Please Indicate Volunteer Location:

☐ St. Charles Bend
2500 NE Neff Road
Bend, OR 97701

☐ St. Charles Redmond
1253 NW Canal Blvd
Redmond, OR 97756

VOLUNTEER SERVICES APPLICATION *(Must be 16 years of age or older.)*

Legal Name _____
First Middle Initial Last

Address _____ City & State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Name to Appear on Badge _____

Work & Volunteer Experience:

Current Employer _____ Dates Employed _____

Supervisor Name _____ Phone Number _____

Volunteer Experience #1 _____ Dates _____ Duties _____

Volunteer Experience #2 _____ Dates _____ Duties _____

Personal Reference: Name _____ Phone Number _____

High School Attended _____ City _____ State ___ Graduated? _____

College Attended _____ City _____ State ___ Graduated? _____

School Currently Attending _____ City _____ State _____

Do you have a family member or close personal relationship with a St. Charles caregiver? ☐ Yes ☐ No

If yes, please provide their name and department (for coordination purposes): _____

Where are you interested in volunteering? _____

How did you learn about Volunteer Services at St. Charles?

___ Website
___ Social Media
___ Community Event
___ Hospital Volunteer
___ Newspaper
___ Local Business
___ Leaflet/Display at Hospital
___ Religious Group
___ Volunteer Website(s)

Skills/Experience/Interests: (Please circle all categories that may be of interest to you in the future.)

Cancer Center	Family Birthing Center	Pediatrics	Other (Please Specify):
Clerical & Office Duties	Gift Shop	Pet Therapy	_____
Entrance Greeter / Runner	Music	Special Events	_____
ER/ICU Family Liaison	Patient Visitor	Supply Stocking	_____

Do you speak any languages in addition to English? Yes No If yes, which? _____

Availability: (Circle) Mon Tues Wed Thurs Fri Sat Sun Preferred Hours: _____

Does your schedule change? Yes No Can we put you on call? Yes No

Legal Status:

Have you ever been convicted of a felony or misdemeanor? Yes No

If yes, what charge and what state? _____

Can you perform the essential functions of the position you are applying for with or without reasonable accommodation, including the attendance requirements? Yes No

The above information is accurate and correct to the best of my knowledge.

I understand this information may be used to determine my eligibility to volunteer for St. Charles Health System.

_____ _____

Signature Date

Lee Copeland

Lee Copeland
Volunteer Services Supervisor
lncopeland@stcharleshealthcare.org
(541) 706-2924

Diana Jackiewicz

Diana Jackiewicz
Volunteer Coordinator – Bend/Redmond
dbjackiewicz@stcharleshealthcare.org
(541) 706-2657

(Please read and sign Volunteer Agreement on the next page.)

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VOLUNTEER AGREEMENT

If accepted as a volunteer for St. Charles Health System, I agree to the following:

1. I will hold all information that I may obtain directly or indirectly concerning patients, doctors or staff, as **absolutely confidential** and will not seek to obtain information from patients. In addition, I will not solicit my political or religious beliefs to patients, their families and/or staff.

2. My services are donated to the hospital without contemplation of compensation or promise of future employment.

3. I will submit to medical screening which may include TB skin test and/or immunizations that may be necessary as part of my volunteer assignment.

4. I understand that a criminal background check will be required prior to beginning volunteer service.

5. I agree to commit to my volunteer position for a minimum of six months.

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

7. I will make every effort to resolve any problems related to my volunteer assignment with my supervisor and the volunteer coordinator.

8. I will make my best effort to fulfill my commitment to St. Charles Health System by completing all volunteer assignments that I accept.

9. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of failure to comply with hospital policy; absences without prior notification; unsatisfactory attitude, work or appearance; or any other circumstance which in the judgment of the volunteer coordinator, would make my continued service as a volunteer contrary to the best interests of the hospital.

10. I understand that it is a violation of the health system's policy to solicit business or act as an agent for outside business or to solicit business from patients or staff.

11. I will not sell or attempt to sell goods or services, request contributions, or solicit people to sign or distribute political petitions on hospital property, unless I receive the express authorization of the volunteer coordinator.

I agree to the above conditions and consent to and authorize St. Charles Health System to complete a criminal background check.

_____ _____

Volunteer Signature Date

_____ _____

Parent/guardian signature if volunteer is under 18 years of age. Date

CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK IN COMPLIANCE WITH THE FCRA (FAIR CREDIT REPORTING ACT)

Date:	Driver License #:	Driver License State of Issue:
Last Name:	First Name:	Middle Initial:
Maiden and/or Other Last Names		
Address (No PO Boxes):	City, State, & Zip Code: *	County of Residence: *
Date of Birth: **	Social Security Number: **	Male [ ] Female [ ]

I consent to and authorize the organization to complete a pre-employment check, including employment, compliance, criminal background, degree verification, and consumer credit report. I release and hold employers, from all claims, liability, and damages for whatever reason, related to my background, and my suitability for employment either now or in the harmless all parties and persons, including my present/prior employers, from all claims, liability, and damages for whatever reason, related to providing information regarding my application and my employment. I also release and hold harmless all parties and persons, including my present/prior future. I understand that the organization may, and hereby authorize the organization to, solicit information regarding my character, felony record, driving record, credit history, previous employment and similar background information. I authorize my current and former employers and references to disclose such information to the organization.

I understand that according to the Federal Fair Credit Reporting Act, I am entitled to know whether employment was denied based upon the information obtained and to receive, upon written request, a disclosure of the background report. I also understand that I may request a copy of the report from **Trak-1 Technology PO Box 52028, Tulsa, OK 74152** at telephone number (800) 6008999. After reading this document, I fully understand its contents and authorize the background verification.

*** AS SHOWN ON THE ORIGINAL APPLICATION**
**** TO BE USED ONLY FOR CRIMINAL HISTORY SEARCHES, AND NOT A PART OF THE PERSONNEL FILE**.

As of the date of this authorization, do you have any criminal charges pending against you? [ ] YES [ ] NO

If YES, please provide an explanation below:

THIS SECTION IS TO BE USED TO LIST ALL COUNTIES AND STATES OF RESIDENCE SINCE AGE 18 OR HIGH SCHOOL GRADUATION. YOU MUST BE SPECIFIC ABOUT DATES OF RESIDENCE.

CITY/TOWN	COUNTY	STATE	DATES FROM	TO

I HEREBY CERTIFY THAT ALL INFORMATION PROVIDED IN THIS AUTHORIZATION IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT IF ANY INFORMATION PROVES TO BE INCORRECT OR INCOMPLETE THAT GROUNDS FOR THE CANCELING OF ANY AND ALL OFFERS WILL EXIST AND MAY BE USED AT THE DISCRETION OF THE ORGANIZATION.

By signing below, I also acknowledge that the organization has provided me with a summary of my rights under the federal Fair Credit Reporting Act.

Signature of Applicant Date