Child Life Program
Practicum Application

RANDALL CHILDREN'S HOSPITAL
LEGACY EMANUEL

Contact Information

Name	
Address	
Telephone number	Cell: Home:
E-mail address	

University/College

Name of school	
Major	
Cumulative GPA	
Major GPA	
Year expected to graduate/ Year graduated	
Will this practicum experience be counted towards school credit?	YES ☐ NO ☐

Contact information for your academic advisor (if you will be receiving credit for your practicum)

Name	
Address	
Telephone number	
E-mail address	

Professional organizations

Please list any professional organizations that you are a member of

Reference from most applicable volunteer or paid experience

Employer/Organization	
Your position/title	
Supervisor's name	
Supervisor's phone number	
Start to finish dates	
Total number of hours	

Please answer the following questions in the space provided

How did you learn about the child life profession and what interests you most about this field?

Why are you interested in completing this practicum at Randall Children's Hospital?

What do you feel your role would be as a practicum student? Please list any specific goals or areas of interest.

What are your career goals? How will this practicum assist you in achieving your goals?

What other obligations will you have during your practicum (work, school, volunteering, etc.)?

What days/times are you available to do your practicum hours?

LEGACY
HEALTH

DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION

NOTICE: THIS IS A DISCLOSURE AND AUTHORIZATION FOR LEGACY HEALTH AND ITS AFFILIATES, EMPLOYEES AND AGENTS TO OBTAIN A CONSUMER REPORT FOR A LEGITIMATE BUSINESS NEED UNDER THE FAIR CREDIT REPORTING ACT

Name: _____
(Last) (First) (Middle Initial)

Social Security Number (required): _____

Date of Birth (used only to verify identity as some records do not include social security number): _____

Driver's License Number: _____ State Issued: _____

Please list any other names that you have used: _____

Physical Address: (no P.O. Box) _____

City: _____ State: _____ Zip: _____

This release and authorization acknowledges that Legacy Health may now or at any time while I am volunteering, conduct a verification of my education, previous employment/work history, driving record, and to receive any criminal record information pertaining to me which may be in the files of any Federal, State or Local criminal justice agency in any State. A photocopy or telephonic facsimile (Fax) of this Authorization and Consent for Release of Information shall be valid as the original. The results of this verification process will be used to determine eligibility for volunteer assignments. All results will be kept confidential. The information obtained will not be provided to any parties other than to designated Legacy personnel.

I authorize Employer's Reference Source (ERS) and any other party to disclose orally and in writing the results of this verification process and/or interview to authorized representatives.

I do hereby agree to forever release and discharge Legacy Health and its affiliates, agents, and employees, ERS and its associates, and my former employers, to the full extent permitted by law, from any claims, damages, losses, liabilities, costs, and expenses, or any other charge or complaint arising from the retrieving and reporting of information. Although I am not an employee entitled to such disclosure under the Fair Credit Reporting Act, Legacy Health will inform me if a volunteer assignment was denied based on information obtained from a consumer report or investigative report, and will provide me upon written request, a disclosure of the nature and scope of any investigative report.

Volunteer's Name Typed or Printed: _____

Signature of Volunteer Authorizing Release: _____ Date: _____

LEGACY
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FAIR CREDIT REPORTING ACT
DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS: Please read this form carefully including all of the legal notices and release. If you agree, please provide the information and sign the enclosed Disclosure and Authorization to Release Information Form.

FCRA NOTICE: THIS IS A DISCLOSURE AND AUTHORIZATION TO RELEASE INFORMATION ("DISCLOSURE") FOR LEGACY HEALTH SYSTEM ("LEGACY") AND ITS AFFILIATES, EMPLOYEES AND AGENTS TO OBTAIN A CONSUMER REPORT AND INVESTIGATIVE CONSUMER REPORT FOR A LEGITIMATE BUSINESS NEED UNDER THE FAIR CREDIT REPORTING ACT ("FCRA"). PRIOR TO TAKING ANY ADVERSE ACTION BASED UPON ANY INFORMATION CONTAINED IN A CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT, LEGACY WILL PROVIDE YOU WITH:

- NOTICE OF THE ADVERSE ACTION;
- A COPY OF THE REPORT;
- A SUMMARY OF YOUR RIGHTS UNDER THE FCRA;
- THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONSUMER REPORTING AGENCY (INCLUDING A TOLL-FREE TELEPHONE NUMBER ESTABLISHED BY THE AGENCY IF THE AGENCY COMPILES AND MAINTAINS FILES ON CONSUMERS ON A NATIONWIDE BASIS) THAT FURNISHED THE REPORT TO LEGACY;
- NOTICE OF YOUR RIGHT TO OBTAIN, UNDER SECTION 612 OF THE FCRA, A FREE COPY OF YOUR CONSUMER REPORT AND INVESTIGATIVE CONSUMER REPORT FROM THE CONSUMER REPORTING AGENCY WITHIN 60-DAYS; AND
- NOTICE OF YOUR RIGHT TO DISPUTE, UNDER SECTION 611 OF THE FCRA, WITH A CONSUMER REPORTING AGENCY THE ACCURACY OR COMPLETENESS OF ANY INFORMATION IN A CONSUMER REPORT OR INVESTIGATIVE CONSUMER REPORT.

PLEASE NOTE THAT THE CONSUMER REPORTING AGENCY LEGACY USES DOES NOT MAKE ANY DECISION REGARDING SUCH ADVERSE ACTIONS AND IS UNABLE TO PROVIDE YOU WITH SPECIFIC REASONS WHY THE ADVERSE ACTION WAS TAKEN.

WASHINGTON APPLICANTS: IF YOU ARE A WASHINGTON RESIDENT OR APPLYING FOR: (A) EMPLOYMENT, (B) VOLUNTEER WORK, OR (C) INITIAL OR CONTINUED MEDICAL STAFF APPOINTMENT, CLINICAL PRIVILEGES OR AUTHORIZATION TO PRACTICE AT LEGACY SALMON CREEK HOSPITAL, PURSUANT TO REVISED CODE OF WASHINGTON ("RCW") §43.43.830-.845, THIS DISCLOSURE IS NOTICE THAT LEGACY MAY MAKE AN INQUIRY TO THE WASHINGTON STATE PATROL ("WSP") UNDER RCW §43.43.832 AND/OR AN EQUIVALENT INQUIRY TO A FEDERAL LAW ENFORCEMENT AGENCY. LEGACY WILL NOTIFY YOU OF THE WSP'S RESPONSE WITHIN TEN DAYS AFTER LEGACY RECEIVES IT AND WILL PROVIDE YOU WITH A COPY OF THE RESPONSE.

AUTHORIZATION: This Disclosure authorizes Legacy or any of its affiliates, employees, agents or contractors to conduct a verification of, discuss with, and receive information from persons or entities (each a "Provider") in possession or control of the following information and records ("My Information") regarding:

- my education records including applications, grades and discipline;
- my previous and current employment/personnel records, salary information, and discipline (not applicable for non-employed medical staff applicants);
- my professional licensing, certifications, investigation and discipline;
- my medical staff membership, privileges applications and discipline;
- my driving record and related information related to my driver's license; and
- any criminal, municipal, or civil adjudication information pertaining to me which may be in the files of any federal, state or local law enforcement agency in any state including but not limited to the Washington State Patrol.

I have read and understand this Disclosure and I authorize all the Providers to disclose, interview and discuss My Information with Legacy or Legacy's authorized representatives including Employer's Reference Source ("ERS"). For medical staff members and other credentialed practitioners, this authorization remains valid while a member of the medical staff and/or granted clinical privileges or authorization to practice. A photocopy or facsimile of this Disclosure shall be valid as the original.

My Information will solely be used to process and determine the eligibility of my application for employment, volunteer work, or initial or continued medical staff membership, clinical privileges or authorization to practice. My Information will not be further disseminated for any other purpose except as required or permitted by law. I understand that My Information and all results of this Disclosure will be kept CONFIDENTIAL (except as required in the credentialing process for medical staff applicants) The information obtained will not be provided to any parties other than to designated Legacy personnel, medical staff leadership, or authorized representatives.

RELEASE: I RELEASE, HOLD HARMLESS, COVENANT NOT TO SUE AND DISCHARGE ALL PROVIDERS, LEGACY AND ITS AFFILIATES, AGENTS, AND EMPLOYEES, AND ERS AND ITS ASSOCIATES (COLLECTIVELY THE "RELEASES"), TO THE FULL EXTENT PERMITTED BY LAW, FROM ANY CLAIMS, DAMAGES, LOSSES, LIABILITIES, COSTS, AND EXPENSES (EXCLUDING BUT NOT LIMITED TO ATTORNEY'S FEES), OR ANY OTHER CHARGE, CLAIM OR COMPLAINT ARISING FROM OR RELATED TO THE RELEASES' PROVIDING, RECEIVING, REQUESTING, DISCUSSING, VERIFYING AND REPORTING OF MY INFORMATION.