



Volunteer Services Application

Name Last _____ First _____ M.I. _____

Address _____ City/State _____ Zip _____

Home phone (____) _____ Cell phone (____) _____

Email address _____ Employer _____

School attending _____ Grad. year _____

Emergency contact:

Name _____ Relationship _____ Phone (____) _____

Volunteer experience _____

Employment experience _____

Education or special training (include any foreign language skills and licenses) _____

Hobbies, skills, special interests _____

Location preferred (check box)

- | | | |
|---|---|--|
| <input type="checkbox"/> Legacy Emanuel | <input type="checkbox"/> Legacy Good Samaritan | <input type="checkbox"/> Legacy Hospice–Portland |
| <input type="checkbox"/> Legacy Meridian Park | <input type="checkbox"/> Legacy Mount Hood | <input type="checkbox"/> Legacy Hopewell House Hospice |
| <input type="checkbox"/> Legacy Salmon Creek | <input type="checkbox"/> Legacy Hospice–McMinnville | <input type="checkbox"/> Randall Children’s Hospital |

Days preferred (check box)

- Sun Mon Tue Wed Thurs Fri Sat Morning Afternoon Evening (4 p.m. on)

Service area preferred (please rank by preference)

- | | |
|---|-----------------------|
| ____ Patient/Family support | ____ Clerical support |
| ____ Respite care (hospice only) | ____ Gift shop |
| ____ Children’s programs (Randall and hospice only) | |

Goal State briefly what you wish to give or accomplish as a Legacy volunteer and what you hope to gain from this experience.

References whom we may contact. Please provide names and complete addresses of two people who are not family members or significant others.

Name _____ Relationship _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Email _____

Name _____ Relationship _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Email _____

Are there essential functions of your volunteer service assignment for which you would need a reasonable accommodation? (Check) Yes No If Yes, please explain: _____

Volunteer Acknowledgement and Consent (Please read and sign below)

1. As part of the evaluation process, a consumer report including a criminal history background check may be obtained from one or more consumer reporting agencies. I give Legacy Health permission to obtain information regarding previous employment and volunteer experience, criminal history, and to investigate all information provided during the application process.
2. I acknowledge that I will need to provide proof of immunizations or have documented immunity to: varicella, mumps, rubella/rubeola and agree to tuberculosis screening prior to the start of assignment and then tuberculosis screening yearly, if required.
3. I understand that I will be required to undergo safety and Health Insurance Portability and Accountability Act (HIPAA) training before beginning my volunteer assignment. I also understand that I must comply with all laws, regulations, patient care directives, and Legacy policies while performing volunteer services and that use or possession of illegal drugs or alcohol is prohibited while performing volunteer services or at any Legacy facility.
4. I understand that Legacy respects patients' rights with regard to privacy of information and I agree to respect these rights in the performance of my volunteer duties and adhere to confidentiality in all my statements outside the hospital. I agree to respect patients' rights to privacy, as well as those of the family of patients and the hospital whenever I make community presentations or participate in volunteer recruitment programs. The content of these presentations will be approved in advance by the Manager of Volunteer Services or the department head.



Disclosure and Authorization to Release Information

Notice: This is a disclosure and authorization for Legacy Health and its Affiliates, employees and agents to obtain a consumer report for a legitimate business need under the fair credit reporting act.

Name: _____
(Last) (First) (Middle initial)

Social Security number (required): _____

Date of birth (used only to verify identity as some records do not include social security number): _____

Driver's License Number: _____ State issued: _____

Please list any other names that you have used: _____

Physical Address: (no P.O. Box) _____

City: _____ State: _____ Zip: _____

This release and authorization acknowledges that Legacy Health may now or at any time while I am volunteering, conduct a verification of my education, previous employment/work history, driving record, and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any State. A photocopy or telephonic facsimile (Fax) of this Authorization and Consent for Release of Information shall be valid as the original. The results of this verification process will be used to determine eligibility for volunteer assignments. All results will be kept confidential. The information obtained will not be provided to any parties other than to designated Legacy personnel.

I authorize Employer's Reference Source (ERS) and any other party to disclose orally and in writing the results of this verification process and/or interview to authorized representatives.

I do hereby agree to forever release and discharge Legacy Health and its affiliates, agents, and employees, ERS and its associates, and my former employers, to the full extent permitted by law, from any claims, damages, losses, liabilities, costs, and expenses, or any other charge or complaint arising from the retrieving and reporting of information. Although I am not an employee entitled to such disclosure under the Fair Credit Reporting Act, Legacy Health will inform me if a volunteer assignment was denied based on information obtained from a consumer report or investigative report, and will provide me upon written request a disclosure of the nature and scope of any investigative report.

Volunteer's name typed or printed: _____

Signature of volunteer authorizing release: _____ Date: _____



FAIR CREDIT REPORTING ACT DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS: Please read this form carefully including all of the legal notices and release. If you agree, please provide the information and sign the enclosed Disclosure and Authorization to Release Information Form.

FCRA NOTICE: THIS IS A DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION ("DISCLOSURE") FOR LEGACY HEALTH SYSTEM ("LEGACY") AND ITS AFFILIATES, EMPLOYEES AND AGENTS TO OBTAIN A CONSUMER REPORT AND INVESTIGATIVE CONSUMER REPORT FOR A LEGITIMATE BUSINESS NEED UNDER THE FAIR CREDIT REPORTING ACT ("FCRA"). PRIOR TO TAKING ANY ADVERSE ACTION BASED UPON ANY INFORMATION CONTAINED IN A CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT, LEGACY WILL PROVIDE YOU WITH:

- NOTICE OF THE ADVERSE ACTION;
- A COPY OF THE REPORT;
- A SUMMARY OF YOUR RIGHTS UNDER THE FCRA;
- THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONSUMER REPORTING AGENCY (INCLUDING A TOLL-FREE TELEPHONE NUMBER ESTABLISHED BY THE AGENCY IF THE AGENCY COMPILES AND MAINTAINS FILES ON CONSUMERS ON A NATIONWIDE BASIS) THAT FURNISHED THE REPORT TO LEGACY;
- NOTICE OF YOUR RIGHT TO OBTAIN, UNDER SECTION 612 OF THE FCRA, A FREE COPY OF YOUR CONSUMER REPORT AND INVESTIGATIVE CONSUMER REPORT FROM THE CONSUMER REPORTING AGENCY WITHIN 60-DAYS; AND
- NOTICE OF YOUR RIGHT TO DISPUTE, UNDER SECTION 611 OF THE FCRA, WITH A CONSUMER REPORTING AGENCY THE ACCURACY OR COMPLETENESS OF ANY INFORMATION IN A CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT.

PLEASE NOTE THAT THE CONSUMER REPORTING AGENCY LEGACY USES DOES NOT MAKE ANY DECISION REGARDING SUCH ADVERSE ACTIONS AND IS UNABLE TO PROVIDE YOU WITH SPECIFIC REASONS WHY THE ADVERSE ACTION WAS TAKEN.

WASHINGTON APPLICANTS: IF YOU ARE A WASHINGTON RESIDENT OR APPLYING FOR: (A) EMPLOYMENT, (B) VOLUNTEER WORK, OR (C) INITIAL OR CONTINUED MEDICAL STAFF APPOINTMENT, CLINICAL PRIVILEGES OR AUTHORIZATION TO PRACTICE AT LEGACY SALMON CREEK HOSPITAL, PURSUANT TO REVISED CODE OF WASHINGTON ("RCW") §43.43.830-.845, THIS DISCLOSURE IS NOTICE THAT LEGACY MAY MAKE AN INQUIRY TO THE WASHINGTON STATE PATROL ("WSP") UNDER RCW §43.43.832 AND/OR AN EQUIVALENT INQUIRY TO A FEDERAL LAW ENFORCEMENT AGENCY. LEGACY WILL NOTIFY YOU OF THE WSP'S RESPONSE WITHIN TEN DAYS AFTER LEGACY RECEIVES IT AND WILL PROVIDE YOU WITH A COPY OF THE RESPONSE.

AUTHORIZATION: This Disclosure authorizes Legacy or any of its affiliates, employees, agents or contractors to conduct a verification of, discuss with, and receive information from persons or entities (each a "Provider") in possession or control of the following information and records ("My Information") regarding:

- my education records including applications, grades and discipline;
- my previous and current employment/personnel records, salary information, and discipline (not applicable for non-employed medical staff applicants);
- my professional licensing, certifications, investigation and discipline;
- my medical staff membership, privileges applications and discipline;
- my driving record and related information related to my driver's license; and
- any criminal, municipal, or civil adjudication information pertaining to me which may be in the files of any federal, state or local law enforcement agency in any state including but not limited to the Washington State Patrol.

I have read and understand this Disclosure and I authorize all the Providers to disclose, interview and discuss My Information with Legacy or Legacy's authorized representatives including Employer's Reference Source ("ERS"). For medical staff members and other credentialed practitioners, this authorization remains valid while a member of the medical staff and/or granted clinical privileges or authorization to practice. A photocopy or facsimile of this Disclosure shall be valid as the original.

My Information will solely be used to process and determine the eligibility of my application for employment, volunteer work, or initial or continued medical staff membership, clinical privileges or authorization to practice. My Information will not be further disseminated for any other purpose except as required or permitted by law. I understand that My Information and all results of this Disclosure will be kept CONFIDENTIAL (except as required in the credentialing process for medical staff applicants) The information obtained will not be provided to any parties other than to designated Legacy personnel, medical staff leadership, or authorized representatives.

RELEASE: I RELEASE, HOLD HARMLESS, COVENANT NOT TO SUE AND DISCHARGE ALL PROVIDERS, LEGACY AND ITS AFFILIATES, AGENTS, AND EMPLOYEES, AND ERS AND ITS ASSOCIATES (COLLECTIVELY THE "RELEASES"), TO THE FULL EXTENT PERMITTED BY LAW, FROM ANY CLAIMS, DAMAGES, LOSSES, LIABILITIES, COSTS, AND EXPENSES (EXCLUDING BUT NOT LIMITED TO ATTORNEY'S FEES), OR ANY OTHER CHARGE, CLAIM OR COMPLAINT ARISING FROM OR RELATED TO THE RELEASES' PROVIDING, RECEIVING, REQUESTING, DISCUSSING, VERIFYING AND REPORTING OF MY INFORMATION.

Thank you for choosing Legacy Health.

**Each Legacy facility has its own volunteer program.
Please send your application to the facility where you would like to volunteer.**

Legacy Emanuel Medical Center

Attn: Volunteer Services
2801 N. Gantenbein Ave.
Portland, OR 97227
503-413-4839

Randall Children's Hospital

at Legacy Emanuel
Attn: RCH Volunteer Services
2801 N. Gantenbein Ave.
Portland, OR 97227
503-276-6950

Legacy Good Samaritan Medical Center

Attn: Volunteer Services
1015 N.W. 22nd Ave.
Portland, OR 97210
503-413-7012

Legacy Meridian Park Medical Center

Attn: Volunteer Services
19300 S.W. 65th Ave.
Tualatin, OR 97062
503-692-2186

Legacy Mount Hood Medical Center

Attn: Volunteer Services
24800 S.E. Stark St.
Gresham, OR 97030
503-674-1217

Legacy Salmon Creek Medical Center

Attn: Volunteer Services
2211 N.E. 139th St.
Vancouver, WA 98686
360-487-1040

Legacy Silverton Medical Center

Attn: Volunteer Services
342 Fairview St.
Silverton, OR 97381
503-873-1786

Unity Center for Behavioral Health

Attn: Volunteer Services
1225 N.E. 2nd Ave.
Portland, OR 97232
503-944-7537

Legacy Hospice – Portland

Attn: Volunteer Services
P.O. Box 3426
Portland, OR 97208
503-220-1000

Legacy Hopewell House Hospice

Attn: Volunteer Services
6171 S.W. Capital Highway
Portland, OR 97239
503-244-7890

Legacy Hospice – McMinnville

Attn: Volunteer Services
2275 N.E. McDaniel Lane
McMinnville, OR 97218
503-472-9685 or
800-361-8506

Our legacy is good health for:

Our people

Our patients

Our communities

Our world

