PROVIDENCE
Health & Services

The Providence Mission:	"As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."
Core Values:	***RESPECT COMPASSION JUSTICE EXCELLENCE STEWARDSHIP***

APPLICATION FOR VOLUNTEERING

Date _____

- ◆ Providence Alaska Medical Center *
- ◆ Providence Extended Care Center.
- ◆ Providence Hospice **(Must be 18 to volunteer)**
- ◆ Providence Horizon House
- ◆ Providence Kodiak Island Medical Center **(Must be 18 to volunteer)**
- ◆ Providence Seward
- ◆ Providence Valdez

***100 hour commitment of service required for Providence Alaska Medical Center**

Thank you for your interest in applying to volunteer for Providence Health and Services Alaska. Please read this application carefully and submit all required documents with this application. While we have a variety of departments in which to volunteer, we recruit as needed. IF YOU CHOOSE TO HANDWRITE THIS FORM, PLEASE BE SURE YOUR HANDWRITING IS LEGIBLE

Are you interested a health career? Yes ☐ No ☐ If Yes, which one? _____

If accepted, do you have a department preference in which to serve? _____

Are you available to volunteer on the same day and time each week for 6 months? Yes ☐ No ☐

How did you learn of the opportunity to volunteer at Providence?
Please explain: _____

PERSONAL DATA

Legal Name: _____ (Last) _____ (First) _____ (Middle) Gender: M ☐ F ☐

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone: _____ Work Phone _____ Cell Phone _____

Email Address: _____ Social Security Number: _____

Birth date: _____ Age Group: Junior ☐ 14–17 Juniors please complete Junior Volunteer form Adult ☐ 18+

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Work Phone _____ Cell Phone _____

JUNIOR VOLUNTEERS ONLY ***Note: Volunteer Opportunities are limited for 14 & 15 Year olds***

Father's Name: _____ Tel: _____

Email: _____

Mother's Name: _____ Tel: _____

Email _____

REFERENCES

Please provide two references who are not family members:
*** Volunteers 18+ interested in serving the Children's Hospital at Providence must include references from people who have seen you interact with infants/children. Note: references must be someone who has known you for at least six months and not family.**

Name _____ Relationship: _____ Years/Months Known _____

Home Phone: _____ Cell Phone: _____ Email: _____

Name _____ Relationship: _____ Years/Months Known _____

Home Phone: _____ Cell Phone: _____ Email: _____

Were you referred by a vocational counseling or employment agency? Yes ☐ No ☐

Are these volunteer hours for a school project or credit? Yes ☐ No ☐
If so how many hours are required and when are they due? Please describe assignment below:

BACKGROUND INFORMATION

Have you ever been convicted of a crime including, but not limited to, a misdemeanor or felony?
Yes * see below ☐ No ☐

Have you ever been or are you currently on parole or probation? Yes * see below ☐ No ☐

***If you answered yes to either of these questions, please provide a copy of your judgment and a completion of conditions letter. These must be attached to your application.**
A conviction will not necessarily bar you from volunteering.

Volunteers 16 and over will need to complete a criminal background check which includes fingerprinting. I understand that if I am accepted into the volunteer program, my volunteer position is conditioned on the receipt of a satisfactory report from the State of Alaska Background Check Unit.

Have you been fingerprinted in the State of Alaska in the last five years? Yes ☐ No ☐

Volunteers interested in volunteering at the Center for Child Development must also obtain, at their expense, an Interested Persons Report* from the Alaska State Troopers, fee $20. *Speak to staff prior to this step.

I understand that my volunteer badge is property of Providence Health & Services Alaska and must be returned when I no longer plan to volunteer. I further understand that any violation of confidentiality will be grounds for immediate dismissal from my volunteer position.

MEDICAL INFORMATION

IMPORTANT: Several volunteer positions require the volunteer be mobile, such as: standing, walking, bending, stooping, pushing carts or wheelchairs and the ability to lift 10 lbs. Do you have limitations that would prevent you from doing tasks that would require active mobility? Yes ☐ No ☐

Required Immunizations - Please include a copy of your medical immunization record(s) when you present your application packet.

-2 MMR vaccinations, or a titer verifying immunity to Rubella, Rubeola and mumps
-2 Varicella (chicken pox) vaccinations or a titer verifying immunity to Varicella**. Documentation of a shingles shot may not be substituted as verification of immunity to Varicella.**
-2 TB tests (PPD) - One within the past year is acceptable, plus one more is required.
*1 Tdap (Tetanus, diptheria and pertussis) immunization **(required for the NICU but is highly recommended that volunteers working with children and/or vulnerable adults obtain one if possible)**
Flu Vaccine is recommended

VOLUNTEER EDUCATION / WORK HISTORY

Occupation: _____ Active Duty Military: ☐ Military Veteran: ☐

Academic Background:

High School: ☐ College: ☐ (area of study) _____

Other (please explain) _____

Are you a current or former licensed medical professional? Yes ☐ No ☐

If yes, please describe: _____

List any activities, hobbies and skills: _____

List /describe Previous Volunteer experiences and length of service:

1. _____ Years Months

2. _____ Years Months

List any foreign languages spoken or sign language: _____

VOLUNTEER AVAILABILITY

Volunteering at Providence requires a commitment of one year and no less than 100 hours. What days and hours are you available to volunteer?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I understand that by signing this form that I am making a commitment to honor the hours of service required by the facility I am volunteering at to offset the fees and expenses of on boarding me as a new volunteer of Providence Health & Services.

Furthermore, if I do not communicate any planned/unplanned service absences, I will be subject to termination. If that should occur, my background clearance will be revoked from the State of Alaska Background Check database and after 100 days I will need to reapply for a background check if I wish to return to Providence. In such an event, I will be responsible for all fees associated with a second background check.

Volunteer Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian's Signature:_____ Date: _____
(If junior volunteer)

A vital part of the requirements to volunteer includes obtaining immunizations and / or records. According to policy, all volunteers are required to provide the immunizations listed above for their volunteer file.

Safety Updates and TB tests are required annually for all volunteers. Flu vaccines are available to active volunteers during the flu season through Employee Health Services.

JUNIOR VOLUNTEER PARENTAL CONSENT FORM

Must be completed by the parent/guardian of Junior Volunteer (14-17 years)

I_____, Parent /Guardian of :_____ (student's name) enter into the following agreement with Providence Alaska Medical Center permitting my child to participate in the Junior Volunteer Program.

I understand and agree to hold Providence Alaska Medical Center (its agents or employee's) harmless for any loss, damage or injury to person or property which may occur as a result of _____'s (student) participation in volunteer activities or going to or from the facility.

Further, I understand and agree to indemnify Providence Alaska Medical Center for all damages, expenses and costs which it may incur as a result of any demand, claim or suit which I initiate.

I, as parent / guardian of the above named minor:
CONSENT to his/her participation in the Providence Alaska Medical Center R Volunteer Program.
AGREE to the provisions of this release of liability and to reimburse Providence Health System or Providence Alaska Medical Center for any damages incurred by it for which this minor would be liable if he/she were of the age majority.

Printed Name _____

Signature _____ Date _____

IMPORTANT: All volunteers who are enrolled in high-school must obtain a letter of recommendation by an academic advisor (teacher or counselor), pastor or someone in a civic/community position that can provide a testimony to the character of the junior applicant.

ALL VOLUNTEERS PLEASE PRINT AND RETURN THIS FORM WITH ALL BACKGROUND AND MEDICAL REQUIREMENTS

Department of Health & Social Services Background Check Program

RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, _____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

_____ _____

Applicant Printed Name Date

_____ _____

Applicant Signature Applicant SSN

_____ _____

Department of
Health and Social Services

DIVISION OF HEALTH CARE SERVICES
Background Check Program

4601Business Park Blvd., Bldg K
Anchorage, Alaska 99503-7167
Main: 907.334.4475
Fax: 907.269.3488

Alaska Background Check Application

Asterisks mark required fields. Applications will not be processed without complete information.

Personal Information

Full Legal Name: _____ (*Last, *First, M.I.) ___/___/___ Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address: _____ (*Physical Street Address) _____ (*Apartment/Unit #)

_____ (*City) _____ (*State) _____ (*ZIP Code)

Mailing Address (if different than Permanent/ Physical Address): _____ (*Mailing Address) _____ (*Apartment/Unit #)

_____ (*City) _____ (*State) _____ (*ZIP Code)

Primary Phone: ( ) Secondary Phone: ( )

*Applicant's Email Address: _____

*SSN (or ITN) : _____
☐ This is an ITN

Demographic Information

*Race: (Asian, Black, White Native American, or Unknown) _____

*Gender: (Male, Female, Unknown, Other) _____

*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) _____

*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) _____

*Height: _____ FT _____ IN

*Weight: _____ Lbs.

*Place of Birth (Country/State): _____

US Citizen(Y/N): _____

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: _____ Middle Name: _____

Last Name: _____ SSN/ITN: This is an ITN☐ _____

Date of Birth: (mm/dd/yyyy) _____

First Name: _____ Middle Name: _____

Last Name: _____ SSN/ITN: This is an ITN☐ _____

Date of Birth: (mm/dd/yyyy) _____

Background Check Application for: First Name: _____ Last Name: _____ DOB: _____

Prior Address History

Prior Addresses in the last 10 years: Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

Pre-Employment Information

Pre-Employment Information: Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.

Provider Name: _____

State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: _____

Position Title: _____

Position Type: _____
(Employee/Independent Contractor/Volunteer/Other)

Instructions

1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: https://nabcs.dhss.ak.local/bcpapplicant. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are $76.50 and are **not refundable.**
5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
7. A complete application includes this application form, non-refundable payment in the amount of $76.50, and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, _____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

_____ _____
Applicant Signature Date

Revised 10.10.2014

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VOLUNTEER AGREEMENT

IF ACCEPTED AS A VOLUNTEER, I AGREE TO THE FOLLOWING:

- I am responsible for meeting all requirements (to include a health screening, a background check, attending an orientation and interview) before receiving a volunteer assignment.

- Volunteer service is both a privilege and a responsibility. As a volunteer, I am an integral part of the patient care system and accept the code of ethics for volunteers. All information I hear, directly or indirectly, MUST be considered confidential and not discussed with anyone.

- My services are donated for charitable or humanitarian reasons and with no expectation of compensation or promise of future employment.

- I will not request contributions, solicit signatures, distribute materials or try to sell goods.

- I understand that I will be expected to conduct myself in a courteous manner and that my commitment includes regular attendance & punctuality.

- I must adhere to all Hospital / departmental infection control standards and practices.

- I understand that Providence is a Mission-driven organization and the Core Values of Respect, Compassion, Excellence, Justice, and Stewardship are integrated into daily volunteer activity.

- I understand my volunteer status may be terminated as a result of:

  - ✓ Any breach of confidentiality.
  - ✓ Non-compliance of hospital or departmental policies, rules, or regulations,
  - ✓ Repeated absences without prior arrangements / notification,
  - ✓ Circumstances that would be contrary to the best interests of patients or the hospital

- I understand that every year I am required to complete an annual Safety Update and have an annual TB screening; failure to do so will result in my being suspended from volunteer service until complete.

- I understand I am committing to a minimum of 100 hours of volunteer service. (6 months @ 4 hrs/wk)

- I understand my badge belongs to Providence Health and Services and must be returned when I will no longer volunteer.

_____ _____

VOLUNTEER SIGNATURE DATE