Mason Health
Mason General Hospital • Mason Clinic

Dear Volunteer Applicant,

Thank you for your interest in volunteering with Mason Health. Please fill out the packet then return the completed packet via email to volunteer@masongeneral.com. Please note that your paperwork must be submitted as one complete packet. If any pieces of the packet are missing, we will be unable to process your application.

The packet includes the following documents:

- The Application
- Public Venue Release Form
- Vaccination Forms
- Volunteer Commitment Form

If you are unable to email your application, you may mail it to:

Volunteer Office
Mason Health
901 Mountain View Drive
P.O. Box 1668
Shelton, WA 98584-8614

After your paperwork is received, we will advise you of the next steps in the process via email within 2 weeks. If you have further questions or concerns, the Volunteer Office can be reached at (360) 427-3621, or volunteer@masongeneral.com.

We value the dedication and hours of service our volunteers give each year. Again, thank you for your interest in being part of our team!

Sincerely,

Kim Lutey

Kim Lutey | Volunteer Program Specialist

Mason Health
Mason General Hospital • Mason Clinic

901 Mountain View Drive POB 1668
Shelton, WA 98584
Phone: (360) 427-3621 | Ext. 28899
Cell: (360) 968-0001 | Fax: (360) 432-3267
Email: klutey@masongeneral.com

Mason Health
Mason General Hospital • Mason Clinic

Mason Health Volunteer Application

901 Mountain View Dr. • PO Box 1668 • Shelton, WA 98584 • (360) 427-3621 • volunteer@masongeneral.com

Contact Information

First Name _____ Last Name _____

Date of Birth _____ Home Address _____

City _____ State _____ Zip _____ Preferred Pronouns (She/her, etc.) _____

Cell Phone _____ Email _____

How do you prefer to be contacted? ☐Email ☐Phone Call ☐Text

Position Applying for (check all positions interested in) – All positions 18+ unless noted otherwise; Not all positions always have availability for new volunteers.

☐ Mason Health Concierge (ages 16+) ☐ Emergency Department Concierge

☐ Volunteer Chaplain ☐ Culinary Volunteer ☐ Development/Marketing Office (ages 16+)

☐ Gift Shop ☐ No One Dies Alone (NODA) ☐ Other _____

Emergency Contact, Age of Applicant Verification & References

Mason Health requires Parental/Guardian approval if the applicant is younger than 18 years old.

☐ I certify that I am 18+ years of age on the date of signing this application.

☐ I am younger than 18 years of age and will have a parent/guardian sign the approval form below.

In case of emergency please notify:

Name _____ Relationship _____ Phone _____

Please provide two references who are not family members:

Name _____ Relationship _____ Phone/Email _____

Name _____ Relationship _____ Phone/Email _____

Knowledge, Skills & Abilities

Do you have access to and routinely use a computer for email, social media, office work, and internet access? ☐Yes ☐No

Please list those computer applications and office equipment that you are proficient in:

_____

_____

Why do you want to volunteer at Mason Health? _____

_____

_____

List the languages you are proficient in: _____

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Volunteer Application

Would you prefer to receive the monthly newsletter (check one): ☐ Email ☐ Mailing Address

How did you learn about this volunteer opportunity? _____

Availability – Interview and Shifts

Circle day(s) and time(s) that you would be available for a 30-minute interview. Once your application is processed, we will contact you to finalize a date for the interview:

Tuesdays	Wednesdays	Thursdays
☐ Between 8am – 10am	☐ Between 8am – 10am	☐ Between 8am – 10am
☐ Between 10am – 12pm	☐ Between 10am – 12pm	☐ Between 10am – 12pm
☐ Between 12pm – 2pm	☐ Between 12pm – 2pm	☐ Between 12pm – 2pm
☐ Between 2pm – 4pm	☐ Between 2pm – 4pm	☐ Between 2pm – 4pm

How soon can you start a weekly shift? _____

Please select what shifts you are available:

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8am-11am							
11am-2pm							
2pm-5pm							
Evenings							

Are you available to be called outside of your normal volunteer time to cover shifts? ☐Yes ☐No

Certification, Authorization & Release

All information provided by me on the application is complete and accurate. I understand that if my application is incomplete, it may not receive further consideration. I understand that any false answers or statement made by me on this application or any supplement thereto, or any omission of any requested information, may be grounds for immediate discharge. I understand this is an application for volunteering only and does not imply or create a volunteer contract.

I grant permission for Mason Health to investigate and solicit information related to my personal information, professional licensure/certification, education and training, criminal background information, references and employment history, and I hereby release Mason Health and all other parties from any and all liability and claims for damages that may result therefrom. If I am accepted as a volunteer, I release Mason Health from any liability for future reference it may provide regarding my volunteer history at Mason Health.

Printed Name: _____ Signature: _____

Date/Time: _____ Parent/Guardian Signature (*if under 18*):_____

Prior legal names of applicant (if applicable): _____

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Volunteer Application

Volunteer Consent

By signing this consent form, you acknowledge that you should not volunteer on a day you are experiencing any illness. You will be given access to health and safety training online that you need to complete prior to your volunteer shifts. If a volunteer applicant is younger than 18 years old at the date of application, please have the parent or guardian also review and sign this consent form.

I, the undersigned, understand that volunteering at Mason Health can lead to exposure to a variety of infectious diseases. These include but are not limited to Covid-19, Influenza, RSV, viral hepatitis, HIV, tuberculosis, meningitis, and other bacterial and viral infections.

Printed Name: _____ Signature: _____

Date/Time: _____ Parent/Guardian Signature (*if under 18*):_____

Mason Health
Mason General Hospital • Mason Clinic

Employee Health
Tel: 360-432-7704
Fax: 360-432-7751

COVID-19 VACCINE CONSENT/DECLINATION

PLEASE PRINT			
Last Name:		First Name:	Employee ID #:
Date of Birth:	Department: Volunteer	(Circle One): Contracted Provider Volunteer	

	YES	NO
1. Have you ever had a covid-19 shot before?	☐	☐
2. Ever had any problems or allergic reaction to the covid-19 shot?	☐	☐
3. Are you sick today or do have a fever?	☐	☐
4. Are you allergic to eggs or latex?	☐	☐
5. Do you have a history of Guillain Barre Syndrome?	☐	☐

☐ **I choose to receive the 2024-2025 Covid-19 vaccine.** In signing below, I release Mason General Hospital and Family of Clinics or any of its employees responsible for any possible untoward effects related to this vaccine administration. I further assume all responsibility for obtaining medical or other professional help for any health problems that may occur as a result of this immunization. I understand side effects may occur. I have had the opportunity to ask questions. I also approve to have this healthcare information faxed to the Employee Health Department of the facilities I have indicated on this form.

I have been provided with the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that I am receiving. I have read or had read to me the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits and risks of vaccination. I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I have made the decision to receive the COVID-19 vaccine voluntarily and freely and I assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area or an area identified by my health care provider for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call Mason Health, my doctor, or call 911. I request that the vaccine be given to me or the stated person named above for whom I am authorized to make this request.

☐ I **do not** wish to receive the Covid-19 2024-2025 vaccine.

☐ **I have already received the 2024-2025 Covid-19 vaccine**. *Copy attached*.

Signature:	Date:

For Office Use Only			
Vaccine:		**Date on EUA fact sheet:**	
Date Given:		**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	

Mason Health
Mason General Hospital • Mason Clinic

Employee Health
Tel: 360-432-7704
Fax: 360-432-7751

INFLUENZA VACCINE CONSENT 2024-2025

PLEASE PRINT			
Last Name:		First Name:	Employee ID #:
Date of Birth:	Department: Volunteer	(Circle One): Contracted Provider Volunteer	

	YES	NO
1. Have you ever had a flu shot before?	☐	☐
2. Ever had any problems or allergic reaction to the flu shot?	☐	☐
3. Are you sick today or do have a fever?	☐	☐
4. Are you allergic to eggs or latex?	☐	☐
5. Do you have a history of Guillian Barre Syndrome?	☐	☐

☐ **I choose to receive the flu vaccine.** In signing below, I release Mason General Hospital and Family of Clinics or any of its employees responsible for any possible untoward effects related to this vaccine administration. I further assume all responsibility for obtaining medical or other professional help for any health problems that may occur as a result of this immunization. I understand side effects may occur. A Vaccine Information Statement was available for me and I have had the opportunity to ask questions. I also approve to have this healthcare information faxed to the Employee Health Department of the facilities I have indicated on this form.

There are many different flu viruses and they are constantly changing. The composition of U.S. flu vaccines is reviewed annually and updated as needed to match circulating flu viruses. Flu vaccines protect against the three or four viruses (depending on vaccine) that research suggests will be most common.

☐ I **do not** wish to receive the flu vaccine.

☐ **I have already received the 2024-2025** flu vaccine. *Copy attached*.

Signature:	Date:

For Office Use Only			
Vaccine:	Inactivated Influenza Vaccine	**Date on VIS:**	**08/6/2021**
Date Given:		**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	

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2024 ANNUAL TB SYMPTOM EVALUATION FORM:

MGH & FC has completed an annual assessment for Tuberculosis risk and this year we have been classed as "**LOW RISK**". As such, we are not required to do annual skin testing. However, every employee must complete and return to Employee Health a "**TB Symptoms Evaluation**" form.

Print Name: _____ **Date of Birth ____/____/_____**

Department: _____Volunteer Department_____

Signature: _____ **Date: __/__/_____**

Please check any of the following signs and symptoms of tuberculosis that you may be experiencing at this time:

I currently have the following signs and symptoms:

☐ Coughing (>3 weeks)	☐ Chest pain	☐ Fatigue
☐ Night sweats (not hormone related)	☐ Coughing up blood	☐ I have been exposed to someone with active TB in the past year
☐ Unintentional weight loss	☐ Loss of appetite	☐ Fever/chills

☐ I am **NOT** experiencing **ANY** of the above signs and symptoms

If you are concerned at any time that you may have TB symptoms, or been exposed to TB contact Employee Health at ext. 28851 M-F 7am-3:30pm or the House Supervisor ext. 27000

Mason Health
Mason General Hospital • Mason Clinic

PUBLIC VENUE RELEASE FORM

The undersigned hereby consents to the use of their personal information as identified below, by Public Hospital District No. 1 of Mason County, WA (doing business as Mason Health) and waived the right to inspect or approve such photos, stories, etc. or to receive any monetary compensation for this photo, story, etc. **A copy of this release form may be provided upon request.**

This information will be used for the following marketing campaign/purpose _____

The following Personal Information about myself or child may be used:

- ☐ Name (Please print) _____
- ☐ Name of Baby/Child (Please print) _____
- ☐ A photograph (picture) of myself
- ☐ A photograph (picture) of child
- ☐ Company Name _____
- ☐ The following information (attach a separate sheet if needed) _____
- ☐ Date of Birth _____

Please provide your contact information so we may contact you if necessary. This information will not be shared.

_____ Home Address

_____ Email

_____ City, State, Zip

_____ Phone Number

I agree that my information may be used in all of the following publications, except _____

- Mason Health Web Page
- Internet and Telephone Directories
- Newspapers and Happenings Newsletters
- Radio and Television
- Scope, Making the Rounds or other District Publications
- Reader Board
- Digital Stories, DVD's, as well as any and all social media and web based (and other) media outlets
- Any Years of Service recognition for duration of employment
- Individual Physician or Allied Health Profiles
- Educational material, i.e. flyers, banners, pamphlets
- Donor or Volunteer Recognition
- MGH Foundation Publications
- In the case of digital stories, videos, etc. I have reviewed the materials produced and I approve the final digital story/DVD that has been produced

_____ Signature of Client or Legal Guardian

_____ Date

Revocation of Public Venue Release

If, in the future, you no longer want Public Hospital District No. 1 of Mason County, WA, to use your information in a public venue, you need to contact Mason Health and sign a revocation statement. This can be done in person or via a fax notice to 360-427-1921.

I no longer want my personal information used in a public venue. I understand that it may take up to 60 days for this revocation to be put into effect.

_____ Signature

_____ Date

Return this form to the

Mason Health Development Office
PO Box 1668
Shelton, WA 98584
Call 360-427-3623 or email
foundation@masongeneral.com
if you have questions.

PUBLIC VENUE RELEASE FORM
Mason Health
PO Box 1668, 901 Mountain View Drive
Shelton, WA 98584

Mason Health
Mason General Hospital • Mason Clinic

Volunteer Commitment Form

Please read the following criteria, then initial and sign where indicated.

I understand that I am responsible for completing 50 documented hours of volunteer service before I am eligible to have my community service paperwork and evaluation signed off. I understand that I must make an email request for any validation of community service hours to the Volunteer Office at least two weeks in advance of when it will be submitted. _____ (Initial)

I understand that I am responsible for attending any scheduled shifts. If I am unable to make my assigned schedule, I will email the department manager and the Volunteer Office to notify them of my absence. If these volunteer expectations are not met, this could result in the termination of my volunteer status. _____ (Initial)

When I have reached the end of my volunteer experience/availability, I will contact the Volunteer Office at volunteer@masongeneral.com to let them know I am no longer able to volunteer. _____ (Initial)

I understand that I am expected to take an online training course every year, to stay up to date on my understanding of hospital procedures, HIPAA policies, and other pertinent information. I promise to comply with the Volunteer Office's requirements to participate in volunteering with Mason Health. _____ (Initial)

I understand that to remain in compliance with hospital standards, I will complete and turn in the required vaccination consent/declination forms every year when they are due. _____ (Initial)

I understand that I am responsible for attending any required in-person meetings as required by my volunteer program. If I am unable to attend, alternative means of communication are allowed, but I must notify the Volunteer Office of the absence at least 24 hours in advance of the meeting time. _____ (Initial)

Applicant Name (printed): _____ Date/Time: _____

Signature: _____

(If under 18 years old)
Parent/Guardian Name (printed): _____ Date/Time: _____

Parent/Guardian Signature: _____