VOLUNTEER APPLICATION

Name: ______________________________________ **Email:** ______________________________

Address: ____

City: ______________________________ **State:** _____ **Zip:** ________ **Birthday:** __________

Home Phone: _______________________ **Secondary Phone:** __________________________

Emergency Contact: ______________________ **Emergency Contact Phone:** ______________

Circle all your areas of interest:

- ☐ Clerical Mailings
- ☐ Fund Raising
- ☐ Men's Club
- ☐ Guild
- ☐ Patient Interaction:
- ☐ Resource Center
- ☐ Patient Greeter
- ☐ Health Fairs / Expos
- ☐ Library
- ☐ Special Events
- ☐ Other: __________

Special Skills or Interests: ____

Days of week/hours available: ____

I would like to volunteer:

- ☐ Regularly
- ☐ Once a Week
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ On-call

Do you have any limitations that should be considered? ☐**Yes** ☐**No**

If yes please explain: ____

List your volunteer experience: ____

How did you hear about volunteering at the Cancer Center? ____________________________________

I understand that all information on this form is voluntarily supplied and may be used and disclosed for volunteerism purposes only. I hereby volunteer my services.

Volunteer signature: ______________________________Date:_____________________

Please return this form to: Tri-Cities Cancer Center Attn: Kim Berg, Volunteer Coordinator
7350 W. Deschutes Ave., Kennewick, WA 99336
(509) 737-3434 Fax (509) 737-3487 kberg@tccancer.org

VOLUNTEER APPLICATION

CONFIDENTIALITY STATEMENT FOR VOLUNTEERS

CONFIDENTIALITY OF PATIENT AND EMPLOYEE INFORMATION

PURPOSE: To communicate the importance and imperative need to protect confidentiality for the patients and employees of the **TRI-CITIES CANCER CENTER**

POLICY: It is a primary responsibility of all volunteers to protect the confidentiality of the **TRI-CITIES CANCER CENTER'S** patients and employees. Breach of confidentiality is the repeating of any information, written or spoken, where unauthorized or indiscreet disclosure could be harmful or injurious to the interests of a patient or an employee.

Patient information, medical records, employee personnel records, financial reports or fundraising donor records are private and of a sensitive nature and are considered **STRICTLY CONFIDENTIAL**. **THIS INFORMATION SHOULD NEVER BE DISCUSSED WITH ANY OTHER PERSON.**

VIOLATIONS: ANY VOLUNTEER WHO IS FOUND TO HAVE VIOLATED THE CONFIDENTIALITY POLICY WILL BE SUBJECT TO DISCIPLINARY ACTION THAT MAY INCLUDE SUSPENSION AND/OR IMMEDIATE DISCHARGE.

I have read and understand the **CONFIDENTIALITY OF PATIENT AND EMPLOYEE INFORMATION POLICY** listed above. I understand the contents and agree to comply with this policy as stated.

VOLUNTEER SIGNATURE ____DATE_____________

VOLUNTEER COORDINATOR_____________________________________DATE_____________