Poor
Responsibility	___ Excellent	___ Average	___ Poor
Problem Solving	___ Excellent	___ Average	___ Poor
Teamwork	___ Excellent	___ Average	___ Poor

- Is there any additional information about this student's qualifications that we would find helpful?

Reference Name ________________________________ Date ______________

Signature ________________________________

Email ________________________________ Phone ______________

PLEASE RETURN TO:

Volunteer Services | Salem Hospital | P.O. Box 14001 | Salem, OR 97309-5014

Salem Hospital

665 Winter St. SE
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Reference Name ________________________________ Date ____________________

Signature ________________________________

Email ________________________________ Phone ____________________

PLEASE RETURN TO:

Volunteer Services | Salem Hospital | P.O. Box 14001 | Salem, OR 97309-5014