Volunteer Information

Thank you for your interest in becoming a volunteer at Samaritan Pacific Communities Hospital. Enclosed please find an informational brochure, application form, criminal records check consent/authorization, a summary of your rights under the Fair Credit Reporting Act, reference forms, and a return envelope.

Process for becoming a Samaritan Pacific Communities Hospital Volunteer:

1. Complete and return the enclosed application materials. The reference forms must be completed by individuals outside your family (friends, teachers/professors, work associates). All materials submitted must be original copies (scanned reference form will be accepted, originals are preferred).

   Applications will be considered complete only when all forms are received by the Volunteer Services Department. This includes the application form, two references and the criminal background check consent/authorization forms.

2. Volunteers are placed based on skills and available positions.

   At the interview you will receive volunteer information, and review service descriptions and schedules. We will review your skills and interests. When a volunteer assignment has been determined you will receive a packet of information which will include required training and Volunteer Medical Information Form (see item #5).

3. You will have your picture taken for an identification badge.

4. You will be provided with **mandatory** general and volunteer orientation instructions.

5. You will be required to complete a Volunteer Medical Information form and meet immunization/test requirements with the Employee Health Department.

6. Once you have completed mandatory general and volunteer orientation requirements and have been cleared by the Employee Health Department you will contact your area of service to be trained.

Other requirements:

- Volunteers must be at least 15 years of age to participate.
- Volunteers must make a minimum commitment of six months.
- Typically, individuals volunteer once per week for 2 to 4 hours.

Thank you for your interest in Samaritan Pacific Communities Hospital.

For questions or additional information please contact the Volunteer Services Department
at 541-574-2537 or email mleis@samhealth.org

VOLUNTEER APPLICATION

SAMARITAN PACIFIC COMMUNITIES HOSPITAL
Volunteer Services Department
930 SW Abbey, P.O. Box 945
Newport, Oregon 97365 (541) 574-2537

FOR OFFICE USE ONLY
Date rec'd _____
Contact _____
_____
Interviewed _____

INSTRUCTIONS: Please furnish all information requested on this form. If you wish to supply additional education or work history information, attach a separate sheet. Please type or print clearly all information. We appreciate your interest in volunteering here and we are sincerely interested in your qualifications. A clear understanding of your abilities and interests will aid us in placing you in an available opening for which you are best suited.

Samaritan Health Services does not discriminate in volunteer practices because of race, color, national origin, religion, disability, age, sex (including pregnancy, sexual orientation, gender and gender identity), family relationship, veteran status, injured worker status, or the use of genetic information.

Personal Data

Name

_____
Last First Middle

Mailing Address

_____ (___) _____ (___) _____
Street City State Zip Home Phone Number Work Number

(___) _____
Cell Phone Number E-mail Address

Education

High School

_____ No ____
Name Location Diploma Received?

College or Schools after high school (including military service)

_____ No ____
Name Location Academic Major or Trade Degree Received?

_____ No ____
Name Location Academic Major or Trade Degree Received?

Work Experience

Name of employer, supervisor, address, phone #	Dates employed From: To:	Job title and description of duties:
Name of employer, supervisor, address, phone #	Dates employed From: To:	Job title and description of duties:

Volunteer Experience

Name of volunteer organization, address, phone #	Dates of service: From: To:	Type of service:
Name of volunteer organization, address, phone #	Dates of service: From: To:	Type of service:

Did you work for any of the above organizations under a different name? No _____ If yes, please give the name under which you worked for each organization: _____

Have you ever been employed by Samaritan Health Services? No _____ If yes, provide the name of the facility where you worked and employment dates: _____

Skills

PLEASE CHECK TRAINING AND/OR EXPERIENCE:

Data Entry ☐ Computers ☐ Bookkeeping ☐ Accounting ☐ Sewing ☐

Describe other specialized job skills or abilities which will assist in evaluating your qualifications

Volunteer Work Desired

If known, please list type of volunteer position desired:

Days Preferred

Time Preferred

	Morning	Afternoon	Evening
Monday	☐	☐	☐
Tuesday	☐	☐	☐
Wednesday	☐	☐	☐
Thursday	☐	☐	☐
Friday	☐	☐	☐
Saturday	☐	☐	☐
Sunday	☐	☐	☐

Special Interests

Names, phone numbers, and email of references submitted with this application:

1.)_____ 2.) _____

EMERGENCY CONTACT:

Name

Relationship to Applicant

Address

City State Zip

Cell/ Home Phone: _____

Business Phone: _____

Volunteer Commitment

Upon acceptance to the volunteer program, I will accept responsibility to be punctual and dependable. I will perform my assignments, refrain from doing what I have not been trained to do and abide by hospital ethics, policies, and conduct myself in alignment with Samaritan's values of Passion, Respect, Integrity, Dedication, Excellence (PRIDE).

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I certify that the information set forth in this Volunteer Application is true, complete, and accurate to the best of my knowledge. I understand that any false or materially misleading statements on this application shall be considered sufficient cause for refusal to be accepted as a volunteer or termination of volunteer status, regardless of when it is discovered.

I further understand that my approval for volunteer service is contingent upon successful completion of satisfactory references, educational and criminal background information. I consent to and authorize Samaritan Health Services and its personnel to request information concerning my previous employment/ volunteer service record as indicated on this Volunteer Application. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such job/volunteer service related information. I also understand that a post-offer health history questionnaire and testing (if applicable to position) may be required upon acceptance of volunteer service with Samaritan Health Services. I understand that if approved for volunteer service, either I or Samaritan Health Services may terminate the volunteer relationship, with or without cause, and with or without notice, at any time, provided such termination does not violate applicable law.
If applicable: My typed name below shall have the same force and effect as my written signature.

Signature of Applicant_____ Date _____

Consent (for junior volunteers only)

My minor child_____ has my consent to serve as a volunteer at Samaritan Pacific Communities Hospital/Samaritan Health Services, Newport, Oregon, meeting all the above stated requirements.

Signature of Parent or Guardian

Date

Printed Name of Parent or Guardian

SAMARITAN PACIFIC COMMUNITIES HOSPITAL
VOLUNTEER SERVICES DEPARTMENT
930 SW Abbey, P.O. Box 945, Newport, OR 97365

REFERENCE FORM

Name of Applicant

_____

The above named applicant has requested you to write a reference for a volunteer application. The applicant must include this completed reference form with their application. Please complete the areas which you feel comfortable commenting upon. Thank you for your assistance.

How long have you known the applicant?

From (month/year) To (month/year)

In what capacity or job?

_____

Please complete the following:

		Optimal	Satisfactory	Unsatisfactory
1.	Attendance	☐	☐	☐
2.	Performance	☐	☐	☐
3.	Work habits	☐	☐	☐
4.	Responsibility	☐	☐	☐
5.	Interaction with others	☐	☐	☐
6.	Leadership	☐	☐	☐
7.	Dependability	☐	☐	☐
8.	Other: _____	☐	☐	☐

9. Would you work with this person again? Yes☐ No☐

Please share any additional information that will support your evaluation of the applicant:
(Use reverse side or additional paper if needed.)

If applicable, my typed name below shall have the same force and effect as my written signature.

_____ _____
Signature Date

_____
Printed Name

Phone Home/Cell #: _____ Business/ Alternative Phone#_____

Address: _____

SAMARITAN PACIFIC COMMUNITIES HOSPITAL
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_____

Please complete the following:

	Optimal	Satisfactory	Unsatisfactory
1. Attendance	☐	☐	☐
2. Performance	☐	☐	☐
3. Work habits	☐	☐	☐
4. Responsibility	☐	☐	☐
5. Interaction with others	☐	☐	☐
6. Leadership	☐	☐	☐
7. Dependability	☐	☐	☐
8. Other: _____	☐	☐	☐

9. Would you work with this person again? Yes ☐ No ☐

Please share any additional information that will support your evaluation of the applicant:
(Use reverse side or additional paper if needed.)

If applicable, my typed name below shall have the same force and effect as my written signature.

_____ _____
Signature Date

_____
Printed Name

Phone Home/Cell #: _____ Business/ Alternative Phone#_____

Address: _____

Universal
Background Screening™

Request for Background Check

Account #006364

Social Security Number ___ — ___ — ____

Date of Birth - used for identification purposes only

MONTH ___ DATE ___ YEAR ____

First Name	**Middle Name**	**Last Name**
Other Names Used (maiden name, AKA names, etc.)		**Phone Number**

Current Residential Address		
City	**State**	**Zip Code**

Have you ever been convicted of a Felony or Misdemeanor?

Yes☐ No☐ If yes please explain.

List each CITY, STATE and ZIP CODE (if known) where you have lived during the past seven years:

City	**State**	**Zip Code**	**From Date**	**To Date**	
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

Driver's License Number	**State of Issue**

Cleared in HR database: Yes / No

Record Found: Yes/No

HR Representative:

Background Check Date:

Approved for Placement: Yes/No

FCRA DISCLOSURE AND ACKNOWLEDGMENT
IMPORTANT -- PLEASE READ CAREFULLY BEFORE
SIGNING AUTHORIZATION

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Samaritan Health Services Inc ("the Company") may obtain information about you from a third party consumer reporting agency for volunteer purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your affiliation with the Company to the extent permitted by law.

Signature _____ Date _____

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Samaritan Health Services Inc ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

• In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

• A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

• By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Signature	Date
Full Name (First/Middle/Last)	Social Security Number (SSN)*
Driver License State / Number	Date of Birth*
Current Address	City, State and Zip Code