St. Bernards HEALTHCARE
The Heart of Great Medicine

Our Mission
is to provide Christ-like healing to the community through education, treatment, and health services.

Volunteer Application

Name:_____Birthdate:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Business Phone:_____

Email address:_____

Occupation:_____

Business
Address:_____City:_____State:_____Zip:_____

Social Security Number:_____ Marital Status: _____

Spouse's Name:_____ Number of Children:_____ Ages:_____

REFERENCES (Please list names and addresses):

1._____Telephone:_____

2._____Telephone:_____

3._____Telephone:_____

Do you know anyone who volunteers at St. Bernards Medical Center? __ Yes __ No *If so, please lit their names below:*

_____

Have you ever volunteered at St. Bernards Medical Center? ___Yes ___No *If so, please indicate where below:*

_____

Are you a veteran? ___Yes ___No

Have you belonged to any other volunteer organizations? ___Yes ____No *If so, please list the name of the organizations:* _____

MEMBER PROFILE:

Previous business experience (list by title please):_____

_____

What skills have you developed?

Writing ___	Secretarial__	Art___	Musical___	Nursing___
Event Planning___	Photography___	Advertising___	Bookkeeping___	Public Speaking___
Fundraising___	Planning___	Calligraphy___	Crafts___	Public Relations___
Computer Use___	Other_____			

Did any particular event lead to your decision to volunteer at St. Bernards Medical Center?
_____

What type of assignment are you seeking?_____

How many hours per week do you feel you can commit to volunteering?_____

Please list any available day, night, time and frequency you would be able to volunteer:_____

_____

Best Time to call:_____ Are you willing to be assigned to short-term projects? ___Yes ___No

In the event of a community-wide disaster (i.e., plane crash, tornado, major fire) which resulted in the immediate admission of a large number of emergency patients, would you be willing to work extra hours wherever needed?
__Yes __No

Other Commitments?:_____

Have you ever been convicted of a crime other than a minor traffic offense? If yes, please discuss with us in confidence_____

MEDICAL REPORT

The following information is for the use of the Volunteer office to assist in safeguarding your health.

What is your general state of health? __Excellent ___Good ___Fair ___Poor

Have you ever been hospitalized for treatment of alcoholism or mental illness? __Yes __No
If yes, explain:_____

Do you have any back trouble? ____Yes ___No
If yes, explain:_____

Are you unable to stand or walk for long periods of time or are you restricted in any other way? __Yes __No
If yes, explain:_____

Physician to be called in case of accident or illness:
Name: _____ Telephone:_____

Persons to be notified in case of emergency:
Name:_____ Telephone:_____

Name:_____ Telephone:_____

Application for Hospice Patient Care Volunteer — Please complete this section

1. Have you had a significant loss in the past 2 years? (i.e. death, divorce, move)_____

   _____

2. Can you describe your recovery?_____

   _____

3. What are your prejudices? Race, Age, Sexual Orientation, AIDS_____

4. Do you drive?_____ Do you have a valid driver's license?_____ How far are you willing to travel?_____

   Do you drive at night?_____

5. Do you have adequate auto insurance coverage?_____

Volunteer Dismissal

Volunteers are a special gift to our hospitals. There are no words to adequately describe the value they bring to our quality of healthcare. Volunteers enable us "to provide Christ-like healing" to those we serve. It is our expectation that volunteers will have a positive experience and be successful in giving their time to help others. It is rare that any volunteer must be asked to leave the St. Bernards Volunteer program, but certain instances or behaviors may necessitate their dismissal. Volunteers may be removed from service for:

- DISHONESTY AND/OR THEFT
- EXCESSIVE ABSENCE OR TARDINESS
- BREACH OF CONFIDENTIALITY
- DISRUPTIVE BEHAVIOR
- FAILURE TO ACCEPT SUPERVISION FROM ST. BERNARDS STAFF
- ACCEPTING GRATUITIES FROM PATIENTS OR THEIR FAMILIES
- APPEARANCE ON THE ST. BERNARDS CAMPUS UNDER THE INFLUENCE OF ALCOHOL OR DRUGS
- LOUD, ABUSIVE, PROFANE LANGUAGE
- LACK OF MOTIVATION, INTEREST OR ABILITY TO PERFORM THE ASSIGNED TASK
- FAILURE TO TAKE PROBLEMS, CRITICISMS OR SUGGESTIONS TO THE VOLUNTEER DIRECTOR
- INSUBORDINATION
- FAILURE TO REMAIN IN ASSIGNED WORK STATION
- SEXUAL HARASSMENT
- IMPROPER FRATERNIZATION WITH PATIENT(S), FAMILY MEMBERS(S) OR GUESTS
- BRINGING A WEAPON ON THE ST. BERNARDS CAMPUS
- FIGHTING
- (FOR JR. VOLUNTEERS) LEAVING THE ST. BERNARDS CAMPUS WITHOUT THE EXPRESSED PERMISSION OF THEIR PARENT OR GUARDIAN AND WITHOUT THE PARENT OR GUARDIAN NOTIFYING THE VOLUNTEER OFFICE.
- ACTIONS WHICH CAST A BAD REFLECTION ON ST. BERNARDS

(The above is a serious, <u>but not all inclusive</u> list of offenses which may result in dismissal)

Non-Disclosure Agreement

St. Bernards Medical Center has a legal and ethical responsibility to safeguard the privacy of all patients and families and protect the confidentiality of their health information. In the course of my volunteer assignment at St. Bernards Medical Center or any Facility, I may come into possession of confidential patient and family information, even though I may not be directly involved in providing patient services. This information includes, but is not limited to, electronic information, telephone conversations, spoken words and written information.

I understand that such information must be maintained in the strictest confidence. As a condition of my volunteer assignment, I here by agree that:

1. I will only access confidential information for which I have a **need to know**.
   * I will not access information using another individual's password or credentials.
   * I will not in any way divulge, release, sell, loan, review, alter or destroy any confidential information except as properly authorized.
   * I will use discretion to assure conversations with other health care providers cannot be overheard by others who are not involved in the patient's care.
2. I will safeguard and not disclose my password(s) or any other authorizations I have that allow me access to confidential information unless authorized.
3. I accept responsibility for all activities undertaken using my password(s) and other authorizations.
4. I will report activities by any individual or entity that I suspect may compromise the privacy and/or security of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law including the name of the individual reporting the activities.
5. I understand my obligations under this agreement will continue after termination of my volunteer assignment.
6. I understand that St. Bernards Medical Center may at any time revoke my password(s), authorizations or access to confidential information if I fail to safeguard the privacy and security of all confidential information.
7. I understand that violation of this agreement may result in dismissal from my volunteer assignment at St. Bernards Medical Center or any Facility.

_____

I hereby apply for the St. Bernards Medical Center Volunteer Program and agree to abide by the rules and regulations governing this organization.

I have read the above and understand the Volunteer Orientation, Dismissal form, Non-Disclosure Statement and Safety information that has been given to me.

I voluntarily give St. Bernards Medical Center the right to investigate my past or present employment, education, and other information pertaining to my suitability for volunteer assignments. I understand that final approval to become a volunteer will be subject to this review.

_____ _____ _____

Volunteer Signature | Parent or Guardian Signature | Date

_____

For Office Use:

___ Name Badge ____TB Skin Test ____Background Check