

Volunteer Services  
Student Volunteer Form Packet



**GUIDELINES**

**This sheet must be completed and submitted as part of your student volunteer form packet. Initial on each blank line to verify you have read and agree to each item.**

- \_\_\_\_\_ I understand that I must be at least 14 years old to volunteer.
- \_\_\_\_\_ I have attended a student volunteer information session on \_\_\_\_\_  
(date).
- \_\_\_\_\_ I have submitted my online student volunteer application.
- \_\_\_\_\_ I have read the documents in this form packet and have signed each one.
- \_\_\_\_\_ I understand that a parent or guardian must sign on each form with me as indicated if I am under 18.
- \_\_\_\_\_ I understand that I must not be failing any classes and that I will be asked about my grades as part of the student volunteer screening.
- \_\_\_\_\_ I understand I must submit this completed form packet to the Volunteer Services staff on the day of my interview.
- \_\_\_\_\_ I understand that interviewing for a volunteer position does not mean I am automatically accepted as a hospital volunteer.
- \_\_\_\_\_ I understand that I may not be allowed to participate in the volunteer program if my application does not meet the program's minimum standards or if I unable to pass a criminal history check.
- \_\_\_\_\_ I understand that volunteers must serve for a minimum of 6 consecutive months, for a regular weekly shift of 2.5 - 3 hours on a weekday before 6pm.
- \_\_\_\_\_ I understand that becoming a hospital volunteer includes training, tuberculosis (TB) screening, and online mandatory education. More information will be provided to accepted volunteer applicants about these requirements.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**FORM PACKET INSTRUCTIONS**

1. Print this packet. Read all the forms included and sign off on everything you can to complete them.
2. The final two forms are reference check forms. These must be completed by someone who is not a relative; ideally, a supervisor, manager, mentor, instructor, coach or someone similar can complete this for you. A different person must complete each form for a total of two references.
3. Contact us in Volunteer Services if you have any questions. Our number is 503-561-5277.
4. This form packet must be completed before you come in for your scheduled volunteer interview.

**Volunteer Services | Career Exploration  
Personal Appearance Standards**



The personal appearance of participants of Volunteer Services & Career Exploration programs at Salem Health is important to the impression that our patients, their families, visitors and other customers have about each of us and of Salem Health. Our program participants will dress with taste and discretion to convey a clean, well-groomed, professional appearance.

Dress Element	Expectations
ID Badge	<ul style="list-style-type: none"> <li>• Worn at all times.</li> <li>• Easily readable.</li> <li>• Worn above the waist.</li> </ul>
Hair	<ul style="list-style-type: none"> <li>• Clean, dry and neat.</li> <li>• Well-groomed so that it does not interfere with safe participation.</li> <li>• Long hair (including facial hair) secured while in patient care or other clinical areas.</li> <li>• Mustaches, sideburns and beard neatly trimmed and combed.</li> </ul>
Jewelry	<ul style="list-style-type: none"> <li>• Professional and kept to a minimum (includes necklaces, bracelets and earrings).</li> <li>• Must not interfere with work or pose a risk for injury to participant or patient.</li> <li>• Pierced jewelry limited to the ear and a single small nose stud.</li> </ul>
Fingernails	<ul style="list-style-type: none"> <li>• Clean, trimmed to a length that will not interfere with participation.</li> <li>• Nail polish un-chipped and freshly applied.</li> <li>• Adornments limited.</li> </ul>
Fragrance	<ul style="list-style-type: none"> <li>• All personal care products must be unscented or fragrance-free.</li> </ul>
Tattoos	<ul style="list-style-type: none"> <li>• Should not be visible - every reasonable effort must be made to cover them.</li> </ul>
Clothing	<ul style="list-style-type: none"> <li>• Attire must be business casual.</li> <li>• Excessively tight (“skin-tight”), revealing, or baggy clothes, including bare midriffs and cleavage exposure, is not acceptable.</li> <li>• Skirts or dresses no shorter than 4” above the mid knee. Backless or shoulder exposing clothing should be covered with a jacket or sweater.</li> <li>• <b>Jeans or denim pants</b>, shorts, leggings or yoga-style pants, or sweats are not acceptable.</li> <li>• Denim skirts, dresses, and jumpers may be worn.</li> <li>• Clothing with large logos, slogans or sayings is not to be worn, except for items related to hospital-sponsored or approved events.</li> </ul>
Shoes	<ul style="list-style-type: none"> <li>• Shoes must be closed-toe. Sandals are not allowed.</li> </ul>
Hosiery	<ul style="list-style-type: none"> <li>• When in clinical or patient care areas, hosiery or socks must be worn.</li> </ul>

By signing below, I agree to follow the above dress code and understand that arriving for scheduled program events wearing clothes that do not meet the dress code may result in my being sent home. If I have any questions or clarifications about the dress code, I will discuss them with the Volunteer Services staff so I can fulfill my commitment to following these dress code standards.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

*(If participant is under 18 years old)*

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

**Salem Health Non-Employee Confidentiality Statement  
Volunteer Services | Career Exploration**



Confidentiality means protecting a patient’s privacy and sharing hospital business only with those who have a need to know. The “need to know” is defined as the need to have the information to perform your job. Confidential patient information includes, but is not limited to: patient’s presence, medical, financial, quality assurance/quality improvement/ performance improvement, and risk management data.

I agree to maintain absolute confidentiality of all Salem Health information. This expectation pertains to patient, physician, employee, as well as my own personal medical records and those of my family members (including children, parents, spouses, siblings) and other non-workforce or business arrangement information.

I understand that this means that I will not discuss confidential patient information with others or access information, including online, unless it is required in the performance of my job duties, is the minimum necessary, and as identified in the level indicator that is associated with my job and/or service.

I further agree that if I require computer access, the user ID and password that will be issued to me are my means of accessing the computer system. It is to be used solely in connection with the performance of my authorized job function. I will take all necessary steps to prevent anyone from gaining knowledge of my login and password and I will not use anyone else’s login and password. The use of these unique codes by anyone other than the person to who they have been assigned is prohibited and will be reported to my supervisor when detected. I will sign-off each time I leave the terminal to ensure the security of my password and the information.

I agree that when it is necessary as part of my job duties or work assignment for me to discuss patient information with other employees that I will be certain the conversation is in a private area. I understand that I may not access my personal lab results, physician dictated reports, x-ray reports; in short, anything in my personal medical record is considered Protected Health Information (PHI). If I desire access to my medical record, I will sign an authorization form available in the HIM department and get such records from them. I further understand that I may not access my family members’ (including children, parents, spouses, siblings) medical records, and that these are also considered Protected Health Information (PHI).

Any breach of confidentiality is grounds for immediate withdrawal of onsite privileges, termination of my service and/or indemnification afforded me by Salem Health, or corrective action up to and including termination of my employment and/or service.

I have read the above confidentiality statement of policy. I understand it, and I agree to comply.

**School:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**Printed Name of Student:** \_\_\_\_\_

**Signature of Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_  
**(if student is under 18 years old)**

**Volunteer Services | Career Exploration  
Consent Form**



**\*If you are 18 or older, please sign & date this form, writing “self” on the relationship line\***

My son/daughter, \_\_\_\_\_, has my permission to participate in Salem Health’s Career Exploration and Volunteer Services Programs. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her. If the above-named participant is over 18, he or she may complete this form for him/herself, in lieu of a parent or guardian.

I understand my child may be required to have a Tuberculin skin test prior to beginning his or her hospital experience and I give my permission for my child to have this test performed by Salem Hospital’s Occupational Medicine Department.

Participation in these programs will include observing patients and healthcare professionals in a hospital setting and observing medical, laboratory, and/or business procedures. I do hereby release Salem Health and its staff and sponsors from any responsibilities of injury or accident as a result of the Career Exploration and Volunteer Services Programs. Any medical expenses incurred as a result of injury or accident will be my responsibility.

I understand that, in case of a medical emergency, every attempt will be made to contact the emergency contact person for the above-named participant. However, this document is my consent as parent, guardian, or participant for emergency treatment and/or procedures necessary for my son/daughter/myself by the professional staff at Salem Health.

I also understand that it is my responsibility to find or provide transportation for my child to and from his or her assignment if my child is unable to drive him or herself. I understand that my child is expected to notify the appropriate person, in advance, if they are unable to report at the prearranged time and that any absences or failure to comply with program standards may disqualify them from participating in Career Exploration and Volunteer Services programs with Salem Health in the future.

\_\_\_\_\_  
Printed Name of Parent/Guardian (if participant is under 18) or Self

\_\_\_\_\_  
Relationship\*

\_\_\_\_\_  
Signature of Parent/Guardian (if participant is under 18) or Self

\_\_\_\_\_  
Date\*

\_\_\_\_\_  
Street Address of Parent/Guardian

\_\_\_\_\_  
Daytime Phone #     Home                       Work

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Evening Phone #     Home                       Work

**Emergency Contact: (only complete to list someone other than parent/guardian as emergency contact)**

\_\_\_\_\_  
Name of Emergency Contact (If other than contact above)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number



## Volunteer Agreement

I certify that the information contained in this application is true, correct, and complete to the best of my knowledge. I understand that continuation of any subsequent volunteer placement depends upon true and accurate representation of the facts stated or implied herein. In addition, I hereby authorize Salem Health to make inquiries regarding my education, work experience and references, unless otherwise stated. I hereby release all parties and persons associated with any such inquiries from all claims, liabilities, and damages for whatever reason in connection with information they give.

I acknowledge and agree that I am not obligated if called upon to perform the volunteer services herein applied for, and that Salem Health is not obligated to assign or actively seek to assign me to a placement.

I understand this application is not a contract of employment. If I am accepted as a volunteer, I agree to abide by and conform to all policies and procedures of Salem Hospital and Volunteer Services.

I understand that my services are donated to the hospital without contemplation of compensation or future employment, and are given with humanitarian reasons. I also understand that becoming a volunteer does not ensure that I will become a paid hospital employee in the future.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Name – Printed

\_\_\_\_\_  
Parent/Guardian's Signature – **If Applicant is UNDER 18 Years Old**

\_\_\_\_\_  
Date



## Student Consent to Photograph or Interview

As requested by Salem Hospital or a member of the media, I consent to and authorize photographs or videotape recordings to be taken.

I also consent to be interviewed by a representative of the media or Salem Hospital for purposes of publication.

I further authorize and consent to the use of the still or video images by the media and/or Salem Hospital in print publications, hospital or media Web sites, or broadcast productions.

Applicant's printed name: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_

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

\_\_\_\_\_  
**Printed Name of Parent/Guardian (if student is under 18)**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Signature of Parent/Guardian (if student is under 18)**

\_\_\_\_\_  
**Date**



Applicant Name: \_\_\_\_\_

### SALEM HOSPITAL STUDENT VOLUNTEER RECOMMENDATION FORM

At Salem Hospital, we are committed to improving the health and well-being of the communities we serve. To help us meet our mission, we bring on service-oriented volunteers who want to provide support to the community. We look for individuals to join our student volunteer program who represent our commitment to excellent service, who are team players, and who are friendly and outgoing.

To help us determine if the applicant named above would be a good asset to our volunteer workforce, please answer the following questions. Use the back of this page, if needed.

- How do you know this student applicant?
  
- Why would this student be an excellent volunteer, based on our organizational values (below)?
  
- Knowing about the qualifications for our student volunteers, would you recommend this applicant to our program and why?
  
- How would you rate this student on the following values: (check one for each line)
 

Service	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Ethics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Responsibility	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Problem Solving	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Teamwork	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
  
- Is there any additional information about this student's qualifications that we would find helpful?

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

Signature \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_



Applicant Name: \_\_\_\_\_

### SALEM HOSPITAL STUDENT VOLUNTEER RECOMMENDATION FORM

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Problem Solving	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Teamwork	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
  
- Is there any additional information about this student's qualifications that we would find helpful?

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

Signature \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_