

## General Volunteer Onboarding

This application is for those who would like to volunteer with South Peninsula Hospital at events, as greeters, in the gift shop, etc. If you're interested in volunteering in Long Term Care, there are additional requirements: please contact Katy Edens at [kedens@sphosp.org](mailto:kedens@sphosp.org) or 907-235-0859.

Before you are able to volunteer, please complete the following steps in order:

### 1. Complete Application

- Completed applications (pages 2-3) can be emailed to [marketing@sphosp.org](mailto:marketing@sphosp.org) or dropped off at registration at the main entrance.

### 2. Employee Health Onboarding

- Set up a meeting with Employee Health at [employeehealth@sphosp.org](mailto:employeehealth@sphosp.org) or 907-235-0227.
- Scheduling is required.
- Complete the attached health packet (pages 4-8) in advance and bring it to your meeting.

### 3. Background Check

- Set up a meeting with Human Resources at [hr@sphosp.org](mailto:hr@sphosp.org) or 907-235-0951.
- Scheduling is required.
- Complete the attached criminal background check (pages 9-11) and bring it to your meeting.
- This meeting will include fingerprinting and taking the photo for your ID badge.

### 4. Orientation Forms

- After Employee Health and Human Resources have processed their packets, the Marketing department will reach out with the volunteer education packet.
- Complete these forms and return to [marketing@sphosp.org](mailto:marketing@sphosp.org).

### 5. ID badge

- Set up a time to pick up your ID badge at Security at 907-235-0870.
- This is to be worn at all times while volunteering at or on behalf of SPH.

### 6. Department-Specific Training

- Attend any other orientation or training required by the department in which you are volunteering. These trainings will be discussed when you are sent your orientation forms.

We understand that these requirements are extensive, but they are the same for all paid and volunteer staff, and they are integral to the high standards of patient care and safety that SPH maintains.

## South Peninsula Hospital Auxiliary

All volunteers are invited to join the Auxiliary, a dues-paying club (\$15 per year) that meets monthly in support of South Peninsula Hospital's mission. You will receive an invitation with more information upon submission of your volunteer application.





# Volunteer Application

South Peninsula Hospital  
4300 Bartlett Street Homer, AK 99603

Full Name: \_\_\_\_\_  
(First) (MI) (Last)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Are you 18 years old or older?  Y  N

Education

High School: \_\_\_\_\_

College: \_\_\_\_\_

Community Affiliations

Please list other local clubs or non-profits you are involved in: \_\_\_\_\_

Do you have any healthcare training or qualifications?  Y  N If so, please list: \_\_\_\_\_

Describe any other special job skills or abilities: \_\_\_\_\_

Do you have a valid driver's license?  Y  N

Volunteer Interests

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Greeter           | <input type="checkbox"/> Waiting Rooms     | <input type="checkbox"/> Computer/Clerical |
| <input type="checkbox"/> Gift Shop         | <input type="checkbox"/> Patient Companion | <input type="checkbox"/> Hospital Events   |
| <input type="checkbox"/> Educational Tours | <input type="checkbox"/> Pet Therapy       | <input type="checkbox"/> Community Events  |

Work Experience

Please list your most recent work or volunteer experience:

Name of Employer/Organization: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates Employed: \_\_\_\_\_ to \_\_\_\_\_

Description of duties: \_\_\_\_\_

\_\_\_\_\_

Supervisor/Contact: \_\_\_\_\_

Contact Number: \_\_\_\_\_ May we contact this person?  Y  N

Background Information

Have you been convicted of a criminal offense (not including minor traffic violations) within the past five years?

Y  N (A "Yes" answer to this question will *not* necessarily disqualify any applicant).

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact Information

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Applicant Agreement:

I affirm that the information provided on this application is true and complete.

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

If under the age of 18, a parent or legal guardian must sign and date.

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

## Please bring immunization or lab immunity records

- Staff are required to be immunized or to exhibit lab immunity against Measles, Mumps, Rubella and Varicella (Chickenpox). There is no declination for this.
- Staff are required to show immunity by lab titers or be lab tested on hire for immunity to Hepatitis B. If non-immune, staff are required to get immunized against or sign a declination for Hepatitis B vaccine.
- Staff are required to be immunized against or sign a declination for Influenza (Flu) from Sept.1-April 30
- Staff are required to have a recent (within 6 months) QFT or other IGRA lab test for Tuberculosis upon hire.
- COVID vaccination is not required, if you have been vaccinated please provide proof of most recent dose.

*Revised 07.25.2024*

## EMPLOYEE HEALTH REQUIREMENTS FOR WORKFORCE MEMBERS

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To protect you, your coworkers, and our patients we need the following health requirements to be completed before you begin your regular work assignment/rotation/shadow.

**Please provide documentation to Employee Health**

<b>Health Requirements</b>	
<b>Measles, Mumps, Rubella (MMR)</b> – documentation of complete vaccine series and/or positive laboratory titers	
<b>Varicella (Chicken Pox)</b> – documentation of complete vaccine series and/or positive laboratory titers	
<b>Hepatitis B</b> – Documentation of laboratory titers	
<b>Tuberculosis Testing</b> – Quantiferon or other IGRA blood test within the last 6 months  <b>If history of positive</b> – provide copies of chest x-ray results within the last 12 months and medical clearance note	
<b>Annual Flu Vaccine</b> – documentation of vaccine, or signed SPH declination form, or SPH Employee Health can administer	
<b>COVID Vaccine</b> – vaccination is not required, however if vaccinated please provide proof or write date of last dose: _____	
View Assigned Videos	
<b>Employee Health Packet</b> – completed Employee Health packet and reviewed onboarding presentation	

I hereby attest that I provided Employee Health all of the necessary documentation as outlined above in order to meet the health requirements of South Peninsula Hospital.

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Signature Date

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Printed Name

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Employee Health Signature Date

**EMPLOYEE HEALTH**  
**EMPLOYEE DEMOGRAPHIC INFORMATION**

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Legal name:

First name you commonly use:

Any other names you have used in the past, including maiden names:

Allergies (include latex if applicable):

SPH ID: (OK to leave blank if unknown):

Have you ever been employed by SPH before?:

DOB:

Department:

Position:

Start date:

End date (if applicable):

Status (check one): full time      part time      casual

Status (check one):

Employee	Traveler	Clinical Student	Volunteer	Provider
Board of Directors	Security	Construction		

Address:

Phone number:

Personal email:

## Employee Health: Tuberculosis (TB) Risk Assessment & Screen

Return completed form to Employee Health

<b>Name:</b>	<b>Date of Birth:</b>	<b>Date:</b>
<b>Department:</b>	<b>Position:</b>	<b>Phone:</b>

- A.** Have you ever had a positive TB skin test / Quantiferon blood test?  Unknown  No  Yes  
 If yes, year: \_\_\_\_\_
- Date of last chest x-ray (if known): \_\_\_\_\_
  - History of treatment?  No  Yes
- If yes, date: \_\_\_\_\_ Medication: \_\_\_\_\_ Duration: \_\_\_\_\_

<b>B. The following symptoms are common with TB infection. Please indicate if you are currently experiencing any of the following symptoms:</b>	No	Yes
• Chronic unexplained cough/persistent cough for more than 3 weeks at a time	<input type="checkbox"/>	<input type="checkbox"/>
• Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
• Coughing up blood or sputum	<input type="checkbox"/>	<input type="checkbox"/>
• Sweating at night	<input type="checkbox"/>	<input type="checkbox"/>
• Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
• Chills	<input type="checkbox"/>	<input type="checkbox"/>
• Persistent fever	<input type="checkbox"/>	<input type="checkbox"/>
• Weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
• Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain: \_\_\_\_\_

**C. Individual TB Risk Assessment:**  
 HCP considered at increased risk for TB if number 2, 3, or 5 below are marked "Yes"

1) Where were you born:  USA  Other: \_\_\_\_\_ - Year of arrival in USA: \_\_\_\_\_

	No	Yes
2) Temporary or permanent residence of $\geq 1$ month in a country with a high TB rate <i>Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe</i>	<input type="checkbox"/>	<input type="checkbox"/>
3) Close contact with someone who has had infectious TB disease since your last TB test	<input type="checkbox"/>	<input type="checkbox"/>
4) Had any live vaccines within 30 days? May interfere with QFT result (MMR, Varicella, Flu Mist, Typhoid)	<input type="checkbox"/>	<input type="checkbox"/>
5) Current or planned immunosuppression <i>Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone <math>\geq 15</math> mg/day for <math>\geq 1</math> month) or other immunosuppressive medication</i>	<input type="checkbox"/>	<input type="checkbox"/>

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Health Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### General Orientation: Employee Health

Employee Name (print): \_\_\_\_\_ Position: \_\_\_\_\_

Training was provided to me during regular working hours in a manner understandable to me and included information about Employee Health requirements, Hepatitis B immunization, infectious and reportable conditions, bloodborne pathogen exposure (BBPE), workplace injuries and illnesses and access to Employee Health records. I was given the opportunity to ask questions which were answered to my satisfaction.

1. I understand SPH Employee Health requirements and guidance including respiratory protection and PPE, TB screening, lab testing, immunities and immunizations, and where related policies, guidelines and protocols can be found on the Staff Information Site (SIS).
2. I understand that all required and some optional vaccinations, including the Hepatitis B vaccine, are provided at no cost, and are available at any time during employment with SPH by contacting Employee Health.
3. Employee Illness: I understand that I am to report to Employee Health any infectious or foodborne conditions I may have or may have been exposed to per HW-103, which are on the SIS, in order to determine work limitation, exclusion, and required tracking per state regulations.
4. For any workplace injury or illness, I will notify my supervisor and contact Medcor (SPH staff) or my school/agency (all others) as is required. I will go to the ER for care of all BBPE's and urgent/emergent occupational injuries or illnesses.
5. Record keeping and access to employee health medical/exposure records: I understand Employee Health records are maintained per OSHA standard 1910.20 and are available to me upon request.
6. I understand that BBPE policies, protocols and guidelines are located on the SIS, I am aware that I can ask my manager or Employee Health for guidance. I understand that bloodborne pathogen exposure requires immediate action including but not limited to: immediately washing/flushing the affected area, contacting your supervisor and going to the ER for a medical evaluation. I understand post-exposure protocol may include initial care, post-exposure prophylaxis treatment and follow-up.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed/reviewed by Employee Health staff on: \_\_\_\_\_ Signature: \_\_\_\_\_

*Revised 07.25.2024*





Alaska Background Check Application

\*Asterisks mark required fields. Applications will not be processed without complete information.

Personal Information

Full Legal Name: Last First M.I. Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address: Physical Street Address Apartment/Unit # City State ZIP Code

Mailing Address (if different than Permanent/ Physical Address): Mailing Address Apartment/Unit # City State ZIP Code

Primary Phone: ( ) Secondary Phone: ( )

\*Applicant's Email Address:

\*SSN (or ITN) : This is an ITN

Demographic Information

\*Race: (Asian, Black, White Native American, or Unknown) \*Gender: (Male, Female, Unknown, Other) \*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) \*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) \*Height: FT IN \*Weight: Lbs. \*Place of Birth (Country/State): US Citizen(Y/N):

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: Middle Name: SSN/ITN: This is an ITN Date of Birth: (mm/dd/yyyy)

First Name: Middle Name: SSN/ITN: This is an ITN Date of Birth: (mm/dd/yyyy)

**Prior Address History**

**Prior Addresses in the last 10 years:** Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ **to** \_\_\_\_\_

State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ **to** \_\_\_\_\_

State: \_\_\_\_\_ Year(s) From: \_\_\_\_\_ **to** \_\_\_\_\_

**Pre-Employment Information**

~~**Pre-Employment Information:** Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.~~

~~Provider Name: \_\_\_\_\_~~

~~State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: \_\_\_\_\_~~

~~Position Title: \_\_\_\_\_~~

~~Position Type: \_\_\_\_\_  
(Employee/Independent Contractor/Volunteer/Other)~~

**Instructions**

1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: <https://nabcs.dhss.ak.local/bcpapplicant>. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are \$76.50 and are **not refundable.**
5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
7. A complete application includes this application form, non-refundable payment in the amount of \$76.50, and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, \_\_\_\_\_, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, \_\_\_\_\_, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



## RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

\*\*\*This form must be signed by the applicant for a background check and must be maintained in the individual's personnel file. If requested by the department, the form must be provided within 24 hours.\*\*\*

I, \_\_\_\_\_, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, \_\_\_\_\_, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

I, \_\_\_\_\_, understand that upon submission of my fingerprints will be used to check the criminal history records of Alaska and of the Federal Bureau of Investigations (FBI).

I, \_\_\_\_\_, understand that procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.

\*\*\*This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.\*\*\*

\_\_\_\_\_  
Printed Name of Applicant (must be legible)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Applicant's SSN

\_\_\_\_\_  
Parent Printed Name, if applicable (must be legible)

\_\_\_\_\_  
Parent Signature.