



WHY SHOULD I BE A VOLUNTEER? And HOW TO VOLUNTEER

New volunteers are always needed at Olympic Medical Center and the rules and regulations of hospital procedure are easily learned. Since supervision of all volunteers is mandatory, you will receive understanding guidance and whatever training you may need.

To volunteer, your first step is to contact Kathy Coombes, Volunteer Coordinator for an application by calling 360-565-9110 or go to the hospital website www.olympicmedical.org. She will want to know the type of tasks you prefer and any background information that supports your eligibility. You will be asked to fill in a formal application and sign a volunteer agreement. Working with her you will reach an agreement on where you will volunteer in the hospital.

YOU WILL BE EXPECTED TO

1. Make a firm commitment on specific services for a specific number of hours, and at specified times and are able to volunteer for no less than a **6 month commitment**.
2. Attend Volunteer orientation.
3. Accept orientation instruction and training in your assigned area/department.
4. Respect the rules of the hospital and support them.
5. Accept the direction and suggestions from those who will supervise you.
6. Maintain professional standards in matters of patient and staff confidentiality.
7. Take complaints to the Volunteer Coordinator for resolution.
8. Complete Health Screening form and meet with the Employee Health Nurse (TB test and flu vaccine is required).

The main function of volunteers is to help. You won't be asked to perform tasks that are normally performed by paid staff members. You will perform extra services that employees do not always have time to do. These services add to the welfare of patients and often help the hospital to function better by freeing employees to take care of essential services.

Thank you for considering Olympic Medical Center in your search for volunteer service.

Kathy Coombes, Volunteer Coordinator
Volunteer Services
Olympic Medical Center
939 Caroline, Port Angeles, WA 98362
(360) 565-9110
kcoombes@olympicmedical.org



Adult Volunteer Services Application

PERSONAL INFORMATION

DATE

First _____ Middle _____ Last _____

Date of Birth _____ Last 4 digits of Social Security # _____

Driver's License # _____ Photo Copy Yes No

Email _____

Address _____

City _____ State _____ Zip _____

Phone _____ Secondary Phone _____

Do you speak any foreign languages? No Yes- If yes, please list. _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to you _____ Home Phone _____

Work Phone _____ Cell Phone _____

QUESTIONNAIRE

1. Why are you interested in volunteering? _____

2. Previous Volunteer Service:

Organization (s): _____

Please list any hobbies, skills, or interest that you think may be of value in your volunteer service:

3. Please check all areas that you are interested in working in the hospital:

- Information Desk/Lobby Greeter
- Gift Shop
- Short Stay Unit
- Emergency Department
- Clerical/Human Resources
- Dietary
- Floor Runner/patient transport
- Emergency Department
- Hospital Events
- Pet Therapy Program
- OMC Cancer Center/ Sequim
- Other work, please list ways you can help: _____
- If a position is available, I would be interested in working in Sequim

EDUCATION & WORK EXPERIENCE

Education: Check highest level High School: 9 10 11 12 GED

Name & State _____

If under 18, please list your primary interest of study/career goals _____

College: 1 2 3 4 Graduate School 1 2 3 4

Degree/Major _____

Employment Experience:

Have you ever worked at a hospital? Yes No

Last Place of Work – if any: _____

Business Name _____

Address _____ Phone _____

Position _____ Supervisor's Name: _____

REFERENCES: PLEASE PROVIDE ADDRESSES

Please include references for any current or former job supervisors, teachers or clergy. Family members, relatives and friends may not provide recommendations.

Reference 1 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Reference 2 Name: _____ Phone: _____

Relationship to you: _____ Business Name: _____

Address: _____ City: _____ State: ____ Zip: _____

OTHER:

1. Have you ever been convicted of a felony? Yes [] No []

2. Have you ever been convicted of a misdemeanor? Yes [] No []

If 'Yes' to either question, please describe the conviction(s) in detail, including dates.

3. How did you hear about this volunteer program? _____

4. Do you hold any special medical or clinical certifications or licenses, or had medical training of any type? No [] Yes [] – Please list: _____

5. When can you start volunteering? _____

6. Check when you wish to volunteer. Most shifts are 3 hours. Gift Shop 4 hours.

[] Monday _____ to _____

[] Tuesday _____ to _____

[] Wednesday _____ to _____

[] Thursday _____ to _____

[] Friday _____ to _____

[] Saturday _____ to _____

PLEASE READ THE FOLLOWING BEFORE SIGNING:

Your placement as a volunteer with Olympic Medical Center is dependent upon the acceptance by Volunteer Services and completion of the hospital health requirements along with the report from the Washington State Patrol request for criminal history information (Child/Adult Abuse Information Act RCW 43.43.830). Olympic Medical Center is required to run a check on all volunteers and employees.

I hereby declare that all the information I have given above is true to the best of my knowledge. I further understand that my volunteering is contingent upon checking of references furnished. I consent to and authorize the hospital and its personnel to request any information concerning work and personal references as indicated on this application for volunteering. I hereby release all parties and persons connected with any request for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such related information.

I am aware that the participation in the Volunteer Program may have risk of injury or illness. I understand there is no compensation or insurance benefit provided to me in the event that become injured or ill in the course of my volunteering. I acknowledge and accept the risks inherent to the Volunteer Program and working in a healthcare setting, and with this knowledge in mind, agree to participate in the Volunteer Program.

I understand I will not be paid for my volunteer services. I also agree to abide by ALL volunteer and hospital program policies and procedures.

_____ I give my permission to be photographed and used for press releases
Initials

_____ I give my permission to share your contact information with the Volunteer Coordinator, OMC volunteers and Auxiliary.
Initials

Applicants Signature

Date

**Auxiliary Membership \$10.00 Annually
Check here if interested _____ Paid _____

Please return signed application to:

**Olympic Medical Center
939 Caroline Street
Port Angeles, WA 98382**

**If you have any questions, please contact Kathy Coombes, Volunteer Coordinator
(360) 565-9110**

**OR
kcoombes@olympicmedical.org**