RESEARCH AND CAPACITY BUILDING

VOLUNTEER APPLICATION PACKET

Royal Jubilee Hospital
Research and Capacity Building
Memorial Pavilion, Kenning Wing, KW 127
1952 Bay Street
Victoria, BC V8R 1J8
Tel: 250-370-8261
Submit Application to: ResearchVolunteer@VIHA.CA

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To become a Research Volunteer at Royal Jubilee Hospital, you must:

1) Commit to volunteering for a minimum of 60-hours over 6 months (a letter of reference will not usually be issued prior to the completion of this 60-hour commitment).

2) Be available to volunteer for a scheduled two to four hour shift once a week on a regular basis, or more, if you wish.

3) Be 14 years of age or over.

4) Submit the following forms:

- Volunteer Registration Forms completed and signed.
- 2 - Reference Survey forms

  OR

  2 - Letters of Reference
  Completed by an non family member who has known you for a minimum of a year

If you are under 19 years of age you also need to complete the Parental Permission Form and during the school year, the Teacher/Counselor Form

5) All volunteer programs require a criminal record check be submitted. Applicants will be referred to the online form to complete. If you don't have access to a computer, a paper form is handed out at the interview. *The Ministry of Justice provides criminal record checks at no cost for volunteers.*

6) When you complete all of the forms, please hand deliver, mail, or email to:

Hand Deliver: Memorial Pavilion, Kenning Wing, Room KW 127 Royal Jubilee Hospital	**Mail:** Royal Jubilee Hospital Attention: Reseach and Capacity Building Memorial Pavilion, Kenning Wing, KW 127 1952 Bay Street Victoria, BC V8R 1J8	**Email:** ResearchVolunteer@VIHA.CA

After receiving your application, and when a tentative placement becomes available, you will then be contacted by phone or email to arrange a specific date and time for an interview. You will be asked to submit a criminal record check. If accepted into the program, you will be notified and scheduled for a general hospital orientation and area orientation(s); these are to be completed before starting any volunteer assignments. Some volunteer assignments also require the completion of 1 or more training shifts with a mentor volunteer. This training is required and important to prepare you for your volunteer placement.

*If you do not hear back from us after submitting your application, it means that you have been placed on a waitlist. If this happens, you are required to check in every month by giving us a phone call or emailing. If you do not reach us please leave us a message stating your full name, phone number, and the date you mailed your application. This allows us to know if you are still interested in volunteering at the Royal Jubilee Hospital. **If we do not hear from you after 6 months your file will be terminated.**

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VOLUNTEER RESOURCES VOLUNTEER APPLICATION FORM

Island Health Site: _____

YOUTH ☐
ADULT ☐
DATE:

LEGAL NAME: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	GENDER: ☐ Male ☐ Female ☐ Other	HOME PHONE:
ALTERNATIVE OR NICKNAME:		CELL PHONE:
ADDRESS:	CITY/PROVINCE:	POSTAL CODE:
DATE OF BIRTH: (dd/mmm/yyyy)		E-MAIL:
IN CASE OF EMERGENCY PLEASE NOTIFY: NAME:	RELATIONSHIP:	PHONE #:

PLEASE GIVE TWO REFERENCES – NO RELATIVES — INCLUDE EMAIL ADDRESSES

NAME:	**RELATIONSHIP:**	**PHONE #:**	**EMAIL:**
NAME:	**RELATIONSHIP:**	**PHONE #:**	**EMAIL:**

ARE YOU EMPLOYED? **Full Time** ☐ **Part time** ☐ **No** ☐ **PLACE OF EMPLOYMENT:** _____

ARE YOU CURRENTLY ATTENDING SCHOOL? Yes ☐ **No** ☐

IF YES, WHAT'S THE NAME OF THE SCHOOL AND PROGRAM? _____

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAM?
VOLUNTEER EXPERIENCE:
WORK EXPERIENCE:

YOUR SPECIAL SKILLS, INTERESTS, HOBBIES?
LANGUAGES? WRITTEN: **SPOKEN:**
WHY ARE YOU INTERESTED IN VOLUNTEERING?
WHAT KIND OF VOLUNTEER ASSIGNMENT WOULD YOU LIKE?
WILL YOU REQUIRE A PARKING PERMIT? **No** ☐ **Yes** ☐ (if yes please complete the attached form)
LENGTH OF COMMITMENT: **6 Months** ☐ **Longer** ☐

TIME AVAILABILITY: (Please Check)

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNINGS							
AFTERNOON							
EVENINGS							

AUXILIARY MEMBERSHIP

ARE YOU A MEMBER OF A HOSPITAL AUXILIARY? Yes ☐ No ☐
IF NOT, WOULD YOU LIKE A MEMBER OF THE AUXILIARY TO CONTACT YOU WITH FURTHER INFORMATION? Yes ☐ No ☐

GENERAL HEALTH STATUS

Do you have any conditions/restrictions that would impact your ability to perform your volunteer duties safely? **YES☐ / NO☐**

If yes, please describe: _____

Do you have any illnesses or conditions that could be transmitted to other personnel or patients during the course of your duties? YES☐ /NO☐
If yes, please describe: _____

FLU POLICY: Please note that Island Health's Influenza Policy applies to volunteers. This means that volunteers must be immunized for influenza during onsite clinics or through other sources of vaccine such as Public Health Units, pharmacies or family physicians. If volunteers choose not to or are unable to, they may wear a mask during flu season – approx. December 1 to March 31 annually. Volunteers who have been immunized are asked to inform their Volunteer Administrator of the date of their shot.

TUBERCULOSIS SCREENING

Have you ever had active Tuberculosis? YES☐ /NO☐

Have you been experiencing any of the following symptoms for longer than one month?

Persistent cough: YES☐ / NO☐ Excessive fatigue: YES☐ /NO☐ Unexplained weight loss: YES☐ /NO☐

Coughing up blood: YES☐ / NO☐ Excessive night sweats: YES☐ /NO☐ Persistent fever: YES☐ /NO☐

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE:

You will need to make an appointment with your family physician to rule out a communicable condition (such as active tuberculosis). If a TB scratch/skin test is required you will need to go to the South Island TB Clinic or the nearest Public Health Unit. Inform the unit that you are planning to volunteer at a VIHA Site. The results of your TB screening will need to be documented below and returned to your Manager/Coordinator of Volunteer Resources before you may begin volunteering.

Volunteers who will be volunteering in high risk areas – **ERs, ICUs, Microbiology Lab and Cytology/Histology Lab, Respiratory Therapy, Renal Units and dialysis units, Transplant Units, Respiratory units, Bronchoscopy and residential settings** are recommended to have the scratch/skin test done prior to starting their volunteer assignment.

Please Note: Volunteers who travel to areas of high TB prevalence (e.g. Brazil, China, India, Philippines, Thailand, remote areas in Canada) may also be asked to have TB testing done upon their return. Please discuss this with your Manager, Volunteer Resources.

I WILL RESPECT CONFIDENTIAL INFORMATION AND THE RIGHTS AND DIGNITY OF ALL PATIENTS AND RESIDENTS.
I WILL HONOUR MY COMMITMENT AS A VOLUNTEER AND PROVIDE ADEQUATE NOTICE OF MY ABSENCES.
I WILL ABIDE BY THE POLICIES AND STANDARDS OF THE DEPARTMENT OF VOLUNTEER RESOURCES.

_____ _____
SIGNATURE OF APPLICANT DATE

IF APPLICANT IS A YOUTH (UNDER THE AGE OF 19), PARENTAL CONSENT IS REQUIRED. PLEASE SIGN BELOW:

_____ _____
SIGNATURE OF PARENT OR GUARDIAN NAME (PLEASE PRINT)

_____
DATE

STATEMENT OF UNDERSTANDING

Please read these next two pages carefully. Your signature at the end indicates you have read, understand and agree to each of the following statements.

I, _____ agree to serve as an Island Health Volunteer, and attend regularly and perform my volunteer service to the best of my ability and according to the guidelines provided by Island Health Department of Volunteer Resources. I will meet the time commitments, or provide adequate notice so that alternative arrangements can be made. I will act at all times as a contributing member of the health care team towards accomplishing the mission of Island Health.

PERMISSION TO PERFORM A BACKGROUND CHECK

I give permission for the VIHA Volunteer Resources Departments to perform a check of my background, which may include:

- criminal record check, including a vulnerable sector check
- driving record
- past employment and/or volunteer history
- personal references
- other persons or sources as is appropriate for the volunteer service(s) in which I have expressed an interest

I understand that information collected during this background check will be limited to that which is appropriate to determining my suitability for the particular types of volunteer service in which I will be involved. I understand that all information collected during the check will be kept confidential.

PERMISSION TO TAKE PHOTOGRAPHS AND TO STORE REGISTRATION or PERSONAL INFORMATION ELECTRONICALLY

I understand that:

- Information collected through registration will be stored electronically and used for management functions by the Volunteer Resources and/or Spiritual Care and/or Auxiliary Departments within Island Health
- All Island Health volunteers will be required to have official Island Health photo identification
- From time to time, pictures may be taken for publicity and display purposes (examples below):

*** Displays * Videos * Local Community Newspapers**

*** Volunteer Resources or Island Health Websites * VIHA publications**

CONFIDENTIALITY, STANDARDS OF CONDUCT AND RESPECTFUL WORKPLACE POLICIES

These policies have been provided to you and/or can be found on the Island Health website http://www.viha.ca/info_privacy/frequently_asked_questions.htm. **Scroll down to *"Does Island Health have a policy about privacy and confidentiality?"*** If you do not have access to a computer, please note you will be given a copy of the policies to read at the interview and/or orientation.

I (print name) _____ hereby acknowledge that I have read and understood Island Health's policy entitled "Confidential Information – Privacy Rights of Personal Information" (Policy number 1.5.1). I further acknowledge that I have read and understood the consequences for breach of these policies. (Separate document). I have also read and understood the Respectful Workplace Policy, the Volunteer Resources Standards of Conduct and the Acceptable Use of Assets Policy. (Separate documents)

(Continued on overleaf)

REQUESTS FOR REFERENCE

Educational institutions and employers recognize the value of volunteer experiences.

I understand that the Freedom of Information and Privacy Protection Act prohibits Island Health from giving references without my written approval**.** I hereby give permission to Island Health's Volunteer Resources Departments to provide references, written and verbal, related to my volunteer service**.** I understand that a reference may only be provided after 60 hours of volunteer service and/or at the discretion of the site's Manager, Volunteer Resources.

INFECTION CONTROL RISKS

I understand that as a volunteer with Island Health there are risks associated with being in a facility and on a unit or ward. As I will be volunteering in a health care setting, these risks include possible exposure to communicable diseases. I will be aware of these risks and as a volunteer keep updated on training and safety procedures that could impact my position. I am aware that I might be asked to have additional testing (e.g. TB) if it is warranted, and vaccinations, (e.g.: Influenza Virus) in order to carry out my duties as a volunteer safely. If I am unsure of a potential risk I will ask my Manager for clarification.

EDUCATIONAL OPPORTUNITIES

You may be offered opportunities to take courses that are part of Island Health's on-line Learning Management System (LMS) offered to volunteers as well as staff. When you use the Course Catalogue Registration System (CCRS) within LMS, Island Health/VCH/PHC/FHA* collects personal information about you, such as your education profile, the date and time you accessed the system and also your grades for any quiz or other assessment. Course managers and your direct supervisor may access your user history to confirm that you achieved a passing grade on any course offered through CCRS. Your personal information is collected and used for the purposes of managing educational opportunities and requirements for your affiliation with Island Health/VCH/PHC/FHA. Island Health/VCH/PHC/FHA collects, uses and shares personal information only in accordance with the BC Freedom of Information and Protection of Privacy Act.

* VCH = Vancouver Coastal Health; PHC = Providence Health Care; FHA = Fraser Health Authority

EMERGENCY AND DISASTER PLANNING

- ❑ I agree to be included on a contact list in the event of a disaster or emergency to provide assistance during a response. I understand that I may not be contacted, and that I may be able to help without waiting to be contacted.

*I understand that my **contact information** may be shared with Island Health staff and other volunteers for purposes related to orientation, training, scheduling and other volunteer management functions.*

I AGREE TO ALL OF THE ABOVE: *(unless otherwise stated on this form)*

Signature: _____ Date: _____/_____/_____
Month Day Year

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REFERENCE QUESTIONNAIRE

(This form is to be completed by two references)

Volunteer Name: _____ **Date**: _____

Please answer the questions below regarding this prospective volunteer's personality, character and qualities for working with Island Health's Research department. All information you share helps us find the right placement for this prospective volunteer.

QUALITY	NOT KNOWN	MINIMAL AVERAGE	BELOW AVERAGE	ABOVE AVERAGE	EXCELLENT
1. Reliability, commitment	☐	☐	☐	☐	☐
2. Trustworthy, hones/Integrity	☐	☐	☐	☐	☐
3. Ability to communicate and be understood	☐	☐	☐	☐	☐
4. Interpersonal skills, working with others	☐	☐	☐	☐	☐
5. Conflict resolution skills	☐	☐	☐	☐	☐
6. Respectful/considerate of others	☐	☐	☐	☐	☐
7. Able to take direction	☐	☐	☐	☐	☐
8. Good common sense	☐	☐	☐	☐	☐
9. Good boundaries	☐	☐	☐	☐	☐
10. Overall personality/character	☐	☐	☐	☐	☐

PLEASE ANSWER THE FOLLOWING	YES	NO	COMMENTS
Is the applicant a suitable candidate?	☐	☐	
Does the applicant require supervision?	☐	☐	
Do you feel the applicant's other commitments may interfere with his/her commitment to volunteering?	☐	☐	

Any further comments:

Reference Name: _____**Relationship to the applicant:**_____

Phone or email:_____ Reference Signature:_____

**Please note an original signature is required unless this form is filled out online and sent from the references' personal email. The personal email will be considered a valid signature.*

Email: ResearchVolunteer@VIHA.CA

Fax: 250-370-8106

Drop Off or Mail to: Research and Capacity Building, Memorial Pavilion, Kenning Wing 127, Royal Jubilee Hospital, 1952 Bay Street, Victoria BC V8R 1J8

Your reference is important and appreciated. Thank you.

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2. Trustworthy, hones/Integrity	☐	☐	☐	☐	☐
3. Ability to communicate and be understood	☐	☐	☐	☐	☐
4. Interpersonal skills, working with others	☐	☐	☐	☐	☐
5. Conflict resolution skills	☐	☐	☐	☐	☐
6. Respectful/considerate of others	☐	☐	☐	☐	☐
7. Able to take direction	☐	☐	☐	☐	☐
8. Good common sense	☐	☐	☐	☐	☐
9. Good boundaries	☐	☐	☐	☐	☐
10. Overall personality/character	☐	☐	☐	☐	☐

PLEASE ANSWER THE FOLLOWING	YES	NO	COMMENTS
Is the applicant a suitable candidate?	☐	☐	
Does the applicant require supervision?	☐	☐	
Do you feel the applicant's other commitments may interfere with his/her commitment to volunteering?	☐	☐	

Any further comments:

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Phone or email:_____ Reference Signature:_____

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Email: ResearchVolunteer@VIHA.CA

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Your reference is important and appreciated. Thank you.

High School Students Only:

TO BE COMPLETED BY TEACHER OR COUNSELLOR

The applicant wishes to be a Youth Volunteer in our hospital. We require a minimum sixty-hour commitment over six months of approximately two-four hours per week. This information must be submitted for the intake process and as Youth Volunteer positions become available.

The information you provide is confidential. Your comments will give us a better understanding of the applicant's background and character. I would appreciate any information or comments you consider important to this application. Thank you for your prompt response.

NAME OF APPLICANT:_____

PLEASE ANSWER THE FOLLOWING	YES	NO	COMMENTS
1. Is the applicant a suitable candidate?	☐	☐	
2. Is the applicant reliable?	☐	☐	
3. Is the applicant considerate of others?	☐	☐	
4. Does the applicant work well with others?	☐	☐	
5. Does the applicant require constant supervision?	☐	☐	
6. Do you feel the applicant's school work would suffer through participation in this program?	☐	☐	

COMMENTS:

_____

_____

WRITTEN SIGNATURE: _____ **POSITION**:_____

PRINT SIGNATURE: _____

DATE:_____

PLEASE RETURN THIS FORM TO:

Royal Jubilee Hospital
Research and Capacity Building
Memorial Pavilion, Kenning Wing, KW 127
1952 Bay Street
Victoria, BC V8R 1J8
Email: ResearchVolunteer@VIHA.CA

Thank you for your prompt response.

For Applicants Ages 14 to 18 Only:

TO BE COMPLETED BY PARENT/GUARDIAN

NAME OF APPLICANT: _____

NAME OF SCHOOL:_____ **GRADE:**_____

I am aware that the above student would like to participate in the Volunteer Youth Program for Royal Jubilee Hospital.

- ❑ I understand that the Volunteer Resources Department *requires my daughter/son to complete a minimum of 60 hours of volunteer service,* prior to asking for a reference.

- ❑ I will ensure all Hospital Items will be returned upon completion of the Volunteer Placement, such as: photo ID, uniform and/or parking permit.

- ❑ I give permission for Volunteer Resources to provide references or certificates relating to my daughter's/son's volunteer experience to schools, education institutes, and employers who recognize and value volunteerism.

- ❑ I give permission for the Island Health to take photographs and to store registration or personal information electronically of my daughter/son. I understand that:
  - Information collected at the time of registration will be stored electronically and used for management functions by the Volunteer Resources.
  - All VIHA volunteers are required to have official IH photo identification

- ❑ I give permission for pictures to be taken of my daughter/son from time to time for publicity and display purposes: (Please check the following boxes)

Displays	☐	IH publications	☐
Videos	☐	Brochures	☐
Volunteer Resources Website	☐	Newspapers	☐

- ❑ I have read this application package.

- ❑ I give my approval and support for the above student's participation. I will support him/her in attending regularly and encourage him/her to perform their volunteer services according to the guidelines provides during their orientation

SIGNATURE OF PARENT OR GUARDIAN: _____

PRINTED NAME OF PARENT/GUARDIAN: _____