



To: **Potential Junior Volunteers**

From: Volunteer Manager – Lourdes Health Network

We'd like to thank you for your willingness to explore volunteering at Lourdes. The rewards of volunteering are countless – gain new skills, build new friendships, ease the burdens of concerned family members, brighten the day of patients, and bring smiles to children, just to name a few.

Lourdes is a non-profit organization that truly appreciates all our volunteers do for us. Volunteers provide an array of support services. Volunteers do not perform direct patient care. Volunteer services includes the Information Desk, Surgery Liaison, Gift Shop, Book Cart, clerical support to Medical Records, Mission & Community Relations, Emergency Services, Foundation, Marketing, Pastoral Care, Physician Services, Human Resources, Financial Services, Plant Operations, Purchasing, Housekeeping, Nutritional Services, Birthplace, Med/Surg. Unit, Ambulatory, Rehab Unit, Pharmacy, Laboratory Services, Radiology, and Health Educational Service, and more. Volunteers also provide financial support to Lourdes Foundation, student scholarships and clinical services.

- **To begin the process, please print this Application Packet.**

The Application Packet includes:

Volunteer Application Form

Background Check Release Form

- When you have completed the packet, please call the Volunteer Office at (509) 546-2301 to schedule an interview. References are welcomed.
- At the interview, you will be scheduled for a training session which will include:
  - Safety Training Packets:
  - Safety Codes
  - HIPAA Training (Health Insurance Portability and Accountability Act of 1996)
  - Abuse/Neglect Training
  - LHN Policies
  - Workplace Violence and Cultural Competencies
  - Standards of Performance
- You will also need to have with you your photo ID and your Social Security Card.
- State and Federal regulations require all our Volunteers have a TB Skin Test. Lourdes Health Network also requires a drug screening. This is done at Lourdes expense. We will be happy to help you meet both of these requirements.
- When all requirements are met, you will be given the paperwork to take to HR to get your badge.
- Start volunteering!

We are pleased that you are considering volunteering with us. We hope the gifts of your time and talents will result in a uniquely rewarding experience for you.

**ATTENTION:**

If you are planning to volunteer to fulfill a school project and a minimal amount of hours (40 hours or less), you must be referred by your teacher as we have limited areas that are participating for **SENIOR PROJECT** and **COMMUNITY SERVICE HOURS**.



**Jr. VOLUNTEER APPLICATION**

Date \_\_\_\_\_

Name \_\_\_\_\_

Phone – Home \_\_\_\_\_  
Work \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_  
month – day - year

\_\_\_\_\_  
\_\_\_\_\_

**Days / Times you could volunteer?**

Emergency Contact:

Mon @ \_\_\_\_\_

Name \_\_\_\_\_

Tue @ \_\_\_\_\_

Address \_\_\_\_\_

Wed @ \_\_\_\_\_

\_\_\_\_\_

Thurs @ \_\_\_\_\_

\_\_\_\_\_

Fri @ \_\_\_\_\_

Phone # \_\_\_\_\_

Sat @ \_\_\_\_\_

Sun @ \_\_\_\_\_

***Please check the areas below that interest you:***

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Billing Clerk | <input type="checkbox"/> ER Host      | <input type="checkbox"/> Information Desk |
| <input type="checkbox"/> Book Cart     | <input type="checkbox"/> Grounds      | <input type="checkbox"/> Medical Records  |
| <input type="checkbox"/> Clerical      | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Nurses Aid       |

***Which facilities would you like to work at?***

- Lourdes Medical Center - Pasco
- Lourdes Counseling Center – Richland
- Lourdes Occupational Health Services - Pasco
- Lourdes Family Health Center – Connell
- Wilson House - Pasco

*Please return completed application to*

**Donna Hopkins, Foundation/Volunteer Specialist**  
**520 N. 4th Ave., Pasco, WA 99301-2568 Phone: (509) 546-2301**

Revised 4/29/2010



## JUNIOR VOLUNTEER PROGRAM

As a Jr. Volunteer, I agree to the following:

1. A TB Skin Test and Washington State Patrol Check will be required for placement in volunteer program.
2. Proof of age: A copy of one of the following is required; Birth Certificate, Driver's License, Baptismal Record, or a Notarized statement from parent or legal guardian stating the age of child.
3. Sign in upon arriving and sign out upon leaving in book located at information desk. This should be witnessed.
4. If I am a \*non-paid volunteer, a free lunch is available, in the cafeteria, if I volunteer for four or more hours the day I want lunch. The lunch is my choice of menu items with a \$4.00 limit per day. Sign-in is required in notebook at the cashier.
5. I will follow the mission statement of Lourdes Health Network:

*Our mission is an extension of the healing ministry of Jesus. We are called to serve our community, our patients, their loved ones, and our co-workers with respect, compassion, and care. We respond to the health care needs of the community in a Christian spirit. We strive for excellent in all we do.*

6. Dress Code:
  - Name Tag
  - Solid color slacks or knee length skirt.
  - No Jeans
  - No shorts
  - No see through clothes or cleavage showing
  - Closed toe soft soled shoes
  - Long hair pulled back and secured
  - No heavy fragrances
  - No jewelry

Should Jr. Volunteer report to work improperly dressed or groomed, the staff will instruct the Jr. Volunteer to return home to change.

\*A non-paid volunteer is one that receives no compensation for working versus one that is paid to volunteer here from other agencies such as WorkSource.

By signing this form you are agreeing to the requirements stated.

Name \_\_\_\_\_ Date \_\_\_\_\_



## PARENT PERMISSION FORM

My son/daughter \_\_\_\_\_ has my  
permission

and support to participate in the Lourdes Health Network Junior Volunteer  
and/or Job

Shadowing Program.

1. I know and approve of his/her arrangements for transportation.
2. I have provided a copy of proof of my child age (Birth Certificate, Driver's License, Baptismal Record, or Notarized statement from parent or legal guardian).
3. He/She has no health condition that would limit his/her participating in this program.
4. If required he/she has my permission for the TB Skin Test for tuberculosis or will provide adequate documentation of such. This service is at no charge to the parent or student if done at LOURDES EMPLOYEE HEALTH SERVICES.
5. I also understand that I as his/her parent am required to have medical coverage on my student in case of injury or illness that occurs while student is at Lourdes Health Network Facilities.
6. I will encourage my Student to abide by the behavior and dress code.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

# WASHINGTON STATE PATROL

Identification and Criminal History Section

PO Box 42633

Olympia WA 98504-2633

(360) 534-2000

<https://watch.wsp.wa.gov>

## REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

**INSTRUCTIONS:** PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION FROM THE IDENTIFICATION AND CRIMINAL HISTORY SECTION. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH \$17.00 CHECK OR MONEY ORDER OR COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. **NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST FOR \$10.00 USING A CREDIT CARD.**

NOTARIZED LETTERS ARE AN ADDITIONAL \$5.00 PER NOTARY SEAL \_\_\_\_\_ Notarized Letter(s)  
(available by mail 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 may be advised of inquiry.

(A)

### SUBJECT INFORMATION: (Please type or print clearly)

Applicant's Name: \_\_\_\_\_  
Last First Middle

Alias/Maiden Name: \_\_\_\_\_

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

(B)

### REQUESTOR INFORMATION: (Please type or print clearly)

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ Donna Hopkins \_\_\_\_\_  
Mo. Day Yr. (print) Name/Title of Requestor Requestor's Signature

Receive background results electronically

Phone No. (509) 546-2301

[dhopkins@lourdesonline.org](mailto:dhopkins@lourdesonline.org)  
Email address

Password (must be at least 8 characters)

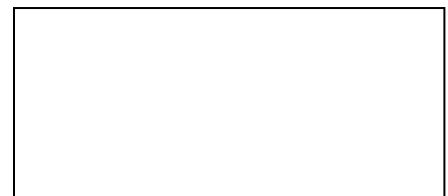
REQUESTOR'S ADDRESS: (type or print clearly)

Right Thumb Print (Optional)

Name Lourdes Health Network

Address 520 North 4<sup>th</sup> Avenue

City Pasco State WA ZIP Code 99301



**DISCLOSURE STATEMENT**

**PURSUANT TO THE REQUIREMENTS OF 1987 WASHINGTON LAWS CHAPTER 486, WE MUST ASK YOU TO COMPLETE THE FOLLOWING DISCLOSURE STATEMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL. (RCW 43.43.830 THRU 845)**

Have you ever been convicted of any of the following crimes against persons or crimes of financial exploitation:

Yes No

- Aggravated Murder
- Arson 1st Degree
- Assault 1st Degree
- Assault 2nd Degree
- Assault 3rd Degree
- Assault 4th Degree (Simple Assault)
- Assault of a Child In 1st Degree
- Assault of a Child In 2nd Degree
- Assault of a Child In 3rd Degree
- Burglary 1st Degree
- Child Abandonment
- Child Abuse or Neglect As Defined In RCW 26.44.020
- Child Buying or Selling
- Child Molestation 1st Degree
- Child Molestation 2nd Degree
- Child Molestation 3rd Degree
- Communication with a Minor for Immoral Purposes
- Criminal Abandonment
- Criminal Mistreatment
- Custodial Assault
- Custodial Interference 1st Degree
- Custodial Interference 2nd Degree
- Custodial Sexual Misconduct 1st Degree
- Custodial Sexual Misconduct 2nd Degree
- Extortion 1st Degree
- Extortion 2nd Degree
- Extortion 3rd Degree
- Felony Indecent Exposure
- Forgery
- Incest
- Indecent Liberties

Yes No

- Kidnapping 1st Degree
- Kidnapping 2nd Degree
- Malicious Harassment
- Manslaughter In 1st Degree
- Manslaughter 2nd Degree
- Murder 1st Degree
- Murder 2nd Degree
- Patronizing A Juvenile Prostitute
- Promoting Pornography
- Promoting Prostitution 1st Degree
- Prostitution
- Rape 1st Degree
- Rape 2nd Degree
- Rape 3rd Degree
- Rape of a Child 1st Degree
- Rape of a Child 2nd Degree
- Rape of a Child 3rd Degree
- Robbery 1st Degree
- Robbery 2nd Degree
- Selling or Distributing Erotic Material To A Minor
- Sexual Exploitation of A Minor
- Sexual Misconduct With A Minor 1st Degree
- Sexual Misconduct With A Minor 2nd Degree
- Theft 1st Degree
- Theft 2nd Degree
- Theft 3rd Degree
- Unlawful Imprisonment
- Vehicular/Negligent Homicide
- Violation of A Child Abuse Restraining Order
- Have you ever been found by any court, state licensing board, disciplinary board, or dependency action to have neglected or sexually abused any minor or adult person?
- Has a court issued an order of protection against you for abuse or exploitation?

**If you answered "YES" to any of the above questions, please describe and provide date(s) of the conviction(s) and the sentence(s) imposed.**

**Use separate sheet of paper if necessary.**

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**I understand that if any of the information provided above is found to be false, it may result in the loss of my employment.** This document is signed and sworn to under penalty of perjury. I certify that the above information is true and correct. My signature below authorizes Lourdes Health Network to obtain conviction records from the Washington State Patrol and other states, to release the results to the facility or person named above, and if I am a nursing assistant, to the Omnibus Budget Reconciliation Act (OBRA) Nurse Assistant Registry.

Signature:

Name (print):

Date: \_\_\_\_\_



### NOTICE TO PROSPECTIVE EMPLOYEES

Under the Balanced budget Act of 1997, the Office of Inspector General of the Department of Health and Human Services ("OIG") is authorized to impose civil monetary penalties on any healthcare provider who employs or contracts with Excluded Individuals or Entities. As a prospective employee, please answer the following questions and declarations.

1. Are you currently excluded from participating in any Federal Healthcare Program? Yes No
  
2. Have you ever been convicted of any offense involving healthcare fraud or abuse? Yes  No
  
3. Have you ever been convicted of any offense involving the neglect or abuse of patients? Yes
  
4. Have you ever been convicted of any offense involving any fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a healthcare item or service? Yes No
  
5. **Declaration:** I have not been excluded from participating in any Federal Healthcare Program or convicted of any offense which would preclude me from participating in any Federal Healthcare program.

Signed Acknowledgment: \_\_\_\_\_

6. **Declaration:** I acknowledge that (a) upon my employment, I will have continuing obligation to disclose promptly to the Director, Human Resources, if I am convicted of any offense related to (1) healthcare fraud or abuse, (2) neglect or abuse of patients, (3) fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a healthcare item or service, or (4) controlled substances, and (b) I will be discharged from employment with the Corporation and the Affiliates upon my conviction of any of the foregoing offenses.

Signed Acknowledgment \_\_\_\_\_

## EMPLOYMENT BACKGROUND AUTHORIZATION

1. I hereby affirm that the information provided in this application (and accompanying resume, if any) is true and complete to the best of my knowledge. I also agree that falsified information or significant omissions may disqualify me and may be considered sufficient justification for dismissal if discovered at a later date. When I responded to questions on this application, I continued on a separate sheet of paper and attached it to this application when I required more space to fully answer all questions.

2. I understand that an investigative report may be generated on me that may include information as to written, oral, or other --from a consumer reporting agency bearing on my creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, mode of living, my character, work habits, performance and experience, along with reasons for termination of past employment, financial credit history. Criminal history records from any criminal justice agency in any or all-federal, state, city and county jurisdictions. Included as well but not limited to State Department of Motor Vehicle/Drivers' License Records to include traffic citations and registration. As well as Military National Personnel Record Center, Educational institutions including but not limited to transcripts or any individual, company, firm, corporation, present and/or past employers, public agencies (including the Social Security Administration and the Immigration & Naturalization Service). I fully give my consent to and understand that Lourdes Health Network and / or their agent Gall & Gall Company, Inc., may be requesting information from public and private sources about any of the information noted earlier in

this paragraph

3. If applicable all medical and workers' compensation information will be requested in compliance with all Federal and State laws including the Americans with Disabilities Act (ADA). According to the Fair Credit Reporting Act (FCRA), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer-reporting agency. If so, I will be notified and be given the name of the agency providing that report.

4. I agree that a photocopy or telephonic facsimile of this authorization shall be valid as the original. This release is valid for most federal, state and county agencies including the Minnesota Department of Labor.

5. Minnesota, Oklahoma, and New York applicants only: Please check this box if you want a copy of the consumer report if one is obtained by Lourdes Health Network"

6. California applicants only: By signing below, you acknowledge receipt of the "Notice Regarding Background Investigation Pursuant to California Law", Please check this box if you would like to receive a copy of the investigative consumer report or consumer credit report if one is obtained by Lourdes Health Network at no charge whenever you have the right to receive such a copy under California law."

7. I hereby authorize, without reservation, anyone contacted by Lourdes Health Network and / or their agent Gall & Gall Company, Inc., to furnish the information described in Section 1.

### APPLICANT COMPLETE THE FOLLOWING:

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Please, print full name \_\_\_\_\_

The following information is required by law enforcement agencies and other positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Please, print other names you have used \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver's License Number and State \_\_\_\_\_ Name as it appears on License \_\_\_\_\_

Have you ever been convicted of or plead guilty to a crime?  No  Yes If yes, please explain: (A conviction will not automatically disqualify you from being considered as a candidate for employment.)

I understand that I have a right to request disclosure of the nature and scope of the report if it involves personal interviews with sources such as my friends, acquaintances, or others who may have relevant information. I understand that I have the right to receive a copy my information report.

**THIS IS NOT AN EMPLOYMENT CONTRACT**

**FAIR CREDIT REPORTING ACT NOTICE:** In accordance with the Fair Credit Reporting Act, this information may only be used to verify a statement(s) made by an individual in conjunction with legitimate business needs. The depth of information available varies from state to state. Status of updates is available on request. Although every effort has been made to assure accuracy. Gall & Gall Company, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement and maintain original release forms of the applicant for those numbers of years to comply with the F.C.R.A. This assures Gall & Gall Company, Inc. that users are familiar with and will abide by their obligations, as stated in the FCRA, to the individuals named in these reports. Gull & Gall Company, Inc., 8555 N. Dixie Drive, Dayton, Ohio 45414, 937-264-4900 or 1-800-759-4255