# Volunteer Services – Application Process, Timeline, and General Policies
# HEALING MUSIC PROJECT

1. Please complete and return the following paperwork to the Volunteer Services Program (address below):
   a. Musician Application (2 pages)
   b. Copy of your driver's license (or state ID card)
   c. Confidentiality Agreement
   d. Letter of Understanding
   e. Criminal History Information
   f. Volunteer Disclosure and Authorization Form
   g. Two (2) Personal Reference Forms

2. We conduct a criminal background check on all volunteer applicants. This information is kept confidential and in a secured location at all times.

3. Send the personal reference forms to two people (non-family members only), and ask them to return the forms to the Volunteer Services Program within one week of you submitting your application.

4. You will receive an email/phone call from the Volunteer Services Coordinator to confirm that your application has been received. Within two weeks of receipt, you will receive further communication regarding your acceptance to the Healing Music Program at the Seattle Cancer Care Alliance and to discuss scheduling.

5. Healing Music Volunteers who play regularly (at least once a month) in the SCCA's outpatient clinic will be issued a photo ID badge that must be worn when volunteering. Healing Music Volunteers who schedule less frequently will be required to wear a generic ID badge when volunteering.

6. For the safety of our patients, all volunteers must be in good health (no cold or flu-like symptoms) if scheduled to perform. If you are ill and need to cancel your performance, please call the Volunteer Coordinator at 206.288.1072. If you suffer from allergies and KNOW they are allergy symptoms, this is acceptable provided your symptoms are under control.

7. If you volunteer to play at least once a month in the SCCA outpatient clinic and/or Hutch School, you will need to follow the same medical compliancy as our regular volunteers and SCCA staff. You will be required to receive **two** tuberculosis (TB) baseline tests at least one week apart and a follow-up exam after each TB test with 48-72 hours (or show documentation of recent TB testing). Individuals who have had a positive reaction to a TB test can request an exemption from annual TB testing. Annual tuberculosis testing and documentation for Chickenpox (Varicella), Measles, Mumps and Rubella are required for all volunteers who have contact with patients. If you are unable to find the proper documentation, a small blood sample will be taken to prove immunization and/or immunity. In addition, volunteers between the ages of 19 and 64 are required to receive a single dose of Tdap vaccine to protect against tetanus, diphtheria and pertussis. **Any medical testing or vaccinations that we require are provided free of charge by our Occupational Health nurses** so please don't feel you need to visit your private physician for these requirements.

8. The dress code for Healing Music Volunteers includes the following: conservative and clean clothing, and no heavy scents such as perfumes, after shave, lotions, etc. Our patients are very sensitive to aromas following some treatments so scents must be kept to a minimum. No shorts but nice blue jeans are allowed.

9. Upon acceptance to the SCCA's Healing Music Program and prior to your first performance, you will be sent an "orientation packet", either electronically or by mail if you prefer. Inside will be the logistics for volunteering at the SCCA: where to park, how to get your parking validated to receive FREE PARKING, check-in instructions, etc. The packet will also contain information about the SCCA, its mission, who our patients are, etc. You will be required to take a short, self-guided orientation on information important to your volunteering at the SCCA. Our organization, staff and volunteers are subject to inspections by regulatory agencies and this orientation will give you the tools to be able to answer any questions posed to you, enable you to react appropriately in case of emergency, and to ensure that you have a quality volunteer experience.

10. And lastly, thank you so much for wishing to be a part of the Healing Music Program at the Seattle Cancer Care Alliance! We look forward to receiving your application and to schedule you to perform as soon as possible. If you have any questions, please call the Volunteer Services Coordinator at 206.288.1072.

****Please return your application, forms (7 pages total) and a copy of your driver's license to:**

Volunteer Services Program
Seattle Cancer Care Alliance
825 Eastlake Avenue East, LA-201
P.O. Box 19023
Seattle, WA 98109-1023 Fax: 206.288.1074

**Seattle Cancer Care Alliance / Volunteer Services Program**
**Healing Music Project - MUSICIAN APPLICATION**

Name ______________________________ Preferred Phone ______________________

Street Address ____________________________ Secondary Phone ______________________

City / Zip ______________________________ Email __________________________________

In case of an emergency, please notify: ________________________ Telephone ___________________

**PLEASE TELL US ABOUT YOURSELF AND YOUR MUSIC:**

☐ **Individual** *Please list instrument(s):* ______________________________________________________

☐ **Group member** *Type of music:* ________________________________________________________

*Level of play:* ☐ **Student**
☐ **Professional** *(full or part-time employment as a musician)*
☐ **Dedicated hobbyist** *(background in music but does not play professionally)*

*Please give us a short description of your music:* _________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

*If you have a website, MySpace page or YouTube posting, please provide the web address so that we can hear a sample of your music:* _________________________________________________________________

______________________________________________________________________________________

**VOLUNTEER SERVICE PREFERENCES AND AVAILABILITY**

Please let us know which facility you would like to volunteer at, as well as your availability. In many cases, your availability will determine which facility (or specific floor/clinic) you will be able to volunteer. *The SCCA Clinic has the greatest need for musicians and weekday/daytime availability is required.*

Place a check mark next to the type of volunteer service that you would like to provide – if you are interested in multiple areas, please place a number next to the facility in the order of your preference:

☐ **Seattle Cancer Care Alliance Outpatient Clinic** *(825 Eastlake Avenue E, Seattle/South Lake Union)*
☐ **Hutch School** *(525 Minor Avenue N, Seattle/Mercer/South Lake Union)*
☐ **Special Events** *(holiday events, remembrance services, etc.)*

**Availability:**

☐ **Weekdays** *(1-2 hour block between 9am – 4pm) Day/Time preferred:* ___________________________
☐ **Availability for Special Events** *Day/Time preferred:* ______________________________________

**Frequency:**

☐ **Once a week** ☐ **Once a month** ☐ **Quarterly** ☐ **Once a year** ☐ **Other** __________________

*Why would you like to be a part of our Healing Music Program?*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

*How did you hear about us?* ____________________________________________________

______________________________________________________________________________

**List the two (2) non-family members you have asked to complete the Personal Reference Forms:**

1.

2.

____________________________________ ________________________

Applicant's Signature Date

**Applications can be mailed to:**

Volunteer Services Program
Seattle Cancer Care Alliance
825 Eastlake Avenue East, LA-201
P.O. Box 19023
Seattle, Washington 98109-1023 FAX: 206.288.1074

**VOLUNTEER SERVICES STAFF:** **Date Received:** _____________

**Notes:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Paperwork Complete:**

- ❑ **Application**
- ❑ **Copy of Drivers License**
- ❑ **Confidentiality Agreement**
- ❑ **Letter of Understanding**
- ❑ **Criminal History Information**
- ❑ **Disclosure and Authorization Form**
- ❑ **Personal Reference #1**
- ❑ **Personal Reference #2**

**Badge type (based on frequency of performances):** ________________________

**Medical requirements (based on frequency of performances):** ________________________

**Seattle Cancer Care Alliance / Volunteer Services Program**

# HEALING MUSIC PROJECT

## CONFIDENTIALITY AGREEMENT FOR VOLUNTEERS

Patients, family members and caregivers act in good faith, expecting their medical and personal circumstances to remain confidential. Volunteers are obligated by law and ethics to reciprocate.

1. No medical or personal information about a patient or family (e.g. a patient's diagnosis and medical progress, family conflict issues, financial issues) may be discussed, except when it is appropriate within the Volunteer Services Program. For example, a patient/family's circumstances may be discussed with Hutchinson Center and Seattle Cancer Care Alliance staff, for the purposes of problem solving and guidance for the volunteer.

2. The medical and social work staff will not share patient information with volunteers, except when it is clinically appropriate. Likewise, as a confidant to the patient/family, a volunteer should share confidential information with the medical and social work staff only if a person may be in jeopardy.

3. Volunteers may not read patients' clinical charts.

4. Discussing a patient's medical status or a family's personal matters outside of the Volunteer Services Program, even though names were not revealed, will be considered a breach of confidentiality, and will result in dismissal from the program. That is, one might describe a situation in detail and never mention names or other descriptive information, and still reveal enough information to enable the listener to identify the patient or family.

5. The volunteer may share his/her emotional reactions with his/her family and friends, but should refrain from discussing details of a patient's or family member's personal circumstances.

6. When participating in a Volunteer Services Program's volunteer support group, all discussions must be kept confidential. In addition, volunteers should not discuss a patient/family's personal issues in a manner, which discloses the patient's identity at support group meetings. Please discuss these issues with the Manager of Volunteer Services or your volunteer supervisor at the Seattle Cancer Care Alliance.

7. If a case has been made public by the news media, the patient and family still have confidentiality rights.

8. The volunteer should consider the following questions before sharing information about a patient or family member:
   a. Why do I need to discuss this situation with another person?
   b. Why does the third party need to know the specifics of this situation?

9. Breaking confidentiality should be considered only when:
   a. The safety of the patient or family member is endangered (e.g. a post-transplant outpatient has no caregiver, child abuse or neglect, a plan to commit suicide, substance abuse).
   b. The safety of a third party is endangered (e.g. threats to harm physicians or nurses).
   c. The general welfare of society is endangered (e.g. person has firearms or explosives).

**I agree to abide by these confidentiality guidelines, and understand that a breach of confidentiality is grounds for dismissal from the FHCRC/SCCA Volunteer Services Program.**

**In addition, unauthorized disclosure of patient information is subject to civil and federal penalties.**

**Signature** ________________________________________ **Date** ____________________________

**Printed Name** _____________________________________

**Seattle Cancer Care Alliance / Volunteer Services Program**

## HEALING MUSIC PROJECT

## LETTER OF UNDERSTANDING FOR VOLUNTEERS

I have agreed to volunteer time and effort to the Seattle Cancer Care Alliance (SCCA) and Fred Hutchinson Cancer Research Center (FHCRC) to perform activities, which, due to budgetary and other considerations, are not being performed by regular employees. I understand that I will receive no pay, fringe benefits, or worker's compensation insurance from the SCCA and the Hutchinson Center in my capacity as a volunteer.

If I am an authorized volunteer driver, I understand that when I transport patients and families I will be using my personal vehicle. I also understand that my personal automobile insurance is the primary coverage and the FHCRC/SCCA's insurance policy is the secondary coverage. In addition, I am responsible for maintaining adequate automobile insurance coverage for my vehicle and will provide proof of active insurance to Volunteer Services annually.

**Signature** ____________________________________ **Date** ________________________

**Printed Name** _________________________________

**SEATTLE CANCER CARE ALLIANCE**

# Volunteer Services
# Conviction/Criminal History Information

Federal Law and Washington State law requires the Seattle Cancer Care Alliance (the "Alliance") to ask prospective applicants (employees, non-employees and volunteers) questions related to criminal history and/or history of healthcare-related offenses. Please complete this form, providing as much detail as requested, before signing and dating the form where indicated. As a matter of policy, the Alliance submits disclosure forms to Intelius Inc. for confirmation of the information disclosed here. As required by law, the Alliance also periodically monitors the Specially Designated nationals ("SDN") and Clocked Persons listings. Questions about the use of conviction/criminal history information in the application process may be referred to Employment Services at (206-667-4700) or Volunteer Services at (206-288-1071)

**Name (Last)** **First** **MI**

**Maiden name/Aliases** **Date of Birth**

**Home Address** **City, State** **Zip, Postal Code**

## 1. CRIMES AGAINST PERSONS AND CRIMES RELATED TO FINANCIAL EXPLOITATION

**Have you ever been convicted of any of the crimes listed below?**

☐ **YES**
☐ **NO**

**If YES, please describe below:**

| | | | | |
|---|---|---|---|---|
| ☐ Arson (1st degree) | ☐ Child Molestation (1st/2nd/3rd Degree) | ☐ Forgery or related crimes | ☐ Murder, Aggravated | ☐ Selling/Distributing Erotic material to a Minor |
| ☐ Assault (1st/2nd/3rd Degree) | ☐ Communication with a Minor | ☐ Incest | ☐ Patronizing a Juvenile Prostitute | ☐ Sexual Exploitation of a Minor |
| ☐ Assault of a Child (1st/2nd/3rd Degree) | ☐ Criminal Abandonment | ☐ Indecent Exposure – Felony | ☐ Promoting Pornography | ☐ Sexual Misconduct with a Minor |
| ☐ Assault, Custodial | ☐ Criminal Mistreatment (1st/2nd Degree) | ☐ Indecent Liberties | ☐ Promoting Prostitution (1st Degree) | ☐ Theft or related crimes (1st/2nd/3rd Degree) |
| ☐ Assault, Simple (4th Degree) | ☐ Custodial Interference (1st/2nd Degree) | ☐ Kidnapping (1st/2nd Degree) | ☐ Prostitution | ☐ Unlawful Imprisonment |
| ☐ Burglary (1st Degree) | ☐ Extortion (1st/2nd/3rd Degree) | ☐ Malicious Harassment | ☐ Rape (1st/2nd/3rd Degree) | ☐ Vehicular Homicide |
| ☐ Child Abandonment | | ☐ Manslaughter (1st/2nd Degree) | ☐ Rape of a Childe (1st/2nd/3rd Degree) | ☐ Violation of Child Abuse |
| ☐ Child Abuse or Neglect | | ☐ Murder (1st/2nd Degree) | ☐ Robbery or related crimes (1st/2nd degree) | ☐ Restraining Order |
| ☐ Child Buying or Selling | | | | |

**2. DRUG_RELATED CRIMES**

**Have you ever been convicted of a crime related to the manufacture of, delivery of, or possession with intent to manufacture of deliver a controlled substance?**

- ☐ **YES**
- ☐ **NO**

**3. RELATED PROCEEDINGS**

**Have you ever been found in a dependency action, domestic relations proceedings, disciplinary board hearing, or protection proceeding to have: sexually assaulted or exploited, sexually or physically abused, a minor or developmentally disabled person OR to have financially exploited or abused a vulnerable adult?**

- ☐ **YES**
- ☐ **NO**

**4. GENERAL CONVICTION INFORMATION:**

**Aside from those crimes listed above, within the past 10 years have you ever been convicted of any other crimes, excluding parking tickets/minor traffic citations?**

- ☐ **YES**
- ☐ **NO**

**If YES, indicated all conviction dates, prison release date(s) and the nature of the offense(s).**

**You will not be considered for a volunteer role if you do not complete and sign this form.**

**I declare under penalty of perjury pursuant to the laws of the State of Washington that the information I have provided is true and correct to the best of my knowledge. I authorize the Alliance to make inquiries regarding my criminal conviction history. [Note: Volunteers must also sign and complete the Volunteer Disclosure and Authorization Form].**

**Signature:** ______________________ **Date:** __________ **City/State:** __________

## VOLUNTEER DISCLOSURE AND AUTHORIZATION FORM

***The Seattle Cancer Care Alliance*** ("Alliance") will procure a consumer report and/or investigate consumer report on you in connection with your non-employee application. Intelius Inc., a consumer reporting agency, will obtain the report for the Alliance. Intelius is located at 500 – 108th Avenue NE, 25th Floor, Bellevue, WA 98004, and can be reached at (425) 974-6100.

The report may contain information bearing on your character, general reputation, and personal characteristics. The types of information that may be obtained include, but are not limited to: ***criminal records checks, public court record checks, and driving records checks.*** The information contained in the report will be obtained from private and/or public record sources.

Provided to you with this authorization is a summary of your rights under the FCRA in a form prescribed by the Federal Trade Commission. Please do not sign the authorization until you have reviewed this summary.

You also are entitled to request more information about the nature and scope of the report we are requesting your authorization to obtain by submitting a written request to ***Volunteer Support at 206-288-1075***.

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I have carefully read and understand this notice and authorization form and I have read and understand the "Summary of Your Rights Under the FCRA" provided with this form. By my signature below, I consent to the release of consumer and/or investigative consumer reports to the Alliance as described above and consistent with the requirements imposed on the Alliance as described in the Summary.

I understand that, to the extent allowed by law, information contained in my volunteer application or otherwise disclosed to the Alliance by me before, during or after my non-employee service, if any, may be utilized for the purposed of obtaining such consumer reports and/or investigative consumer reports about me.

I understand that if the Alliance allows me to volunteer, it may request a consumer report and/or an investigative consumer report about me, to the extent allowed by law, for business related purposes during and after my service. I understand that if I am volunteering for the Alliance my consent will apply throughout the entire time I am volunteering at the Alliance unless I revoke or cancel my consent by sending a signed letter to ***Human Resources at 206-667-4700***.

Last Name ______________________________ First Name ______________________ M.I. _____

Present Address __________________________________________________________________________

City/State/Zip ____________________________________________________________________________

Driver's License Number _______________________________ State Issued ____________________

**FOR IDENTIFICATION PURPOSES ONLY**

Date of Birth __________________ Gender ______

Signature ____________________________________________________ Date ______________

______________________________ has applied to serve as a volunteer at the Seattle Cancer Care Alliance, a partnership between Fred Hutchinson Cancer Research Center, UW Medicine, and Children's Hospital and Regional Medical Center. Your name was given as a personal reference.

Designated as a comprehensive cancer center by the National Cancer Institute, the Hutchinson Center has an international reputation for its pioneering research in bone marrow and peripheral blood stem cell transplantation, cancer prevention, human biology, and the basic sciences. It is considered a place of last hope for critically ill people who have been diagnosed with leukemia, lymphoma, solid tumors, and a variety of blood disorders.

Patients and their family members are in a vulnerable situation while they cope with a difficult medical treatment in an unfamiliar city, often without the support of friends and extended family for several months. We are fortunate to have dedicated volunteers who provide vital practical and social support in a variety of ways.

Every volunteer must be able to support patients and family members in a positive and compassionate manner, while maintaining emotional boundaries. We would appreciate any information that you can share to help us determine the suitability of this person's application to the Volunteer Services Program. Please provide an honest and complete summary of your impressions of the applicant on the reference form that is on the back of this letter. Your comments will be held in strict confidence and will not be shared with the applicant at any time.

We ask that you return your personal reference in the envelope that has been provided as soon as possible. Please do not hesitate to call us at (206) 288-1072 if you have any questions or would like to provide additional information. Thank you very much.

**Volunteer Services Program**
**Seattle Cancer Care Alliance**
**825 Eastlake Avenue East, LA-201**
**P.O. Box 19023**
**Seattle, Washington 98109-1023** **FAX: 206 288 1074**

**Seattle Cancer Care Alliance and Fred Hutchinson Cancer Research Center**
**Volunteer Services Program**

## PERSONAL REFERENCE FORM

Applicant's Name ______________________________________ Date _____________________

How long have you known the prospective volunteer and in what capacity?

Please circle the number in the scale that reflects your opinion of the person. Few people will fall in the highest or lowest categories. Please use these extremes to indicate significant impressions about the person.

| | LOW | | AVERAGE | | HIGH |
|---|---|---|---|---|---|
| Stability and harmony of the person's life | 1 | 2 | 3 | 4 | 5 |
| Compassion for other people | 1 | 2 | 3 | 4 | 5 |
| Interpersonal communication and listening | 1 | 2 | 3 | 4 | 5 |
| Ability to be flexible | 1 | 2 | 3 | 4 | 5 |
| Respect of diverse lifestyles, cultures, religions | 1 | 2 | 3 | 4 | 5 |
| Emotional health and boundaries | 1 | 2 | 3 | 4 | 5 |
| Dependability | 1 | 2 | 3 | 4 | 5 |
| Judgment and problem-solving skills | 1 | 2 | 3 | 4 | 5 |

Has the volunteer applicant experienced a major life transition during the last two years (such as the death of a loved one, serious illness, etc.) that might affect his/her ability to serve as a volunteer? If yes, please explain.

Does the applicant currently have alcohol or drug abuse issues? If yes, please explain.

Please share any additional comments about the volunteer applicant.

**NAME** ______________________________**TELEPHONE** __________________

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**Seattle Cancer Care Alliance and Fred Hutchinson Cancer Research Center**
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| Dependability | 1 | 2 | 3 | 4 | 5 |
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Does the applicant currently have alcohol or drug abuse issues? If yes, please explain.

Please share any additional comments about the volunteer applicant.

**NAME** _______________________________**TELEPHONE** ___________________ 