



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

1. **Please note that the minimum age to volunteer is 18.**
2. Please complete and return the following paperwork to the Volunteer Services Program (address below):
 - a. Volunteer Application (2 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. Two (2) Personal References Forms
 - h. Copy of your driver's license (or state identification card)
3. You will receive an email/phone call from the Volunteer Services Coordinator to confirm that your application has been received and begin our onboarding process.
4. Once accepted to our program the following steps will be taken:
 - Our Volunteer Program Assistant will reach out to set up an interview/training including completion of the self-guided orientation.
 - We will run your background check. You will receive an email from TalentWise requesting that you enter in your social security number to a secured site. We typically receive your completed report within 3 to 5 business days.
 - You will be scheduled to meet with our Occupational Nurse to begin your medical compliance. Once compliant, you may begin volunteering.
5. Thank you so much for your interest in joining the Healing Music Program at the Seattle Cancer Care Alliance! We look forward to receiving your application and scheduling you to perform as soon as possible. If you have any questions, please call the Volunteer Coordinator at 206.606.1072.

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 References 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.



Seattle Cancer Care Alliance / Volunteer Services Program

Healing Music Program - MUSICIAN APPLICATION

Name _____

Cell Phone _____

Street Address _____

Home Phone _____

City / Zip _____

Email _____

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, 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 placed. *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)
- SCCA House** (207 Pontius Ave. N, Seattle/South Lake Union) Weekday/Weekend Shifts Available
- Special Events** (holiday events, etc.)

Availability:

- Weekdays** (1-2hour block between 8:30 am – 4:30 pm) Day/Time preferred: _____
- Weekends** (1hour block between 10:00 am - 5:00 pm) 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? _____

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.

Applicant's Signature

Date

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

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 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:

<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 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 206-606-1075**.

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 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



VOLUNTEER IMMUNIZATION FORM

Name (Print Legibly): _____ Date of Birth: _____

Email Address: _____

To protect SCCA patients and staff from exposure to and possible transmission of Tuberculosis and vaccine-preventable diseases, the following immunization requirements must be met:

Tuberculosis (TB) Screening

Do you have a history of a positive TB skin test? Yes* No

If YES, do you have a record of a chest x-ray? Yes* No

**If you have documentation of the positive TB skin test and chest x-ray, please attach copies of your records. If you do not, we will notify you of the procedure for obtaining a chest x-ray.*

Please note: Two-step TB skin testing is required of all new volunteers (two TB skin tests at least one week apart). Once the 2-step baseline tests are completed, annual TB testing is required.

Tdap (Tetanus, Diphtheria, Pertussis)

Have you received the newly licensed Tdap vaccine? Yes* No Unsure

(Available since 2005, also called Boostrix or Adacel)

**If you have received the Tdap vaccine, please attach copies of your records.*

Chickenpox (Varicella)

To show proof of immunity, you must have documentation of receiving TWO Varicella vaccines or documentation of positive blood test results for antibodies to this illness.

If you have **all or part of this, please attach copies of your records. If you do not, vaccines/blood tests will be provided.*

Measles, Mumps, Rubella (MMR)

To show proof of immunity, you must have documentation of receiving TWO measles (rubeola), mumps, rubella or MMR vaccines or documentation of positive blood test results for antibodies to these illnesses.

If you have **all or part of this, please attach copies of your records. If you do not, vaccines/blood tests will be provided.*

***Hepatitis B Vaccination (Cosmetology/Barber Volunteers ONLY)**

It is recommended that the **Cosmetology/Barber Volunteers** receive the Hepatitis B vaccination. If you have already received this, please provide documentation for our records. These volunteers will also be required to attend a Bloodborne Pathogens class.

Please complete this form and return with application

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



Seattle Cancer Care Alliance – Volunteer Services Program PERSONAL REFERENCE FORM

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 206-288-1072. Thank you for your assistance.

PROSPECTIVE VOLUNTEER’S NAME: _____ **Date:** _____

1. Select the check box that reflects your opinion of the applicant:

	LOW		AVERAGE		HIGH
Displays courtesy, tact and patience	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Respectful of diverse lifestyles, cultures and religions	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Is dependable and punctual	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Accepts responsibility and supervision	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Shows compassion for other people	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Communicates well and is an active listener	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5
Maintains emotional health and boundaries	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4			<input type="checkbox"/> 5

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

3. 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.

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

5. Please share any additional comments about the volunteer applicant.

YOUR NAME _____ **PHONE** _____

YOUR EMAIL ADDRESS _____

Please return completed form to:

Email: volunteer@seattlecca.org | Fax: 206.606.1074

Volunteer Services | 825 Eastlake Avenue East, K2-231 | PO Box 19023 | Seattle, WA 98109-1023



Seattle Cancer Care Alliance – Volunteer Services Program PERSONAL REFERENCE FORM

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		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Respectful of diverse lifestyles, cultures and religions	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Is dependable and punctual	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Accepts responsibility and supervision	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Shows compassion for other people	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Communicates well and is an active listener	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	
Maintains emotional health and boundaries	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
		<input type="checkbox"/> 4		<input type="checkbox"/> 5	

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