LEGACY HEALTH

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)*

☐ Legacy Emanuel	☐ Legacy Good Samaritan	☐ Legacy Hospice–Portland
☐ Legacy Meridian Park	☐ Legacy Mount Hood	☐ Legacy Hopewell House Hospice
☐ Legacy Salmon Creek	☐ Legacy Hospice–McMinnville	☐ 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.

5. While present at a Legacy facility, I will at all times wear an identification badge designating me as a volunteer. I will obtain express permission from the department manager or designee prior to entering any procedural area, including, but not limited to, any operating room or other surgical area, other than in my normal volunteer assignment.

6. I understand that my assignment is completely voluntary and a privilege. Legacy or I may end my volunteer service at any time, for any reason. Advance notice is appreciated so that Legacy may fill assignments. I may be removed from my assignment or moved to another assignment at any time. I understand that Legacy will attempt to accommodate but cannot guarantee my service assignment preference. No employee is authorized to offer or change my volunteer assignment except for the Manager of Volunteer Services.

7. Each site has expectations for service commitment. We are unable to accommodate short-term volunteer assignments.

8. I understand that as a volunteer, I am not an employee of Legacy and therefore I will not receive any wages, salary, benefits, insurance, or any other compensation or remuneration for my services. I am volunteering to improve patient care in my community and understand that volunteering is not a promise of future employment (or continued employment if I am also a Legacy employee) and is not a contract of any kind, whether express or implied, for employment or otherwise.

9. Because I am not an employee of Legacy, I understand that I am not covered by Worker's Compensation laws in the event that I have a volunteer-related injury or disease; however, I understand that Legacy carries insurance for each volunteer, at no charge, which may cover certain medical expenses in the event I am injured while providing volunteer services. Should I file a claim under such insurance, I promise and covenant to sign an Authorization to use and disclose protected health information allowing my treating physicians and other covered entities under HIPAA to disclose medical records and information to the insurance carrier for purposes of payment of claims and to Legacy for the purpose of case management. I understand that if I do not so authorize, any claim may not be accepted. I also understand this insurance is subject to change or termination at any time.

By submitting this application, I acknowledge that I have read and understand the above statements. I certify that all answers to questions in this application and all additional information I may have submitted are true and complete to the best of my knowledge. I understand that giving false information, misrepresenting facts, and material omissions may be grounds for denial and a permanent bar to volunteering at Legacy or any affiliate. I also understand that if I am also a current employee of Legacy, such information may be shared with and considered by Human Resources.

_____ _____

Volunteer Applicant Signature *Date* *Manager, Volunteer Services*

If Applicant is under 18 years old: _____

Parent or Legal Guardian *Date*

LEGACY
HEALTH

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: _____

RESET FORM PRINT FORM

LEGACY
HEALTH

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.