VOLUNTEER SERVICES APPLICATION

ST. CHARLES HEALTH SYSTEM
2500 NE Neff Road
Bend OR 97701 (541) 706-6354

(Must be 16 years of age or older.)

Legal Name_____
First Middle Initial Last

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

E-mail _____ Other names used_____

Previous states lived in_____

Current employer _____Address_____

Dates employed_____Supervisor Name_____Phone Number_____

Previous employer _____Address_____

Dates employed_____Supervisor Name_____Phone Number_____

Volunteer experience_____Dates_____Supervisor Name_____

Personal Reference: Name_____Phone Number_____

High School attended_____City_____State_____Graduated _____yes_____no

College attended _____City_____State_____Graduated_____yes_____no

School currently attending_____

Available: Mon Tues Wed Thurs Fri Sat Sun Hours: _____Flexible_____As needed_____

Areas of interest to volunteer_____

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

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

Accounting	Data Entry	Organizing/Planning	Statistics
Animals/Pet Therapy	Foreign Language	Photography	Teaching
Art/Graphics	Greeter/Escort	Public Speaking	Telephoning
Bookkeeping	Home-based Projects	Receptionist	Writing
Calligraphy	Knitting/Crocheting/Sewing	Special Events	Other_____
Clerical/Office	Library	Special Projects	
Computer	Music		

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?_____

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 at St. Charles Medical Center.

_____ _____
Signature Date

(Please read and sign Volunteer Agreement on reverse side.)

VOLUNTEER AGREEMENT

If accepted as a volunteer at St. Charles Medical Center, 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 three 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 Medical Center 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 hospital 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 persons 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 Medical Center to complete a criminal background check.

_____ _____

Volunteer Signature Date

_____ _____

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