SKY LAKES MEDICAL CENTER
LIFE : HEALING : PEACE

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 contact to begin the New Volunteer Application Processing, and onboard process.

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

Required TB Testing 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?

You 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.

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 $20.00

SKY LAKES MEDICAL CENTER
LIFE : HEALING : PEACE

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

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 DO YOU BRING TO VOLUNTEERING? _____

ARE YOU CURRENTLY A MEMBER OF OTHER VOLUNTEER GROUPS? _____

_____

_____

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
_____ Cancer Treatment Ctr
_____ Emergency Dept
_____ Family Birth Ctr
_____ 3rd floor ICU/CCU Greeters
_____ Guilded Quilters
_____ Information Desk
_____ Patient Surgery Liaison
_____ Retail Shop – LINK
_____ Retail Shop – OASIS
_____ Special Activities

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

SUN MON TUE WED THU FRI SAT **MORNING AFTERNOON EVENING**

JOINING FEE $ 5.00 **One time fee** One time as long as you remain a member

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

SKY LAKES MEDICAL CENTER VOLUNTEERS

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!

_____

_____

_____

_____

_____

_____

_____

_____

_____
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

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

10/17

SKY LAKES MEDICAL CENTER VOLUNTEERS

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!

_____

_____

_____

_____

_____

_____

_____

_____

_____
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

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

SKY LAKES MEDICAL CENTER VOLUNTEERS

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!

_____

_____

_____

_____

_____

_____

_____

_____

_____
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

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

10/17