



Volunteer Services – Application Process and Timeline May 2019 Orientation for New Volunteers

1. Please note that volunteers must be a minimum age of 18; some roles the minimum is 21. We require a commitment of at least six months with our Shine Retail and Gift Shop roles. And 3 months for all other roles
2. Please complete and return the following paperwork to the Volunteer Services Program (address below) by **Monday, May 13th, 2019:**
 - a. Volunteer Application (3 pages)
 - b. Volunteer Agreement and Release Form
 - c. Volunteer Criminal History Form
 - d. Volunteer Disclosure and Authorization Form
 - e. Volunteer Photo Release Form
 - f. Volunteer Immunization/Health Assessment Form (see information below)
 - g. Volunteer Two (2) Personal References Forms
 - h. Copy of your driver's license (or state identification card)

**** Complete the Immunization/Health Assessment Form (or provide copies of records where applicable) and return with your application. To ensure the health of our patients, all volunteers are required to complete this form and follow up as necessary. The Occupational Health Nurse will need time to review these forms before providing the necessary testing therefore it must be completed by the above due date.**
3. **In the event that you are applying for a role with limited opportunities, placement will be determined by the date your complete application is received.**
4. You will receive an email/phone call from the Volunteer Coordinator week prior to the start of orientation to confirm your attendance and to answer any questions you might have.
5. **Attendance at BOTH sessions is required**

Monday, May 13th	Timeline for Orientation:
Wednesday May 15, 3:30-6:30pm	Deadline: Application & Paperwork
Friday/Saturday, May 17/18	Volunteer Orientation – part #1
Wednesday, May 22, 3:30-6:30pm	Return to Occupational Health for reading of TB test #1 (takes 10 min)
Friday/Saturday, May 24/25	Volunteer Orientation – part #2
May 27 - 31	Return to Occupational Health for reading of TB test #2 (takes 10 min)
	Interview scheduled with department supervisor
6. 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). **This service is provided free of charge by our Occupational Health Nurse and will take place during the training.** Individuals who have had a positive reaction to a TB test can request an exemption from annual TB testing. Annual tuberculosis testing and documentation of vaccination or immunity to Chickenpox (Varicella), Measles, Mumps, Rubella and Tdap (tetanus, diphtheria and pertussis) are required for all volunteers. A small blood sample may need to be taken to prove immunization and/or immunity. **Please read the timeline above to see the different steps involved and to plan accordingly.**
7. After completion of the volunteer orientation, we will schedule an appointment for you to meet with the appropriate department supervisor for an interview and to begin role-specific training.

****Please return your application, a copy of your driver's license, the Immunization/Health Assessment Form, Volunteer Agreement and Release Form, Criminal History Form, Disclosure and Authorization Form, and two Personal Reference Forms to:**

Volunteer Services Program
Seattle Cancer Care Alliance
825 Eastlake Avenue East, K2-231
P.O. Box 19023
Seattle, WA 98109-1023

Email: volunteer@seattlecca.org
Fax: 206.606.1074

We look forward to hearing from you soon! If you have any questions, please call Volunteer Services at 206.606.1072 or email volunteer@seattlecca.org



VOLUNTEER SERVICES STAFF:
Date Received: _____
Date Details Sent: _____
Potential Role: _____

Seattle Cancer Care Alliance Volunteer Services Program - VOLUNTEER APPLICATION

Name: _____ Cell Phone: _____

Street Address: _____ City/Zip: _____

Home Phone: _____ Email: _____

Please note: The following information assists us in assigning volunteers to patients and families, and will not be used in determining eligibility to perform services as a volunteer.

VOLUNTEER EXPERIENCE *(list most recent position first)*

EMPLOYMENT EXPERIENCE *(list most recent position first)*

EDUCATION *(list college degrees, high school and other education)*

Please list any foreign language(s) that you speak and indicate level of fluency.

All volunteers must complete the following:

On our website (www.sccavolunteer.org) are the service descriptions of various volunteer roles at the SCCA, including some of the essential functions of those roles. Do you have any physical, mental and/or sensory disabilities that may prevent you from performing the essential functions of any of these roles?
(Please see next page if you are a cancer survivor or current cancer patient.)

YES _____ NO _____

If your response is YES, please describe:

Volunteer Services Program Application

Page Two

If you are a former SCCA and/or cancer patient, we ask that you wait at least **one year** post active treatment to become a volunteer. If you have received a bone marrow/stem cell transplant, we ask that you wait at least **two years** post-transplant to become a volunteer.

VOLUNTEER SERVICE PREFERENCES (service descriptions at www.sccavolunteer.org)

Many of our roles are currently full or have limited availability – please consider volunteering in a role that has an **URGENT NEED** until space becomes available in your preferred role.

Usual time commitment is one shift/week unless you'd like to be a "float" volunteer and fill in on various shifts.

It is possible to volunteer in more than one role but shifts must be on different days. It is also recommended that a volunteer train in one role and become familiar with that role before adding a second role.

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

The following roles have an URGENT NEED for volunteers (please consider one of these roles):

- Gift Shop Volunteer (SCCA Clinic)**
- Shine Retail Store Volunteer (SCCA House)**
- Cosmetology/Barber Volunteer *MUST BE LICENSED.***
- Comfort Hand Massage Volunteer *MUST BE LICENSED.***

We are currently also recruiting for the following roles:

- Event Committee Volunteer**
- Healing Music Volunteer** (please complete separate application found at www.sccavolunteer.org).
- Guest Services Volunteer**
- Volunteer Driver** (Flexible – weekdays, weekends, daytime, evenings) 21 years and older, good driving record
- Crafts & Conversations (Knitting) Volunteer** (Evenings and Weekends at SCCA House)
- Volunteer Concierge (SCCA House)** (Monday through Friday, 10 am - 1pm, 1 pm – 4 pm, and 5:30 pm – 8:30 pm, Saturdays, 11-2PM and Sundays, 11-2PM & 2-5PM)
- Gen Onc Hematology Lobby Volunteer**
- Child Life Volunteer**
- Wig Fitter**

We are not recruiting for the roles below at this time:

- Labyrinth Volunteer (1st & 3rd Monday of Month)**
- Patient Family Resource Center**
- Physical Therapy** (Weekdays, one 2-3 hour shift per week during office hours)

If you have a specific date/time or shift that you are available to volunteer, please list here: _____

Volunteer Services Program Application
Page Three

Why would you like to volunteer with people with cancer and their families?

In case of an emergency, please notify: _____ Telephone: _____

Relation to you: _____

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

- 1.
- 2.

I understand the seriousness of this volunteer commitment and have answered the application questions honestly and to the best of my knowledge.

Applicant's Signature

Date

Please attach a copy of your Washington driver's license (or state identification card) so that we may complete a background check.

Applications can be sent to:

Volunteer Services Program
Seattle Cancer Care Alliance
825 Eastlake Avenue East, K2-231
P.O. Box 19023
Seattle, Washington 98109-1023

EMAIL: volunteer@seattlecca.org
FAX: 206.606.1074

SCCA VOLUNTEER SERVICES PROGRAM Agreement and Release

I, _____, desire to serve as a volunteer for Seattle Cancer Care Alliance ("SCCA") and to assist SCCA with a variety of projects and in a variety of capacities.

1. Volunteer Services. I am volunteering my services to SCCA because of my desire to participate actively in furthering SCCA's work. I understand that I am providing volunteer services to SCCA without any present or future expectation of compensation in any form, including salary, wages or benefits. I am not, and will not be, considered an employee of SCCA, and I am not subject to any federal, state or local workers' compensation or wage laws.
2. Conduct. I agree to abide by all SCCA policies and rules when performing volunteer services. I also agree to follow the direction and supervision of any SCCA personnel, employee or volunteer to whom I am assigned when performing volunteer services. I also acknowledge and understand that I am required to comply with all federal, state and local laws when providing volunteer services for SCCA. I further agree to be subject to any and all SCCA security measures.
3. Waiver and Release. I understand that my activities as a volunteer at SCCA may involve some risk of physical injury associated with use of office, kitchen and medical equipment, tools, motor vehicle use, and similar tasks and activities. I undertake all activities voluntarily, expressly assume all risks related in any way to my volunteer services, and will follow SCCA's instructions on safety procedures. I hereby WAIVE, RELEASE, AND DISCHARGE any and all claims against SCCA, its officers, directors, employees, and agents, and the owners of the property at which any volunteer activities occur, for any and all damages whatsoever (including, without limitation, personal injury or property damage), which I may have, or which I may subsequently experience, as a result of my service as a volunteer for SCCA. This waiver and release is intended to discharge in advance SCCA, its officers, directors, employees, and agents, and the owners of the property at which any volunteer activities occur, from and against any and all liability (whether for negligence, carelessness, or otherwise) arising out of or connected in any way with my performance as a volunteer. This Waiver and Release is binding as to any other persons who may pursue any such claims on my behalf, including my family members, heirs, executors, and administrators.
4. Motor Vehicle Use. I agree that if any of my volunteer services require use of a vehicle, I will use my personal vehicle to perform such services. I agree to maintain adequate automobile insurance coverage for my vehicle and will provide annual proof of active insurance to SCCA's Volunteer Services group. I also understand that my personal automobile insurance will serve as the primary source of coverage should any claim arise from use of my personal vehicle while performing volunteer services for SCCA, and that SCCA's motor vehicle insurance shall be the secondary source of coverage.
5. Medical Treatment. I hereby release SCCA from any claims that may arise as a result of any First Aid treatment or service administered in connection with my voluntary involvement with SCCA. Furthermore, in the event I am incapacitated as a result of my performance as a volunteer, I

hereby give permission that I may: (a) be given emergency treatment including First Aid and CPR; (b) be transported by ambulance, treated by aid car personnel, and/or transported to an emergency center for treatment; and (c) receive medical, dental, surgical and hospital care treatment and procedures deemed immediately necessary by a physician or other medical or emergency personnel. I waive my right of informed consent to such treatment. I further understand that, except as otherwise agreed to by SCCA in writing, SCCA does not maintain health or disability insurance coverage for any volunteer, and that I am expected and encouraged to maintain my own health or disability insurance coverage.

6. Confidentiality. I understand and agree that all information about SCCA patients and their family members (collectively "Patient Information") is confidential and subject to state and federal health information privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Washington Health Care Information Act. I agree not to disclose or discuss Patient Information with any persons except with other SCCA employees and SCCA health care providers involved in the patient's care, and only as needed to facilitate the services I am providing as a volunteer. I understand and agree that photography is not permitted while I am providing volunteer services. I further agree to read and comply with SCCA's HIPAA Self Study for Volunteers.

7. Representations. I am at least eighteen (18) years old, have read this Volunteer Agreement and Release, and understand it. I make the above representations, warranties, waivers, and releases in exchange for my participation as a volunteer. I recognize that SCCA and any third parties will rely on the information contained in this agreement.

I have read, understand, and agree to the terms of this Volunteer Agreement and Release.

Signature of Volunteer: _____ Date _____



SCCA VOLUNTEER SERVICES PROGRAM 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 206-606-1072**.

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 _____



SCCA VOLUNTEER SERVICES PROGRAM 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 (206-606-1071)

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:

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



SCCA VOLUNTEER SERVICES PROGRAM Photograph and Authorization Release form

I hereby authorize the Seattle Cancer Care Alliance (“SCCA”) and its Affiliates -- Fred Hutchinson Cancer Research Center, UW Medicine, and Children’s Hospital and Regional Medical Center, and their respective designees, licensees, successors and agents (“collectively “Affiliates”) -- to take, use, reproduce, and/or publish without limitation any photographic or video imagery of myself in digital or non-digital format (the “Imagery”) and to copyright the Imagery in its name or the name of any other third parties.

I understand and acknowledge that the Imagery may be taken, used, reproduced and/or published for any purpose whatsoever without restriction and that the Imagery may be altered or otherwise modified. I waive any right to inspect or to approve any Imagery that may be created using my likeness. I also understand and acknowledge that the Imagery may be taken, reproduced, used and/or published multiple times and combined with any text, photos, illustrations and/or other information. I authorize SCCA and its Affiliates to use my name, in full or in part, or a fictitious name in conjunction with the use, reproduction, and/or publication of the Imagery.

I represent and warrant that I own all rights in and to my likeness. I represent and warrant that I have not granted any rights in my likeness to any third party that conflict with the rights granted to SCCA and its Affiliates hereunder. To the extent that I have any ownership interest in or to the Imagery or any part thereof, I hereby irrevocably transfer and assign to the SCCA and its Affiliates all such right, title, and interest. I waive all “moral rights” and other similar rights throughout the world.

I understand that I waive any right that I may have to inspect or approve the finished product or products, or the advertising copy or printed matter that may be used in connection with it, or the use to which it may be applied.

I understand that I will not be compensated for any of my participation pursuant to this release form.

I hereby release, discharge, and agree to hold harmless SCCA and its Affiliates from any liability that may arise from any injury to my person, property, character or pecuniary interest as a result of the use of my likeness. I further waive all rights and release SCCA and its Affiliates from any and all claims I, or any third party, may have now or in the future for invasion of privacy, right of publicity or personality, copyright infringement, defamation or any other cause of action arising out of or relating to the use, exploitation, reproduction, adaption, distribution, broadcast, performance or display of my likeness in the Imagery.

In the event of any breach of this Agreement by SCCA and its Affiliates, I agree that my remedy shall be limited to an action for damages, if any, and in no event shall I be entitled to terminate this Agreement or to seek to enjoin or restrain the exhibition, distribution, advertising, exploitation, or marketing of the Imagery. I agree that any damage caused to me thereby will not be irreparable or otherwise so sufficient as to entitle me to injunctive or equitable relief

I understand that Volunteer Services may use my photo in the Volunteer Services Annual Report, Volunteer Services Facebook posts, Volunteer Services Extranet and Intranet, and for Volunteer Services recruitment and/or any other events.

I have read the above authorization, release, and agreement prior to its execution, and I am fully familiar with the contents.

I hereby warrant that I am of full age and have every right to contract in my own name in the above regard or on behalf of the minor named below.

AGREE: I have been informed of the SCCA Volunteer Services photo use and agree to have my photo taken or used as noted above

DECLINE: I have been informed of the SCCA Volunteer Services photo use and decline to have my photo taken or used as noted above

Print Name

Signature

Date



**Occupational Health Program
IMMUNIZATION HEALTH
HISTORY**



To protect patients and staff from exposure to, and possible transmission of, Tuberculosis and vaccine-preventable diseases, the Seattle Cancer Care Alliance policy requires that the immunization requirements listed below are met.

VOLUNTEER INFORMATION			
Name		Email address	
Date of Birth		Telephone	

Have you ever been employed by SCCA or Fred Hutch? SCCA Fred Hutch No

If yes, are you still currently employed by either organization? Yes No

Please CHECK the applicable box to note that you have attached supporting documentation (i.e. official immunization records, lab results, etc). If you do not have the documentation, leave the box blank.

DISEASE	IMMUNIZATION REQUIREMENT
Measles (Rubeola), Mumps and Rubella	<input type="checkbox"/> 2 doses of Measles (Rubeola), Mumps, Rubella vaccine OR positive titers for Measles (Rubeola), Mumps, and Rubella
Varicella (Chickenpox)	<input type="checkbox"/> 2 doses of Varicella Vaccine OR positive titer for Varicella OR evidence of herpes zoster based on healthcare provider diagnosis
TB (Tuberculosis)	<input type="checkbox"/> Baseline 2-step TB skin test (2 TB skin tests within the last 12 months) <input type="checkbox"/> If history of a positive TB skin test, documentation of positive TB skin test with results in MM and chest x-ray results
Pertussis	<input type="checkbox"/> 1 dose of Tdap Vaccine (Tetanus, Diphtheria & Pertussis Vaccine).
Influenza	<input type="checkbox"/> Influenza Vaccine for Current Influenza Season (Generally September through April) <i>optional for volunteers, but highly recommended</i>

Our Occupational Health department handles all immunization and vaccination requirements. If you do not have immunization records to satisfy the above requirements, they will require a blood titer from our lab. Any titers and follow-up vaccinations will be provided free of charge during the onboarding process.

Please complete this form, attach immunization records, and return with application to:
Seattle Cancer Care Alliance
825 Eastlake Avenue East, K2-231
P.O. Box 19023 Attn: Volunteer Services Program
Seattle, Washington 98109-1023
Fax (206) 606-1074 Email: volunteer@seattlecca.org

Volunteer Services Program

Personal Reference Form



Fred Hutch · Seattle Children's · UW Medicine

The Seattle Cancer Care Alliance is a partnership between the Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children's. Patients come from different parts of the country and around the world for high quality cancer treatment. 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. 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. Please provide an honest and complete summary of your impressions of the applicant. If you have any questions, please call our Volunteer Coordinator at (206) 606-1072. Thank you for your assistance.

Prospective volunteer's name

	Low		Average		High
Displays courtesy, tact and patience	Q1	Q2	Q3	Q4	Q5
Respectful of diverse lifestyles, cultures and religions	Q1	Q2	Q3	Q4	Q5
Is dependable and punctual	Q1	Q2	Q3	Q4	Q5
Accepts responsibility and supervision	Q1	Q2	Q3	Q4	Q5
Shows compassion for other people	Q1	Q2	Q3	Q4	Q5
Communicates well and is an active listener	Q1	Q2	Q3	Q4	Q5
Maintains emotional health and boundaries	Q1	Q2	Q3	Q4	Q5

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

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.

Please share any additional comments about the volunteer applicant.

Your name

Today's date

Your email address

Your phone number

[Submit form](#)

Volunteer Services Program

Personal Reference Form



Fred Hutch · Seattle Children's · UW Medicine

The Seattle Cancer Care Alliance is a partnership between the Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children's. Patients come from different parts of the country and around the world for high quality cancer treatment. 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. We are fortunate to have dedicated volunteers who provide vital practical and social support in a variety of ways.

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Please share any additional comments about the volunteer applicant.

Your name

Today's date

Your email address

Your phone number

Submit form