May 2017

Welcome New Applicants!

Thank you for your interest in the **Health Care Youth Volunteer Program,** sponsored by the **Auxiliary to Cowichan District Hospital.** Volunteering is a very rewarding experience. In addition to giving you the satisfaction of knowing you are helping others, it provides opportunities to develop life and employment-related skills. It is an opportunity to gain exposure to health care, to help you in your possible decision to pursue a career in this area. As a volunteer you will be interacting with patients, residents, family, and staff. Not every task will involve direct contact with the residents or patients, yet each and every assignment assists to enhance the quality of care.

To be a Health Care Youth Volunteer you must:

1. Be in grades 9-12 and attend school or be home schooled. Priority will be given to grades 11 and 12 who need to acquire volunteer hours for graduation.

2. Have a Reference Form completed by a neighbour, teacher, employer, clergy or school Councillor. **It is not appropriate for a family member to supply a personal reference.**

3. Complete an eight-hour online orientation mandated by Island Health Authority by September 1st. You will be given the necessary information of how to access this information once your registration package is accepted. There will be further training required that will be arranged for in September prior starting your rotation. These hours are included in your volunteer rotation.

4. Be willing to commit to designated shifts of 2 hours…4-6pm…once a week at Cairnsmore Place from October 1st to May 31st. Holidays are optional. Anyone who has completed a minimum of a year in this program will be eligible to be interviewed by the Manager of Volunteers for placement in hospital. This would enhance your prospects of enrolment in a health care program or other training like office management or education.

***Agree to have flu immunization**. If you do not wish to do this you must agree to wear mask from November to March as mandated by Public Health.

Hours performed as a youth volunteer provide valuable job skills and can become part of your career portfolio as you prepare for graduation. We will provide you with a record of your hours and references if requested.

The Auxiliary awards bursaries to students in the youth program who have completed a minimum of 100 hours and have been accepted into a health care training program. A committee will review the applicants' applications and volunteer hours and, based on this information, will select the appropriate candidates.

Should you have any questions concerning the program please feel free to contact me.

Sincerely, Claire Wessan, Convenor of Youth Volunteer Program

clairedunkin@shaw.ca 250-748-3593

Auxiliary to Cowichan District Hospital's

HEALTH CARE YOUTH VOLUNTEER

At Cairnsmore Place

APPLICATION PACKAGE May 2017

Program Convener:

Claire Wessan------clairedunkin@shaw.ca.....250-748-3593

Applications to be handed in to school councillor's office by

Thursday, June 29

NO LATE applications will be accepted.

PROCEDURE

☐ Complete this **complete** application package –
PRINT clearly, use a **PEN. Have application stamped with date submitted.**

☐ Include photocopy of picture Id, eg. student card, driver's licence.

☐ Return application form to school councillor's office by June 29, 2017

☐ Keep this page and put the following dates in your family calendar:

Island Health require English to be spoken at ESL Level 6

Island Health have a hand hygiene policy in place which asks all workers in the hospital and Cairnsmore Place **NOT** to wear nail polish, have long nails, extensions, nail jewelry, hand/wrist jewelry while on duty.

IMPORTANT DATES (attendance is mandatory)

Information Session - **Monday, September 18, 2017 from 7 - 8:30 pm** in the Lecture Room (Ground Floor, past Cafeteria) at the Cowichan District Hospital (CDH).

Orientation Session - **Saturday, September 23, 2017 from 9 am – 1 pm** in the Lecture Room at CDH. Arrive 5 minutes early.

There will only be the one information and orientation session held. If you are unable to attend you will have to wait until the Fall of 2018 to enter the program. Your application will be held for one year.

Commitment and Training: – you will volunteer from 4 – 6 pm, on your assigned day per week. Your training will begin on "your day**" during the week of Monday, September 25, 2017– Monday, October 2, 2017.**

CONSENT TO A CRIMINAL RECORD CHECK FOR VOLUNTEERS

(WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS)

IMPORTANT: Please read information and instructions on Page 2. To avoid processing delays, ensure all relevant fields are complete and the form is dated and signed.

WORKS WITH (choose one): ☐ children ☐ vulnerable adults ■ children and vulnerable adults
Please verify with your volunteer organization which "works with" category applies to you.

PART 1: APPLICANT INFORMATION

Legal Surname / Last name:	Legal Given / First Name:	Legal Middle Name:

Date of Birth: ____ (YYYY) ____ (MM) ____ (DD) Gender: ☐ M ☐ F Birthplace: _____

Additional Names (Alias, Maiden Name, etc.):

Surname / Last Name:	Given / First Name:	Middle Name:

Residential Address:	City:	Province:	Country:	Postal Code:
Mailing Address (If Different from above):	City:	Province:	Country:	Postal Code:

Contact Area Code & Phone No.	Driver's Licence #:

PART 2: VOLUNTEER ORGANIZATION INFORMATION

To be completed by an authorized organization representative

SECTION A Complete this section if you have been provided an ID number by the Criminal Records Review Program (CRRP).

Volunteer Organization Name: Island Health (VIHA), Volunteer Resources - Cowichan

Organization Contact Person Name and Title (the person to receive the result of the criminal record check):
Jane Balfour, Manager Volunteer Resources - Cowichan

ID Number (Provided by the CRRP): 1438366

SECTION B If you are unable to provide an ID Number please complete ALL of Section B.

Volunteer Organization Name:

Organization Contact Name or Title (The person receiving the result of the check):

Mailing Address:	City:	Province:	Country:	Postal Code:

Office Area Code & Phone No:	Oganization E-Mail Address:

SECTION C

Volunteer's position/Job Title with volunteer organization: Auxiliary to CDH -

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGMENTS:

I have read and understand the consent for release of information and acknowledgments on Page 2.
I hereby consent to these terms as indicated by my signature below:

Applicant Signature _____ Date Signed YYYY / MM / DD _____

Phone: toll-free 1-855-587-0185 (Option 2) **Fax:** 250-953-0408 **Email:** criminalrecords@gov.bc.ca
Website: http://www2.gov.bc.ca/gov/content/safety/crime-prevention/criminal-record-check

Ministry of Public Safety and Solicitor General
Criminal Records Review Program
Policing and Security Programs Branch, Security Programs Division
PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1

CONSENT TO A CRIMINAL RECORD CHECK -- VOLUNTEERS

CHECKLIST FOR APPLICANT

To get started: My organization has either directed me to complete the paper consent to a criminal record check form and fax or mail to the Criminal Records Review Program or my organization is registered with the CRRP and enrolled for the online service and has provided me with their unique link to go online and complete the consent to criminal record check electronically.

- ☐ - I have completed the form truthfully, clearly and legibly and signed and dated.
- ☐ - I have read and understand the Consent for Release of Information and Acknowledgements and information regarding the Freedom of Information and Protection of Privacy Act (FOIPPA)
- ☐ - My volunteer organization has verified my ID in person to confirm my identity and information on the consent form is accurate.
- ☐ - My volunteer organization will retain the original form and will forward a copy to the Criminal Records Review Program.

CHECKLIST FOR ORGANIZATION

- ☐ - The volunteer / applicant will provide you with the original, completed and signed consent form.
- ☐ - Retain the original form(s).
- ☐ - Forward a copy of the form to the Criminal Records Review Program by mail, fax or email:

  MAIL: Criminal Records Review, Ministry of Justice, PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1
  FAX: 250-953-0408
  EMAIL: criminalrecords@gov.bc.ca

- ☐ - Verify the ID of each volunteer / applicant in person to confirm their identity and to ensure the information matches what was provided on the consent form. NOTE: Please use a Canadian Driver's Licence if the applicant has one.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. Criminal Records Review Act

- ☐ - I hereby consent to a check for records of criminal charges and convictions to determine whether I have a conviction or outstanding charge for any relevant or specified offence(s) under the Criminal Records Review Act;
- ☐ - I hereby consent to a check of all available law enforcement systems, including any local police records.
- ☐ - I hereby consent to a vulnerable sector search to check if I have been convicted of and been granted a pardon for any sexual offences of the Criminal Records Act.
- ☐ - I understand a criminal record check under the criminal records review act is required at least once every five years. Go to the RCMP website for additional details on vulnerable sector checks: http://www.rcmp-grc.gc.ca/en/faqs-about-vulnerable-sector-checks
- ☐ - I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court, corrections, and crown counsel relating to an outstanding charge or conviction of any relevant or specified offence(s) as defined under the Criminal Records Review Act or any police investigations deemed relevant by the Registrar.
- ☐ - Where the results of this check indicate that a criminal record or outstanding charge for a relevant or specified offence(s) may exist, I agree to provide my fingerprints to verify any such criminal record.
- ☐ - The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant or specified offence(s) and the matter has been referred to the Deputy Registrar;
- ☐ - The Deputy Registrar will determine whether or not I present a risk of physical or sexual abuse to children and / or physical, sexual or financial abuse to vulnerable adults as applicable.
- ☐ - The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant or specified offence(s) for which I have received a pardon.
- ☐ - If I am charged with or convicted of a relevant or specified offence(s) at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new signed Consent to a Criminal Record Check form.

***FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT* (FOIPPA):** The information requested on this form is collected under the authority of the *Criminal Records Review Act* section 4(1) and section 26(c) of the *Freedom of Information and Protection of Privacy Act* (FOIPPA). The information provided will be used to fulfil the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA. If you have questions about the collection of your personal information, please contact the Policy Analyst, Criminal Records Review Program, PO Box 9217 Stn Prov Govt, Victoria, BC V8W 9J1 or by phone at 1-855-587-0185.

VOLUNTEER RESOURCES
VOLUNTEER APPLICATION FORM

Island Health Site: COWICHAN

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 ☐

island health

VOLUNTEER RESOURCES - COWICHAN

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

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

_____ _____
MANAGER, VOLUNTEER RESOURCES 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**

STANDARDS OF CONDUCT, RESPECTFUL WORKPLACE AND ACCEPTABLE USE OF ASSETS POLICIES

These policies have been provided to you and/or can be found on the Island Health website at http://www.viha.ca/volunteer_resources/policies_and_procedures.htm. 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 the following Island Health's policies: (Separate documents)

- Respectful Workplace Policy
- Island Health Volunteer Resources Standards of Conduct
- Acceptable Use of Assets and Resources Policy

VOLUNTEER RESOURCES - COWICHAN

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.

If you agree to the above, please indicate if you have any disaster management training or experience:

_____

*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