



Dear Volunteer,

Thank you for your interest in joining the volunteer program at Cody Regional Health. We are very proud of our dedicated team of adult volunteers, including men, women and student volunteers. Cody Regional Health recognizes volunteers as an essential part of our vision. IT is important that your volunteer experience be satisfying and fulfilling, while providing the highest quality of customer service to our patients, visitors and staff. Your time is appreciated and it does make a difference in the lives of others throughout the hospital as well as our community.

The process for being a volunteer includes the following

- The application (3 pages) needs to be filled out completely and signed.
- The background check form must be filled out completely and signed.
- The Cody Regional Health Health Assessment form must be filled out completely and signed.
- The Consent for Photography/ Audiovisual Recording form must be signed.
- If applicable, the Pet Therapy Program Agreement form must be signed.
- Return the completed packet to:

Cody Regional Health
Attn: Amanda Hogan, Volunteer Coordinator
707 Sheridan Avenue
Cody, WY 82414


One of the requirements for all Cody Regional Health employees and volunteers is a TB test. If you could please contact Laura Farnworth, CRH Employee Health Nurse at 578- 2566, to make an appointment for this test, it will speed up the process – once you have completed this process and paperwork, we will proceed with your volunteering at Cody Regional Health.

I look forward to meeting you, and am happy to assist in your new volunteer experience. If you have any questions prior to starting, please do not hesitate to call me at 578-2337 or email me at ahogan1@codyregionalhealth.org.

Sincerely,

Amanda Hogan
Volunteer Coordinator

Cody Regional Health Volunteer Services Application

Cody Regional Health Attn: Volunteer Coordinator 707 Sheridan Avenue Cody, WY 82414 Phone: 307-578-2337 Fax: 307-578-2814 Email: ahogan1@codyregionalhealth.org	
Last Name First Middle	DOB _____/_____/_____
Address	Local Phone #
City, State, Zip	E-Mail

REQUEST TO ACCESS CODY REGIONAL HEALTH

Reason for the request and scope of activities while at Cody Regional Health facilities: Volunteering
Are you currently or have you ever been employed by Cody Regional Health/Cody Regional Health? Yes ___ No ___ Date and reason of separation:
Have you ever plead guilty to or been convicted of a misdemeanor or felony (except minor traffic violations?) Yes ___ No ___ (*A yes answer does not automatically disqualify you from Volunteer Status at Cody Regional Health. The nature of the offense, date and area you are applying for will be taken into consideration.) New Personnel must undergo a thorough background investigation upon applying at Cody Regional Health. The information furnished below will be used strictly for the purpose of identification, facilitating the background investigation and validating its findings. The personal history information contained herein will be retained in the Cody Regional Health Human Resources Department. Failure to disclose any misdemeanor or felony will result in complete termination of all privileges to conduct business at Cody Regional Health.
I hereby request status as a Non-Employee of Cody Regional Health. All of the information submitted by me in this application is true to the best of my knowledge and belief. I fully understand that any significant misrepresentation or omission constitutes cause for denial or revocation of my status as a volunteer. I acknowledge and understand that as a volunteer, I am subject to Cody Regional Health policies and procedures as relevant to the scope of activities outline above and approved within this document. I acknowledge that I can only perform activities that are listed within this document or are demonstrated in the competencies documentation that I have provided and that are retained with Cody Regional Health. I will act professionally and within guidelines of Cody Regional Health Service Excellence Standards. I also understand that Cody Regional Health reserves the right to ask me to leave the facility at any time due to my behavior or organizational need.



Listed below are the volunteer services areas with a brief description. Please check all areas that may be interest to you.

- Greeter & Information Desk – to provide information to patients and guests near the ER entrance
- Office Help – assist with filing, basic office duties help.
- Pet Therapy – visit patients and staff with your dog. Certification of animals through Therapy Dogs, Inc. is required.
- Patient Care Cookie Baker (3rd Floor) - make cookies and deliver them to patients and their family.
- Gift Shop – assist customers with purchases and assist with inventory restocking
- Cancer Center – assist getting lunches from hospital and taking it over to nurses and patients, office help, cookie bakers
- Spirit Mountain Hospice – to volunteer for Spirit Mountain Hospice requires additional training. Hospice House Volunteers (especially receptionists) are always needed. Another volunteer task is to serve in the homes of Hospice Patients.
- LTCC
 - Bingo – assisting residents with their bingo cards and helping with prizes.
 - Manicures – assist residents with manicures, polishing, filing, etc.
 - Music – Assist residents to and from activity.
 - Reading - newspapers, magazines or books to residents and discussing the news with them.
 - Work one-on-one with Alzheimer’s/Dementia residents.
 - Ice Cream Social – Serving ice cream from room to room.
- Other: _____

Please indicate which day and time best meets your availability (you may choose more than one):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning (8am – 11am)							
Afternoon (11am – 4pm)							
Evening (4pm – 6pm)							

How did you learn about our Volunteer Program?
Why do you want to become a Cody Regional Health Volunteer?
What skills or training do you have that may utilized in your volunteer assignment(s)?
Do you have any limitations related to health?



In case of emergency please contact:

Name		Relationship	
Address		Telephone	

Name		Relationship	
Address		Telephone	

I will hold confidential, all information I may hear directly or indirectly concerning patients, physicians or any member of the hospital staff, and I will not seek any information in regard to a patient, physician or member of staff.

Signature _____ Date _____



Consent for Photography/Audiovisual Recording

Signing this form acknowledges consent to the taking of photographs, and/or videotaping/audiotaping for any or all of the following purposes.

Marketing, advertising, or promotional materials for Cody Regional Health, including, but not limited to: newspaper, radio, print advertising; social media, brochures, and other printed materials; billboards and signage; public presentations/displays; annual reports; informal and educational programs; or any other purpose Cody Regional Health deems appropriate for promotional and educational purposes.

I consent to the taking of photographs, and/or videotaping for Cody Regional Health's use in marketing, advertising or promotional materials.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date

I do not consent to the taking of photographs, and/or videotaping for Cody Regional Health's use in marketing, advertising or promotional materials.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date



Cody Regional Health Volunteer Health Assessment

Name: _____ Date of Birth _____ Volunteer Area: _____

Address _____

Phone _____ Physician _____

Allergies: _____

Immunization History- List date received if possible

Tetanus _____ Tdap _____ Polio _____ MMR _____ Hepatitis B series _____ Varicella _____

Other: _____

Have you ever had TB ? _____ When was your last TB test? _____ Results of TB Test: _____

Does anyone in your family or home have TB? _____

Do you have or have you ever had any of the following:

Asthma _____	Emphysema _____	Diabetes _____	Whooping Cough _____
Bronchitis _____	Chronic Cough _____	Frequent Colds _____	Coughing up blood _____
Frequent sore throats _____	High Blood Pressure _____	Fainting spells _____	Cancer _____
Convulsions _____	Frequent Diarrhea _____	Hepatitis _____	Kidney Stones _____
Hay Fever _____	Migraine Headaches _____	Paralysis _____	Hernias _____
Chicken Pox _____	Measles _____	Mumps _____	Rubella _____
Shingles _____	Back Pain _____	Back Surgery _____	Mononucleosis _____
Ulcers _____	MRSA _____	C-Diff _____	STD _____
Alcohol/Drug Problems _____	Knee Injury _____	Shoulder Injury _____	Latex Allergies _____

Do you use tobacco products? _____ Type _____ How many years _____

Current Medications: _____

To the best of my knowledge, I am free of infection and able to perform my duties as a volunteer. The information I have provided on this form is complete and accurate. If I develop a serious health issue or infection I will report these changes to the Employee Health Office.

Volunteer Signature

Date

Reviewed By/date: _____