2865 Daggett Avenue
Klamath Falls OR 97601
541 882 6311 Ph
skylakes.org

# SKY LAKES MEDICAL CENTER VOLUNTEERS APPLICATION

**HOW TO JOIN?**

1. Call Sky Lakes Medical Center Volunteer Services, 541-274-2038, with any application questions.
2. Fill out the application and return it to Volunteer Services. (see address below)
3. Provide three references from adults not related to you; send to each person you are asking for a reference a reference form and a stamped envelope addressed to:

   Volunteer Services
   Sky Lakes Medical Center
   2865 Daggett Av
   Klamath Falls, OR 97601-1180

**OR** the References may be submitted electronically by e-mail to: reid.kennedy@skylakes.org

**WHEN CAN I JOIN?**

Applications may be submitted at any time. You will be contacted to begin the New Volunteer Application Processing, and onboarding process.

**TB Tests, Photo ID, Parking Permit, Background Check, HIPPA & Confidentiality REQUIREMENTS**

Required TB screening is provided by Sky Lakes Medical Center with results on file in Volunteer Services. A Photo ID badge is provided by Sky Lakes Medical Center and is required to be worn while on duty. A Parking Permit is required and will be provided by Sky Lakes Medical Center.
Completion of the Criminal Background Check must be on file prior to training.
Documented HIPAA training must be on file prior to training.
Signed Confidentiality Agreement must be on file prior to training.
Covid Vaccination and proof thereof (vaccination card) is required.

**HOW OFTEN DO I VOLUNTEER?**

Volunteer shifts typically range from 2 – 4 hours, Volunteer at least two shifts a month (you may volunteer more) in each service you volunteer in; this will help to maintain your competency level in each service. A minimum of forty-eight (48) volunteer hours annually will maintain Active Membership status. Volunteers often increase their hours once they have become more comfortable, and as they see more opportunities to serve.

**HOW MUCH WILL IT COST?**

A ONE-TIME joining fee of $5.00 (cash preferred) is payable during the application processing period.
Volunteer uniforms (smocks) are required and cost between $10.00 - $20.00

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# SKY LAKES MEDICAL CENTER VOLUNTEER APPLICATION

**NAME** ______________________________________________ **BIRTHDATE** ______________
last first middle initial month day

**MAILING ADDRESS**

_____________________________________________________________________________
street/or P O box city state zip code

**Home PHONE #** ________________________ **Cell PHONE #** ________________________

**Work PHONE #** ________________________ **E-Mail** ______________________________

**REFERENCES: Applicant will send a reference form to each person listed as a reference. References must be from ADULTS, who are NOT RELATED to the applicant.**

**name address phone number**

1. _________________________________________________________________________

2. _________________________________________________________________________

3. _________________________________________________________________________

**Have you ever been convicted of a crime? (It is necessary to answer this question honestly, as a background check will be conducted on all applicants before being placed as a volunteer.)**
**Yes ___ No ___**
If "Yes", Please explain. (Conviction is not an automatic bar to placement. Each case will be considered on an individual basis.)

**Have you ever used a different name? (Legally changed, maiden name, etc.)**
**Yes ___ No ___** If "Yes" what was the name? ______________________________

**IN CASE OF ILLNESS WHILE ON DUTY, PERSON WE SHOULD CONTACT?**

name ____________________________________________ relationship ____________________

address _______________________________________________________________
street/or P O box city state zip code

home phone ________________ cell phone____________ work phone ________________

**WHAT TYPE OF EXPERIENCE CAN YOU CONTRIBUTE TO VOLUNTEERING?** ____________________

**ARE YOU CURRENTLY A MEMBER OF OTHER VOLUNTEER GROUPS?** ______________________
________________________________________________________________________________
________________________________________________________________________________

**What inspired you to apply?** ____________________________________________________

**SKY LAKES MEDICAL CENTER VOLUNTEER SERVICE AREA OPPORTUNITIES**
**Indicate by preference, i.e.: 1, 2, 3, etc. your choice of the services that interest you**

_______ Books & Magazines

- Assess the Magazine cart, for type, variety and age magazines; pull any needed magazines from the inventory in the Volunteer Workroom to replenish the cart.
- Upon entering the patient and family area waiting areas:
- Organize the existing magazines already in place by title and type.
- Throw away any old or tattered magazines.
- Replenish from the magazine cart the areas low on current magazines.

_______ Cancer Treatment Center

- Moves, operates and maintains the courtesy refreshment cart throughout the Cancer Treatment Center (CTC).
- Maintain stocks of courtesy supplies for the refreshment cart
- Assists regular CTC clerical staff with photocopying, filing and other similar tasks (e.g. stuffing envelopes) as needed or asked

_______ Guilded Quilters

- To make quilts that will keep the patients warm during their treatments and can be used at home when they are resting.
- To make small pillows that is included in a basket of information for women having breast cancer surgery.
- We also make fabric items, such as table runners, potholders, etc.  For door prizes at the SLV card party which benefits the Nursing Scholarship fund.

_______ Information Desk

- Discharge, the providing of transport services to patients being discharged from the Hospital
- The logging of these discharges
- The delivery of gifts, flowers, and live plants to patient rooms
- Wayfinding: the escorting of patients, visitors, and families to location throughout the Hospital
- The cleaning of wheelchairs after each use per the Information Desk approved process.

_______ Day Surgery

- The primary role of the Patient Surgery Liaison Desk (DSU), Volunteer is to assist in the delivery of services to the family members of Day Surgery Patient's and to assist Day Surgery Registration Staff as needed.

_______ Retail Shop – The LINK

- The primary role of The Link Gift Shop Volunteer is to provide retail services. These will include but are not limited to the following:
- A warm hello to all who enter
- The sale of Goods, Edibles, and the replenishment of items where there is back stock available, primarily edibles The dusting of displays as time allows.

_______ Special Activities

- When needed, as needed to assist in Volunteer Celebrations, community events, blood drives, clerical support.

________ Fundraising Opportunities.

- Fundraising events hosted by the volunteers, assist in payroll deduction process for employee.

**DAYS AVAILABLE (circle all your preferences)**

**MON TUE WED THU FRI**

**TIMES PREFERRED (circle your preferences)**

**MORNING AFTERNOON EVENING**

JOINING FEE $ 5.00 **One time fee** One time as long as you remain a member in good standing.

If I am accepted into the Sky Lakes Medical Center Volunteer Program I will be dependable, responsible, confidential, neat and clean, punctual and courteous while in the Volunteer Program. I understand I will be required to have TB Screening, Criminal Background Check and complete HIPAA training that will be provided by The Medical Center, as well as provide proof of COVID vaccination

I declare that all the foregoing statements are true and correct to the best of my knowledge. I also authorized The Medical Center to conduct a background check and to contact my references to make inquiries to determine my suitability for service and training. I hereby release them and The Medical Center from all liability for issuing or receiving same. All facts stated in the application are open to investigation and if anything contained herein is found to be false and misleading, I understand that I will be subject to dismissal at any time without notice. I agree that if accepted into the Volunteer Program, I will abide by all policies and procedures established by The Medical Center.

_____________________________________________________

Signature of applicant date signed

# REFERENCE SHEET

**Please print**
**APPLICANT'S NAME** ____________________________________

**APPLICANT'S ADDRESS** ____________________________________

**CITY** ______________________ **STATE** __________ **ZIP**________

**APPLICANT'S PHONE NUMBER** ______________________

**Before accepting an applicant into the Sky Lakes Medical Center Volunteer Program, we need to know something about the applicant. Please give your opinion on the applicant's character based upon dependability, punctuality, maturity, and attitude toward other people. Please include how long you have known the applicant and in what capacity you know the applicant, i.e., neighbor, friend, club member, teacher etc. Also include any other information about the applicant that you think would be helpful. Thank you!**

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____________________________________________________________
**your signature** **date**

____________________________________________
**please print your name here**

____________________________________________
**address**

____________________________________________
**city** **state** **zip code**

**PLEASE RETURN TO:** **Reid Kennedy**
Director of Volunteer Services
Sky Lakes Medical Center
2865 Daggett Avenue
Klamath Falls, OR 97601-1180

**OR**

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**reid.kennedy@skylakes.org**

**10/17**

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