HUMBOLDT COUNTY MEMORIAL HOSPITAL

Volunteer/Job Shadow Application

Applicant Contact Information:

Name: _____

Address/City/State/Zip: _____

Main Phone: _____

Email Address: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone:_____

I'm interested in: [ ] Volunteering [ ] Job Shadowing

Which area are you interested in volunteering in? *(only required if "volunteer" is selected)*

[ ] Genevieve's Place (Gift & Coffee Shop) [ ] Long Term Care

Hours and days you are available:_____

Which department(s) are you interested in shadowing? *(only required if "job shadow" is selected)*

_____

The Humboldt County Memorial Hospital provides equal employment opportunity to all persons without regard to race, color, religion, disability, sex, gender identity, sexual orientation, age, or national origin, and promotes the full realization of this policy through a positive, continuing program of affirmative action. HCMH is committed to equal opportunity for all applicants and employees in personnel matters, work assignments, training, transfer, advancement and other conditions and privileges of employment, and works to assure a continuation of this policy of equal employment opportunity.

Signature of Applicant: _____ Date: ___/___/___

If under the age of 18, parent/guardian signature required.

Parent/Guardian Signature _____ Date ___/___/___

Authorization for Background Check

Last Name _____

Maiden Name _____

First Name _____

Middle Name _____

Date of Birth _____/_____/_____

Social Security # _____

Professional License #_____ Valid driver's license #: _____

Gender M / F

Additional questions required of prospective employees at Humboldt County Memorial Hospital:

Do you have a record of founded child or dependent adult abuse?

Yes / No

Have you ever been convicted of a crime other than a minor traffic offense in this state or any other state?

Yes / No

Have you ever been convicted of a criminal offense related to health care, or been disbarred, excluded, or otherwise ineligible from participation in federal health care programs?

Yes / No

Please be aware that a criminal history, dependent adult abuse, child abuse, and sex offender record check will be conducted. Offer of employment is contingent on the findings of these background checks.

If you decline to sign this authorization form, the possibility of an offer of employment will not be extended by HCMH.

By signing this release form you are granting permission to HCMH to do a criminal and abuse background check.

Applicant Signature _____ Date ___/___/___

If under the age of 18, parent/guardian signature required.

Parent/Guardian Signature _____ Date ___/___/___

KEY SERVICE BEHAVIOR EMPLOYEE AGREEMENT

I agree to deliver our promise to create exceptional patient experiences by demonstrating the following key service behaviors -ALWAYS.

COMMUNICATES WITH COMPASSION & CLARITY

- Practices active listening skills
- Utilizes AIDET communication tool
- Expresses key terms at key times
- Manages up, while assessing and managing patient expectations

DEMONSTRATES PROFESSIONALISM AND PRIDE

- Greets and initiates conversation using the 10/5 rule with a warm smile, positive tone and demeanor
- Maintains a clean, safe, private, comfortable and quiet healing environment
- Honors the clearly defined dress code

RESPONDS WITH TIMELY CONFIDENCE

- Responds to patient's concerns with H.E.A.R.T. (Service recovery)
- Takes action in the "No Pass Zone"
- Demonstrates the "No Point Policy"
- Purposefully rounds on patients to manage their wait

Name _____ Date _____
(Applicant Signature)

Name _____ Date _____
(Department Leader Signature)

HIPPA

A federal law, Health Insurance Portability and Accountability Act (HIPPA), is designed to protect the privacy and confidentiality of Protected Health Information for patients. Protected Health Information is ANYTHING that can identify a patient such as their name, address, age, family, clinical and treatment information, Social Security numbers, employers, photographs, etc.

All staff, students, and volunteers at Humboldt County Memorial Hospital have a responsibility to protect the privacy of our patients.

Carefully read and sign the following:

As an individual observing or receiving training as a student or as a volunteer at Humboldt County Memorial Hospital:

- I understand that ANY information regarding patients, past or present, which I learn of or am aware of while I am here as a student or volunteer is confidential. It is not to be released to unauthorized personnel or discussed in any way.
- I will excuse myself from any conversations held by HCMH staff, if I do not work with the patient being discussed.
- If I need to access a medical record or a document containing patient information in order to perform my work, I may only have access to the specific portions needed to do my job.
- I understand that I am to destroy any papers I have which contain patient information by placing them in the shredding bins and the end of each day before leaving the premises.
- If I am provided with a user ID or password: I will not share it with another person; never allow another person to access information under my identity; and/or never access information under another person's identity.
- I will refer any questions about patients to my supervisor.
- I will report violations or suspected violations to the Privacy Officer
- If I have additional questions about Privacy, I will contact one of the individuals listed above.
- I understand that if I do not conform to this confidentiality code, I can be immediately dismissed. I also understand that any improper release of medical record or patient information following my experience could be possible grounds for a civil lawsuit.

Applicant Signature _____ Date ___/___/___

If under the age of 18, parent/guardian signature required.

Parent/Guardian Signature _____ Date ___/___/___

Confidentiality Agreement

I understand and accept the legal and moral responsibility of maintaining the confidentiality of all data and patient information. I also understand my role in ensuring the right to privacy of person and institutions cooperating with HIPAA regulations. Furthermore, I understand that HCMH has policies that protect the patients' right to every consideration of their privacy regarding their medical information. I understand that I must not reveal any confidential information to anyone except those individuals authorized to receive such information. I also understand that failure to adhere to this policy may result in termination of services or agreements.

I have read and understand HCMH's Confidentiality Agreement and procedures and pledge to act accordingly.

Print Name:_____

Applicant Signature _____ Date ___/___/___

If under the age of 18, parent/guardian signature required.

Parent/Guardian Signature _____ Date ___/___/___