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Non-Compensated Workforce Member Application

(Student, Intern, Volunteer) **Date**_____

Name: (last, first, Middle)	Home Phone: ( )
Address:	Work Phone: ( )
City: Zip:	Cell Phone: ( )
Email Address:	Date of Birth:
Driver's License Number:	State:
Maiden name/other names used:	*U.S. Citizen?* □ *Yes* □ *No*

Have you worked in any capacity for either Avamere or Signature?

□ Yes □ No If yes, please explain:

How did you learn of this opportunity?

Referred by_____ Newspaper ad:_____ Event:_____

(e.g., Conference, In-Service Presentation Career/Volunteer Fair, etc.)

Website: _____ Flyer (location):_____

Hours available per week: _____ □ Morning □ Afternoon □ Evening	Days of the week available: □ SUN □ MON □ TUE □ WED □ THU □ FRI □ SAT

Areas of Interest

Please list which role(s) within that you are interested in:

___Patient Care (clinical) _____Patient Care (non-clinical) ___ Bereavement Support ___ Office Work
___ Special Projects _____ Group/Patient Activities

Internship

If you are applying under a student internship program, please provide following:

University:

Major:_____ Year of study:_____

Professor:

Telephone:_____ Email:_____

Previous Practicum/Internships:

Volunteer Experience:

Organization:	Role/Duties:

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Organization:	Role/Duties:

Education History:

School | Certificate/Degree/Major | Graduate or Year of Study

Employment History

Current/Most recent employer: _____

Company Name | Supervisor Name | Phone #

Dates of Employment: Job Title: Duties:

Volunteer Areas of Interest:

Please circle the areas of interest and/or particular skills and talents you may have.

Patient Care

Companionship Reading Pet assisted visits _____

Type/breed of pet | certified | non-certified

Current Events Respite Care: Light Housekeeping Running Errands Shopping Cooking

Music: Singing/Playing Instrument _____

(instrument/type of music)

Board Games Cards Chess Cribbage Art & Crafts Gardening

Languages: _____ fluent conversational understand enough

Special Projects

Quilting Knitting Sewing Needlework Card-making

Administrative

Office/Clerical Work Computer/Data Entry Telephone/Reception Project Development

Newsletters Video/Presentation Production Community Education Public Speaking

Other Interests: _____

_____

Signature Date

Avamere does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its program, services and activities, or in employment.

Please complete and return this application to the facility

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Acknowledgement of Volunteer Obligations

I voluntarily and knowingly authorize any present or past employer or supervisor, education institution, administrator, law enforcement agency, state, local, federal agency, DHS OIG, National Health Care Provider Database, personal reference and/or any persons to give records or information they may have concerning my criminal, motor vehicle, license or employment history or any other information request by Signature Hospice deemed pertinent to my volunteer work.

All offers of volunteer opportunities are contingent upon the following:

1. You are legally eligible to work/volunteer in the United States.
2. Verification of information provided by you on your volunteer application
3. We receive a satisfactory response to the complete background investigation which includes, but is not limited to criminal history search, social security trace, motor vehicle report, and other such searches as required by the position for which you are applying.
4. Verification of a valid license or certification as required by the position for which you are volunteering.
5. Proof of satisfactory Tuberculosis screening.
6. Proof of valid automobile insurance and driver's license

Signature Hospice looks forward to working with you! Your agreement to the above is acknowledged by signing below.

Printed Name _____

Signature_____Date _____

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7632 SW Durham Rd Ste 130
Tigard, OR 97224
toll free 800-936-4756
fax 503-682-3989

AUTHORIZATION / RELEASE OF LIABILITY
TB TEST

Printed Name ____ DOB______________________

_____ EMPLOYEE _____ VOLUNTEER

I have reviewed the Signature Hospice policies and procedures and understand that testing for Tuberculosis upon hire and periodically thereafter is required. I agree to the testing as required and release Signature Hospice from any liability for any complications that may present as a result of such TB testing.

____ ______________________
Employee/Volunteer Signature Date

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AUTHORIZATION TO OBTAIN CRIMINAL BACKGROUND (CONSUMER) REPORT PURSUIT TO 15 U.S.C. 1681b(b)(2)(B) AND RELEASE OF INFORMATION FOR EMPLOYEES AND CONTRACTORS

I authorize this Company, and/or a third party designee, to conduct an inquiry into my background. I understand that an inquiry may include, but is not limited to, criminal records, personal or professional references, Federal and state exclusions databases, driving record, education verification, licensure verification and any other matter related to my suitability, depending on my position. An inquiry may be made as part of the screening process as well as at any time during the course of employment or work with this company. No additional notice or authorization shall be needed for future inquiries and/or to obtain additional criminal background or driving record reports.

I hereby release this Company, its designee, my former employers and all references, from any and all claims, demands or liabilities arising out of or related to such investigation or disclosure.

Third Party Designee Criminal Background Checks: If a third party designee (background check vendor) was conducted rather than a state police criminal background check, I understand that I have the right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of any investigative consumer report requested by you. I further understand that if any adverse action is taken based on the information provided in any report, I have a right to receive a copy of my rights under the FCRA and a copy of any report received, with the exception of the LEDS report.

Name of employee/volunteer/contractor: _____
(Please print)

Date:_____ **DOB:**_____ **SSN:** _____

Address: _____ **City:** _____

State:_____ **Zip Code:** _____ **Signature:**_____

Please note: SSN and Date of birth are used <u>only</u> for background screening identification purposes. This company recognizes and abides by the Age Discrimination in Employment Act (ADEA), as well as, state and local Equal Employment Opportunity Commission (EEOC) laws. The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are over 40 years of age.

This authorization and disclosure is pursuant to the Fair Credit Report Act, 15 U.S.C. 1681b(b)(2)(B).

During the past 3 years, have you been outside Oregon 60 or more days in a row?

☐ **No** ☐ **Yes** If yes, list below where and when.

City / State / Country	From (Month/Yr)	Until (Month/Yr)

Have you been convicted of a felony in Oregon in the last 7 years?

☐ **No** ☐ **Yes**

Have you ever been convicted of a felony outside Oregon in the last 7 years?

☐ **No** ☐ **Yes** If yes, list below where and when.

City / County / State	**Date** (Estimate if unknown)

Please list ALL names ever used:

(Maiden or married, first and last names)

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Authorization for Release of Driving Record and Motor Vehicle Records (Employment)

I, _____ do herby authorize and allow OpenOnline / SelectHire, acting as an agent, to obtain a copy of my driver's license record/abstract information, which may include personal information, to be used for verification of information and for Employment purposes, and to release my information to:

Company: **Signature Hospice, Home Health & Home Care**
Address: **25117 SW Parkway, Suite F**
Wilsonville, OR 97070

Drivers Full Name (please print): _____

DL #: _____ State: _____*

DOB: _____ / _____ / _____

PLEASE SUBMIT A PHOTOCOPY OF DRIVERS LICENSE WITH THIS AUTHORIZATION

Driver Signature: _____ Date: _____ / _____ / _____

*State specific DL authorization form received:

____ New Hampshire
____ Pennsylvania
____ Washington
____ Canada
____ British Columbia
____ Quebec