CHI St. Anthony Hospital

NODA VOLUNTEER APPLICATION

The information requested on this profile will aid us in ensuring the No One Dies Alone program is a good fit. Thank you for your interest in this important program and for your cooperation in completing this form. Special training is required before vigils are assigned. If your application is approved you will be contacted to schedule training. Assignments are not made until requirements are completed. Note that you must be at least 18 years of age to volunteer for this program.

Requirements: (Office use)

Start Date: _____

Orientation: _____ Ethics Agreement: __Y_N__

End Date: _____

Confidentiality Statement: _Y_N__ Photo ID Checked: _Y__N_

Personal Data (please print)

Last Name: First Name:

Address:

City: State: Zip:

Phone (cell required):

Birth Date: SSN (required for background check):

IN CASE OF EMERGENCY Who should be contacted?

Name: Relationship: Phone:

Special Skills (please list any applicable skills you feel would be useful in your volunteering)

Job Performance Ability

This program requires sitting for periods of time in quiet, often at night. Is this something you feel able to do? ☐ **Yes** ☐ **NO** If no, explain:

Reason for volunteering

This program consists mainly of sitting with patients who are in the last days of life. Please tell us why you would like to volunteer for this service.

****Please read and sign release on the following page****

Please read carefully before signing.

My services are donated to St. Anthony Hospital without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

Personal health insurance is advised, but not required, given that medical benefits are not covered under the volunteer program.

I certify that the information set forth in this application for a Volunteer position is true and complete to the best of my knowledge. I understand that, if accepted for a Volunteer position, falsified or misleading statements on this application shall be considered sufficient cause for my dismissal.

I understand that my Volunteer position shall be contingent upon proof of identity and verification of eligibility for volunteer/employment in the United States in accordance with the Immigration Reform and control Act of 1986. I further understand that my Volunteering is contingent upon the checking of references and that further steps in the Volunteer process may include passing a drug screening and completing a health evaluation satisfactorily.

I consent to and authorize St. Anthony Human Resource Department to request any information concerning my previous employment, educational history, character, general reputation and similar background information. 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 information.

I understand that all Volunteer positions are contingent upon the review of references, background checks, OIG Excluded Providers, and other relevant information. **I further understand that in accordance with ORS 443.860, SAH will conduct a criminal background check every three years.** Any misleading or incorrect statements, omissions or failure to disclose any health care related criminal conviction or any threatened or actual debarment, exclusion or other ineligibility of participation in federally funded health care programs may remove this application from further consideration for a volunteer position or cause for termination of a volunteer position.

I understand that this application is not a contract of employment. If St. Anthony Hospital accepts me for a volunteer position I agree to conform to the standards of conduct, performance and the policies of that organization.

Applicant's Signature: _____ Date: _____