Dear Prospective Volunteer:

Our volunteers are the heart of Swedish/Edmonds Hospital. Whether you are looking to volunteer to explore an interest in the medical field, brush up on your work skills, keep active after retirement or take a break from a fast-paced career, volunteering at Swedish/Edmonds Hospital is definitely the right choice.

The spectrum of our volunteers ranges from working adults to homemakers, retirees to high school students.

Opportunities are available throughout the hospital. Here are just a few areas in which volunteers contribute to the success of Swedish/Edmonds Hospital:
- Admitting
- Mail Delivery
- Surgery/Recovery
- Emergency Room
- Swedish/Edmonds Gift Shops
- Information Desk
- Clerical
- Patient Care Areas

Special Projects
Don’t have time for a long-term commitment? Our special projects might be the right solution for you. Some of the opportunities available include:
- The Edmonds Art Festival
- Tour De Terrace
- Get Movin at Alderwood Mall
- A Taste of Edmonds
- Serving at hospital events
- Sewing projects at home

If you are interested in joining our team of volunteers, please return your completed application forms along with your immunization record and two reference forms to:
Swedish/Edmonds Hospital
Volunteer Services Office
21601 76th Ave W.
Edmonds, WA 98026

An initial interview will be scheduled to determine the best placement for you according to your area of interest and hours of availability. Orientations are scheduled several times throughout the year. Once accepted you will be scheduled for the next available orientation date.
We ask that you commit to volunteering a minimum of 6 months or 100 hours which ever comes first.

For more information please call the Volunteer Services Department at 425-640-4341; Monday through Friday, 8:00am to 5:00PM

*Thank you for your interest in volunteering at Swedish/Edmonds Hospital!*
Application for Volunteer Services

Instructions: Please complete all sections of this application in detail so we may consider you for volunteering. If a question or blank does not apply to you, write N/A in the space. Upon completion, sign your name in the space provided and return all documents to Swedish/Edmonds Hospital Volunteer Services in the envelope provided.

PLEASE PRINT LEGIBLY IN PEN

Identification Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Maiden Name</th>
<th>Last 4 of Social Security Number</th>
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<thead>
<tr>
<th>Address</th>
<th>(Street)</th>
<th>(City)</th>
<th>(State)</th>
<th>(Zip)</th>
<th>Date of Birth</th>
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<th>Mailing Address (if different from above)</th>
<th>Telephone</th>
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<th>Email Address</th>
<th>Cell phone</th>
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Education/Employment Information – Check All That Apply

Education: 
- Junior High
- High School
- Some College
- Undergrad Degree
- Graduate Degree

Employment: 
- Student
- Employed
- Retired
- Unemployed
- Other

Your occupation

Are you volunteering for school community service? yes no

Name of school ___________________________ Hours needed ________

Availability – Check All That Apply

<table>
<thead>
<tr>
<th>Hours</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<tr>
<td>8am–noon</td>
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<td>Noon–4pm</td>
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<td>4pm–7pm</td>
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<td>Other</td>
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References  Business / School / Community (other than a relative)

<table>
<thead>
<tr>
<th>Name/Relationship</th>
<th>Address</th>
<th>Telephone</th>
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Please provide the Volunteer Services Office with a reference letter or reference form for each of the above.
Interests – please check all that apply
  o Hospitality/Ambassador Volunteer
    (greeting, reception, escort)
  o Administrative Support Volunteer
    (clerical, education, computer)
  o Gift Shop Volunteer
    (sales, clerical)
  o Patient Care Area Volunteer
    (assist staff, stock rooms, answer call lights, etc)
  o Surgery Liaison Volunteer
    (liaison between OR, Recovery, and patient families)
  o Cancer Resource Center Volunteer
  o Home Craft Volunteer
    (sewing, knitting, crocheting)
  o Special Events / Projects Volunteer
    (on call for event support)
  o Other: ____________________________________________

Have you ever volunteered before? yes no If yes, where? And what did you do?

______________________________________________________________

Why did you leave? ____________________________________________

Why did you choose Swedish/Edmonds Hospital for your volunteering?

______________________________________________________________

What is most important to you in a volunteer assignment?

______________________________________________________________

Do you have any restrictions that might limit your ability to perform certain volunteer assignments? (lifting, pushing, and standing)

______________________________________________________________

How did you hear about our volunteer program?

______________________________________________________________

**Emergency Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td>Other phone (work, cell)</td>
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<tr>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Physician</td>
<td>Phone</td>
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</tbody>
</table>

I agree to adhere to the hospital’s Volunteer Services policies, procedures, and rules to the best of my ability. I agree to participate in the hospital’s orientations. I understand that the Director of Volunteer Services or the hospital’s Executive Director may terminate my work as a volunteer at any time, and that I may also terminate my work. I also understand all information regarding patients with whom I work is strictly confidential and I shall maintain that confidentiality.

Volunteer Signature ____________________________ Date ____________________________

All volunteers 14 through 18 years of age must have the consent of a parent or legal guardian.

Signature of Legal Guardian ____________________________ Relationship ____________________________
CONFIDENTIALITY AGREEMENT

Swedish/Edmonds Healthcare employees, volunteers, medical providers, and vendors must make every effort to prevent unauthorized use and disclosure of medical, personal, or other data pertaining to patients, employees, and proprietary hospital operations ("confidential information"). Under no circumstances should confidential information be released or discussed with anyone unless it is in the performance of legitimate job related duties or medical staff functions ("job duties"). To ensure that all Swedish/Edmonds Healthcare employees, volunteers, medical providers and vendors acknowledge their responsibility to protect the privacy and confidentiality of confidential information, please read and sign the following:

1. I acknowledge that all confidential information is confidential and protected against unauthorized viewing, discussion, use and disclosure regardless of format: electronic, written, overheard or observed.
2. I understand that I may view, use, disclose, or copy information only as it relates to the performance of my job duties. Any unauthorized viewing, discussion, use or disclosure of confidential information is a violation of Swedish/Edmonds Healthcare policy and may be a violation of state and federal law. Any such violation may lead to immediate disciplinary action, including termination (or as appropriate to my affiliation with Swedish/Edmonds Healthcare), and possible civil liability and/or criminal charges.
3. I agree not to change, delete or destroy confidential information unless part of my job duties and, if part of my job duties, I agree to follow all established policies in relation to changing, deleting, or destroying confidential information in any form.
4. I agree to use Swedish/Edmonds Healthcare computer based information systems (the “computer systems”) for the sole purpose of performing my legitimate job duties.
5. I agree not to use the computer systems to access confidential information on myself, my family, or any other person except when necessary to the performance of my job duties.
6. I understand that the passwords assigned to me to access the computer systems are confidential, and not to be shared with anyone under any circumstances.
7. I agree to use only my assigned password to access the computer systems and that I am responsible for any access to the computer systems using my password as a result of my own negligence or password sharing.
8. I understand that any actions I take in the Computer Systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me.
9. I agree to report any real or potential breach of confidentiality immediately to the administrator on call.
10. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand, and am committed to its principles.
11. I understand that this signed and dated document will become part of Swedish/Edmonds Healthcare records.

Print Name __________________________ Signature __________________________ Date ________________
VOLUNTEER SERVICES REFERENCE FORM

You have been given as a reference by this applicant. Volunteers play an important role in working with hospital patients and visitors in a sensitive manner. Volunteers must be able to maintain confidentiality, communicate effectively, and follow through with commitments. We appreciate your honesty in responding and if you wish to keep the content of your reply confidential please let us know. Your prompt reply is appreciated.

Please return this form to:
Volunteer Services
Swedish/Edmonds
21601 76th Avenue West
Edmonds, WA 98026

Name of applicant: ________________________________________________________________

How long have you known applicant? ________________________________________________

In what capacity have you known the applicant? _______________________________________

Ratings:

1. Needs Improvement
2. Fair
3. Very Good
4. Outstanding

1. Displays courtesy, tact, patience.  1  2  3  4
2. Works well with a diverse population.  1  2  3  4
3. Exhibits interest and enthusiasm for a volunteer position.  1  2  3  4
4. Accepts supervision in a positive way.  1  2  3  4
5. Seeks opportunity to improve and advance.  1  2  3  4
6. Accepts responsibility and commitment.  1  2  3  4
7. Is dependable and punctual.  1  2  3  4

Comments: ___________________________________________________________________

_____________________________________________________________________________

Date: __________________________________________________________________________

Signature: _____________________________________________________________________

Printed Name: __________________________________________________________________

Address: _______________________________________________________________________

Phone Number: __________________________________________________________________
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Comments: ______________________________________________________
_________________________________________________________________
_________________________________________________________________

Date: __________________________________________________________________

Signature: __________________________________________________________________

Printed Name: __________________________________________________________________

Address: __________________________________________________________________

Phone Number: __________________________________________________________________
Name:__________________________________________

DOB:_____________ SS#__________________________

Dept:__________________________________________

Patient Contact:______________________________

Phone:______________ Cell________________________

Date:__________________________________________

TB Screening
Have you ever had a positive TB skin test/PPD?
  Yes*  no  date: ______________
*Documentation of the positive skin test date, any prophylactic
treatment and a chest x-ray dated after the positive skin test is required.

Circle if you have had any of the following immunizations.
*Documentation is incomplete without official immunization records
Required Immunizations *  Date(s) given

Two-step Initial TB Skin Test  yes  no

Hepatitis B Vaccine  yes  no
  Or Hepatitis B antibody (HBSAB) titer

MMR (Measles/Mumps/Rubella) 2 needed  yes  no
  Or positive titers for Rubeola, Rubella and Mumps

Varicella Vaccine  yes  no
  Or positive titer
    Chickenpox (Varicella) disease  yes  no

Tdap  yes  no

Flu this season  yes  no

Are you latex sensitive or do you have a latex allergy. Please explain:__________________________________________

Do you have any other allergies or medical conditions that we should be aware of?__________________________________________

ETS
WASHINGTON STATE PATROL
Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

A REQUESTING AGENCY/ADDRESS
Swedish/Edmonds1

Agency

Attn
21601 76th Avenue West
Address
Edmonds, WA 98206
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature Date

Volunteer Services (425) 640-4341
Title Area Code/Phone Number

B PURPOSE
Check appropriate box

☐ Educational School District (ESD)/School District Volunteer – no fee
☐ Non-Profit Business/Organization – no fee (Excluding Schools & ESD’s)
☐ Profit Business/Organization – $17
☐ Adoptive Parent - $17
☐ Receive background results electronically

Email address
Password (must be at least 8 characters)

 Fees: Make payable to Washington State Patrol by check, money order, or business account.

Notary letters certifying the results are available upon request (available by mail only). There is an additional $10.00 processing fee per notary seal.

C NOTARIZED LETTER(S)

APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: Last First Middle

Alias/Maiden Name(s):

Date of Birth: Month/Day/Year Sex: Race:

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

D WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

3000-240-430 (R 7/11)
CHILD/ADULT ABUSE RECORD SEARCH GUIDELINES

Refer to Revised Code of Washington (RCW) 43.43.830-43.43.845 for complete information. Child/Adult Abuse Information Act background checks may be conducted by Washington State businesses or organizations. Other states must conduct searches under the Criminal Records Privacy Act, RCW 10.97.

1. Searches may be conducted only on prospective employees, volunteers, or adoptive parents.
   Background checks may be conducted on prospective employees, volunteers, or adoptive parents who will or may have unsupervised access to children under sixteen years of age, developmentally disabled persons, or vulnerable adults. The background check is for initial employment decisions only.
   Background checks on current employees or volunteers should be done through the Criminal Records Privacy Act, RCW 10.97.

2. Applicants must be notified an inquiry may be made.
   A business or organization shall not make an inquiry to the Washington State Patrol unless the business or organization has notified the applicant who may be offered a position as an employee or volunteer that an inquiry may be made.

3. A business or organization must prepare a disclosure statement to be signed by the applicant before a background check may be conducted.
   A business or organization shall require each applicant to disclose whether the applicant has been:
   (a) Convicted of a crime;
   (b) had findings made against him or her in any civil adjudicative proceeding;
   (c) has both a conviction and findings made against him or her.

4. Applicants must be notified of the response.
   The requesting agency shall notify the applicant of the Washington State Patrol’s response within ten days after receipt. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

Notes:
* "Business or organization" means a person, business, or organization licensed in this state, any agency of the state, or other governmental entity, that educates, trains, treats, supervises, houses, or provides recreation to developmentally disabled persons, vulnerable adults, or children under sixteen years of age, or that provides child day care, early learning, or early learning childhood education services, including but not limited to public housing authorities, school districts, and educational service districts.
* The business or organization shall use this record only in making the initial employment or engagement decision. Further dissemination or use of the record is prohibited. A business or organization violating this subsection is subject to civil action for damages.
* Responses are limited to Washington State records only.

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints.
APPLICANT DISCLOSURE; PURSUANT TO RCW 43_43_834
CHILD AND ADULT ABUSE INFORMATION ACT

Answer YES or NO to each listed item. If the answer is YES to any item, explain in the area provided, indicating the charge or finding, the date, and the court(s) involved.

1. Have you ever been convicted of any crimes against children or other persons, as follows: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree rape; first, second, or third degree rape of a child; first, or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide, first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution?

ANSWER _____________ IF YES, EXPLAIN BELOW:

________________________________________________________________________

2. Have you ever been convicted of crimes relating to the financial exploitation if the victim was a vulnerable adult, as follows: first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery?

ANSWER _____________ IF YES, EXPLAIN BELOW:

________________________________________________________________________

3. Have you ever been found in any dependency action under RCW 13.34.030 (2)(b) to have sexually assaulted or exploited any minor or to have physically abused any minor?

ANSWER _____________ IF YES, EXPLAIN BELOW:

________________________________________________________________________
4. Have you ever been found in any domestic relations proceeding under Title 26RCW to have sexually abused or exploited any minor or to have physically abused any minor?

ANSWER ______________ IF YES, EXPLAIN BELOW:

__________________________________________________________________________

5. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?

ANSWER ______________ IF YES, EXPLAIN BELOW:

__________________________________________________________________________

6. Have you ever been found in any protection proceeding under chapter 74/34 RCW, to have abused or financially exploited a vulnerable adult?

ANSWER ______________ IF YES, EXPLAIN BELOW:

__________________________________________________________________________

We may request from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. If you are hired before that report is available, YOUR EMPLOYMENT WILL BE CONDITIONED UPON RECEIPT OF A SATISFACTORY REPORT.

If a report is requested from the Washington State Patrol criminal identification system, you will be notified of the response within ten days after we receive this report. We will make a copy of the report available to you upon your request.

Pursuant to RCW 9A.17.085, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true, correct and complete. I understand that if I am hired, I can be discharged for any misrepresentation or omission in the above statement.

APPLICANT SIGNATURE ________________________________

DATE AND PLACE ________________________________

WITNESS ________________________________

Business or Organization Swedish/Edmonds Hospital

Address 21727 – 76th Avenue West, Suite 102, Edmonds, WA 98026