Mason General Hospital
& Family of Clinics

Dear Volunteer / Job Shadow Applicant,

Thank you for your interest in Mason General Hospital & Family of Clinic's volunteer / job shadow program. I hope that you decide to join our wonderful group of volunteers! We have numerous opportunities, and I am certain we can find one that fits your interests.

Please complete the attached application and return it to:

Lonnie Hatman
Volunteer Services Coordinator
Mason General Hospital & Family of Clinics
901 Mountain View Drive
P.O. Box 1668
Shelton, WA 98584-8614
lhatman@masongeneral.com

When I receive your paperwork, we will schedule an interview to explore your interests, talents and the hospital needs. At that time, I will provide you with additional paperwork to complete and schedule you for an orientation.

If you have further questions or concerns, I can be reached at (360) 427-3621 or lhatman@masongeneral.com

We value the dedication and hours of service our volunteers give each year. Again, thank you for your interest in being part of our team! Please retain this first page with my contact information for your future reference.

Sincerely,

Lonnie Hatman | Volunteer Services Coordinator
Mason General Hospital
& Family of Clinics
901 Mountain View Drive POB 1668
Shelton, WA 98584
Phone: 360-427-3621 | Ext. 28899 | Fax: 360-432-3267
www.masongeneral.com

Mason General Hospital & Family of Clinics

Volunteer / Job Shadow Application Flow Chart

Application

* Download an application from www.masongeneral.com/volunteering or pick up a paper copy at the Volunteer Services desk in Human Resources (downstairs in the hallway with Physical Therapy).
*Fill out the application completely and legibly.
*If a section does not apply please write N/A.
*Applicants under 18 must have Parental Consent, a 2.5 GPA, a letter of recommendation, a copy of your school transcripts, and verification of vaccinations.
*Don't forget to sign and date the application.

Orientation

*Once the Volunteer Coordinator receives your application materials (either electronically or on paper) he will either send you an email with a link to orientation materials or contact you to schedule an orientation session at the Volunteer Services Office.
*If you do not provide an email address these materials must be completed in person at the Volunteer Services Office.
*Orientation materials will cover such topics as Safety, HIPPA, confidentiality, Emergency Codes, etc..
*An open book test will be included with the orientation materials. That test must be completed online or on paper and submitted to the Volunteer Coordinator to show completion of the Orientation materials.
*If you don't have an email account you can create a free one with gmail, yahoo, or several other online companies. If you do not have a computer; there are computers available for use at no charge at the local Timberland Regional Library.

Onboarding

*Once your orientation materials have been completed and the Orientation test returned you will be contacted to schedule an onboarding session at the Volunteer Services Office.
*In some cases the Orientation session and the Onboarding session may be completed together.
*During the onboarding process there are a number of documents required by law or hospital policy that must be reviewed and signed.

Interview

*The Volunteer Coordinator will interview applicants to determine their knowledge, skills, abilities, and personal interests to determine the best fit for the volunteer and the hospital.

TB Test/Flu Shot

*After the onboarding materials are completed the Volunteer Coordinator will schedule Volunteer Applicants for a TB Test/Flu shot if necessary.
*TB Tests are normally conducted on Tuesdays at 1:30.

Volunteer/Shadow Scheduling

*The Volunteer Coordinator will work with Volunteers and Hospital Staff to schedule the volunteer/job shadow.
*Volunteers will be scheduled to work with an experienced volunteer in the area of interest and given a date, time, and location to report.
*Job Shadows will be scheduled with a staff member and given a point of contact and a date, time, and location to report.

Please retain this first page with my contact information for your future reference.

Volunteer / Job Shadow Application

Mason General Hospital & Family of Clinics

901 Mt. View Drive/PO Box 1668◦ Shelton, Washington 98584 ◦ (360) 426-1611

Please Print Clearly — PERSONAL DATA

Last Name _____ First Name _____M.I._____

Address _____ City _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Email _____

Position Applying for:

☐ **Volunteer** ☐ **Job Shadow**

How do you prefer to be contacted? (circle one) Phone or by Email or by US Mail.

Are you at least 18? Yes _____ (Skip to Emergency Contact Section)

No _____ (Complete Parental Consent Section)

PARENTAL CONSENT

A junior volunteer must be at least 15 years of age. They must maintain an overall grade point average of at least 2.5; a letter of recommendation from a school counselor or teacher; a copy of your school transcripts; and verification of vaccination for Measles, Mumps & Rubella (MMR) and the annual flu immunization.

TO BE SIGNED BY PARENT(S) AND/OR GUARDIAN:

I GIVE CONSENT FOR MY SON/DAUGHTER TO VOLUTNEER/JOB SHADOW AT MASON GENERAL HOSPITAL. I UNDERSTAND THAT VOLUNTEERING CAN LEAD TO EXPOSURE TO A VARIETY OF INFECTIOUS DISEASES. THESE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING; HEPATITIS A, B, C, D, E, G, AND SIN-V, TUBERCULOSIS, HIV/AIDS, MENINGITIS, INFLUENZA AND OTHER BACTERIAL AND VIRAL INFECTIONS.

_____ HAS MY (OUR) CONSENT TO PARTICIPATE IN THE VOLUNTEER PROGRAM. I (WE) UNDERSTAND THAT TRANSPORTATION TO AND FROM THE HOSPITAL IS OUR RESPONSIBILITY. I (WE) UNDERSTAND I (WE) NEED TO PRODUCE VERIFICATION OF THE VARICELLA (CHICKEN POX) VACCINE AND THE MEASLES, MUMPS, AND RUBELLA VACCINE OR THAT OUR CHILD HAS BEEN SCREENED.

_____ _____

(Parent and or Guardian's Signature) (Date)

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____ PHONE _____

ADDRESS: _____CITY_____STATE:_____ZIP_____

NAME:_____ RELATIONSHIP:_____ PHONE:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

REFERENCE INFORMATION

Please provide two professional or personal references who are not family members:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

EDUCATION & EMPLOYMENT HISTORY

High School _____ Graduated ☐ Yes No ☐

If No: Year in School (Freshman, Sophmore, Junior, Senior)

_____ Present GPA:_____ Are you involved in after school activities the might conflict with participation in the program? ☐ Yes What:_____

☐ No

College _____ Graduated ☐ Yes No ☐

Degree(s): _____Professional licenses held: _____

Current or last place of employment: _____

City / State: _____ Phone: _____

Job title: _____

Job duties: _____

Volunteer Experience: _____

POSITION PREFERENCES

Is there a specific area/department/volunteer position that you are interested in?

_____

Is there a specific staff member you wish to shadow? _____

Which weeks/days/hours would you prefer? (i.e. 1st and 3rd Wednesdays, Mondays 8–12, Thursday 12-4, Sunday 6-10)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

HEALTH

I UNDERSTAND THAT VOLUNTEERING/JOB SHADOWING CAN LEAD TO EXPOSURE TO A VARIETY OF INFECTIOUS DISEASES. THESE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING; HEPATITIS A, B, C, D, E, G, AND SIN-V, TUBERCULOSIS, HIV/AIDS, MENINGITIS, INFLUENZA AND OTHER BACTERIAL AND VIRAL INFECTIONS.

_____

(APPLICANT'S SIGNATURE) (DATE)

Have you any physical, mental or sensory limitation that would prevent you from performing as a Volunteer/Job Shadow?

YES _____ NO _____ PLEASE EXPLAIN: _____

You will be required to have a two-step tuberculin skin test (TST) or a single QuantiFERON®-TB Gold (QFT) lab test administered at time of hire**. Our Employee Health Nurse will administer** this **free of charge** along with the annual flu immunization if you haven't already been vaccinated.
If you are a minor, your parents will have to sign a TB consent form and a consent form for the Influenza Vaccine.
You will also be required to show verification of having received the Measles, Mumps and Rubella vaccine, or that you have gone through M.M.R. screening.

CERTIFICATION, CONFIDENTIALITY AUTHORIZATION & RELEASE

I UNDERSTAND THAT ALL THE INFORMATION WHICH I MAY HEAR DIRECTLY OR INDIRECTLY CONCERNING A PATIENT, DOCTOR, OR STAFF MEMBER, WILL BE CONSIDERED *STRICTLY CONFIDENTIAL,* AND I WILL NOT SEEK INFORMATION IN REGARD TO ANY PATIENT.

ALL STATEMENTS IN THE APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ANY INFORMATION SUBMITTED PROVES TO BE FALSE, IT SHALL BE CAUSE FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION.

I certify that the information given by me to Mason General Hospital & Family of Clinics (MGH&FC) is true and complete to the best of my knowledge. I understand that, if I am accepted as a hospital volunteer and it is discovered that I gave false, incomplete or if I omit information, it may result in my immediate dismissal. I also understand that if I am hired, my volunteer position is conditioned on your receipt of a satisfactory report from the Washington State Patrol, according to the position for which I am applying.

I authorize MGH&FC to solicit information regarding my character, general reputation, previous employment and similar background information, and to contact any and all references I have given on my application. I hereby release all parties and persons connected with any such request for information from all claims, liabilities and damages for any reason arising out of the furnishing of such information. If I am accepted as a volunteer, I release MGH from any liability for future reference it may provide regarding my volunteer history at MGH&FC.

Applicant's Signature: _____ Date: _____

FOR OFFICE USE ONLY

Interviewed by _____ Date: _____

Assigned position: _____ Department: _____

Orientation date: Department date training: