WASHINGTON STATE HEALTH CARE FACILITY REQUEST FORM FOR COVID-19 VOLUNTEER HEALTH PRACTITIONERS

Please complete this form electronically. Instructions can be found at the end of the form, on page 5.

ORGANIZATION NAME:	**TYPE OF ORGANIZATION:**
MAILING ADDRESS (STREET, CITY, ZIP):	**DATE:**
CONTACT NAME & POSITION:	
CONTACT PHONE:	**CONTACT EMAIL:**

By signing below, the requesting organization (indicated in Organization Name above) attests that this request is either part of their facility's staffing surge plan OR that the facility has exhausted all other sources to fulfill the requested need, including their local health and emergency jurisdiction and any relevant corporate agencies or partnering facilities.

The requesting organization understands and accepts that emergency volunteer health practitioners working under 70.15 RCW can be reassigned by the State of Washington Department of Health for higher priority emergency response work, as authorized in RCW 70.15.030. The Department of Health will provide advance notice before redeploying the volunteers to the extent possible under the circumstances. Volunteers can decline any assignment.

The requesting organization is responsible for all coordination, onboarding, supervision, and demobilization of emergency volunteer health practitioners.

PRINT NAME:	**ELECTRONIC SIGNATURE:**	**DATE:**

REQUEST INFORMATION

POSITION

1. POSITION NAME (CHARGE NURSE, OR NURSE, ETC.):		**2. HEALTH CARE PERSONNEL TYPE:** Other		**3. # OF VOLUNTEERS NEEDED:**
4. # DAYS REQUIRED	**5. EXACT START DATE:** **Start date must be at least one week out.*	**6. EXACT END DATE** **Please do not use "end of covid-19"*	**7. REQUIRED WK DAYS:** ❑ M – F ❑ 7 days/week ❑ Other:_____	**8. REQUIRED DAILY WORK HRS:**

9. EXPECTED DUTIES/WORK TO BE COMPLETED:

10. LANGUAGE SKILLS NEEDED? ❑ Yes ❑ No IF YES, WHAT LANGUAGE(S)? ❑ Written Skills ❑ Verbal Skills	**11. DOES THIS POSITION HAVE ANY PHYSICAL FITNESS REQUIREMENTS (LIFTING, BENDING, RESPIRATORY LIMITATIONS, ETC.)?** ❑ Yes ❑ No IF YES, PLEASE EXPLAIN:	**12. OTHER REQUIRED SKILLS OR EXPERTISE (SPECIALITY SKILLS, ACLS, BLS, ETC.):**

13. REPORTING POINT OF CONTACT:	**15. WILL THIS POSITION WORK REMOTELY?** ❑ Yes ❑ No ❑ Optional
POSITION:	**16. DO YOU HAVE A METHOD IN PLACE FOR VOLUNTEERS AT HIGH-RISK TO PROVIDE CARE NON-DIRECTLY OR VIA TELEHEALTH?** ❑ Yes ❑ No
PHONE:	**17. WILL VOLUNTEERS IN THIS POSITION BE REQUIRED TO WORK AT DISTANCES THAT DO NOT MEET THE SOCIAL DISTANCING RECOMMENDATIONS?** ❑ Yes ❑ No IF YES, PLEASE EXPLAIN:
EMAIL:	
14. VOLUNTEER REPORTING LOCATION (NAME AND ADDRESS):	

18. WILL THEY NEED SECURITY ACCESS?
❑ Yes ❑ No

19. IS THERE ONSITE PARKING?
❑ Yes ❑ No

20. ANY ADDITIONAL INSTRUCTIONS FOR ACCESS WHEN THEY ARRIVE AT THE REPORTING LOCATION?

21. WILL YOUR ORGANIZATION PROVIDE THEM FOOD OR MEAL PER DIEM?
❑ Yes ❑ No

LODGING OR LODGING PER DIEM?
❑ Yes ❑ No

PER DIEM OR OTHER WAGES?
❑ Yes ❑ No

SCRUBS/WORK ATTIRE OR LAUNDERING?
❑ Yes ❑ No

22. WILL PPE BE REQUIRED?
❑ Yes ❑ No

IF YES, PLEASE LIST WHAT PPE WILL BE PROVIDED:

23. WILL INTERNET ACCESS BE AVAILABLE TO THEM?
❑ Yes ❑ No

24. IF THE ASSIGNMENT IS REMOTE, WILL THEY NEED HOME INTERNET ACCESS?
❑ Yes ❑ No

25. SHOULD THEY BRING ANY PERSONAL EQUIPMENT (STETHESCOPE, LAPTOP, PHONE, ETC.)? ❑ Yes ❑ No

IF YES, PLEASE LIST EQUIPMENT:

26. ANY ADDITIONAL INFORMATION OR RESTRICTIONS NEEDED TO EFFECTIVELY PLACE A VOLUNTEER IN THIS POSITION?

REQUEST INFORMATION

ADDITIONAL POSITION (IF NEEDED)

1. POSITION NAME (CHARGE NURSE, OR NURSE, ETC.):

2. HEALTH CARE PERSONNEL TYPE:
Other

3. # OF VOLUNTEERS NEEDED:

4. # DAYS REQUIRED

5. EXACT START DATE:
**Start date must be at least one week out.*

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**Please do not use "end of covid-19"*

7. REQUIRED WK DAYS:
❑ M – F
❑ 7 days/week
❑ Other:_____

8. REQUIRED DAILY WORK HRS:

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❑ Yes ❑ No
IF YES, WHAT LANGUAGE(S)?
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❑ Yes ❑ No IF YES, PLEASE EXPLAIN:

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PHONE:

EMAIL:

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❑ Yes ❑ No ❑ Optional

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❑ Yes ❑ No

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❑ Yes ❑ No
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POSITION:

PHONE:

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IF YES, PLEASE LIST EQUIPMENT:

26. ANY ADDITIONAL INFORMATION OR RESTRICTIONS NEEDED TO EFFECTIVELY PLACE A VOLUNTEER IN THIS POSITION?

Instructions

Washington State maintains an Emergency Registry of Volunteers (WAserv) for citizens who are willing and able to help during disasters and significant events. The purpose of this form is to allow any health care organization to request volunteers who are registered in WAserv and qualified in particular skills. This request will be processed by the Volunteer Management Group (VMG) under Emergency Support Function (ESF) 8.

Please complete all fields. Once the form is completed, email the form and any additional documents or attachments to: doh-volunteer@doh.wa.gov and seoc44@mil.wa.gov.

If you have any additional questions or need assistance completing this form, please reach out to the VMG at volunteer@doh.wa.gov.

GENERAL INFORMATION	
ORGANIZATION NAME	The agency requesting volunteers.
TYPE OF ORGANIZATION	Type of organization (hospital, clinic, long-term care, EMS, etc.)
MAILING ADDRESS	Mailing address of the requesting organization.
CONTACT NAME AND PERSON	This is the requesting organization's main point of contact throughout the entire process of requesting and receiving volunteers.
CONTACT PHONE & CONTACT EMAIL	Contact information for the requesting organization's contact.
REQUEST INFORMATION *Please fill out everything in this section for each specific position. If requesting more than three positions, please attach additional form(s).*	
1. POSITION NAME	Specific title of volunteer position (e.g. charge nurse, OR nurse, etc.)
2. HEALTH CARE PERSONNEL TYPE	Select the health care personnel type(s) required for each specific position. If you need a specific personnel type that is not listed, please select 'Other' and list.
3. NUMBER OF VOLUNTEERS NEEDED	Number of volunteers you are requesting for each specific position.
4. # DAYS REQUIRED	Total number of days you require a volunteer for the position.
5. EXACT START DATE	Start date must be at least one week out to accommodate volunteer processing and minimum 24 hour volunteer notice.
6. EXACT END DATE	Be specific. Do not use "End of COVID-19". These dates are important for the VMG as they identify potential volunteers for your organization. The VMG identifies potential volunteers based on their availability through the WAserv platform.
7. REQUIRED WORK DAYS	Specific days of the week this position will be required to work.
8. REQUIRED DAILY WORK HOURS	How many hours the volunteer will be expected to work each day.
9. EXPECTED DUTIES/WORK	Specific job duties; please be thorough.
10. LANGUAGE SKILLS	Indicate whether language skills other than English are needed, and if applicable, which languages.
11. PHYSICAL FITNESS REQUIREMENTS	Indicate any specific physical fitness requirements and provide applicable details.
12. REQUIRED SKILLS AND EXPERTISE	List any other skills or expertise necessary for the position.
13. REPORTING POINT OF CONTACT	The individual(s) who will be the main point of contact for the volunteer once they report for duty.
14. REPORTING LOCATION	Name of the location and physical address where the volunteer will report—please include building and room number if applicable.
15. REMOTE WORK	Indicate whether the position will or can work remotely.
16. NON-DIRECT CARE/TELEHEALTH	Indicate whether you have a method in place for a high-risk volunteer to provide care non-directly or via telehealth in this specific position
17. SOCIAL DISTANCING EXCEPTION	It is expected that social distancing recommendations will be adhered to whenever possible. If this position requires an exception to these recommendations, please explain.
18. SECURITY ACCESS	Indicate whether special security access is necessary.
19. PARKING	Indicate whether free, onsite parking is available.
20. REPORTING INSTRUCTIONS	Anything else the volunteer needs to know when reporting.
21. FOOD/LODGING/PAY/ATTIRE	Indicate whether food—free of charge—or meal per diem will be provided, whether lodging or lodging per diem will be provided, and whether per diem pay or other wages will be provided.
22. PPE REQUIRED	Indicate whether PPE will be required, and if so, list the specific PPE that will be provided.
23. INTERNET ACCESS AVAILABILITY	If the position will or can operate on site, indicate whether internet access will be available.
24. HOME INTERNET ACCESS NEED	If the position will or can operate remotely, indicate whether home internet access is required.
25. PERSONAL EQUIPMENT	Indicate whether the volunteer will need to bring any equipment, and if so, identify the equipment. The Department of Health is not responsible for providing any equipment.
26. ADDITIONAL INFORMATION	Additional information regarding logistics, restrictions, etc. This section is important for the VMG to understand how to best help your agency throughout the process and how to select the volunteers best fit for your agency's needs. Please attach additional documents if necessary.