

**All items are to be completed to attend Teen Volunteer Training**

- Complete **Hospital Orientation** online - [www.stelizabeth.com/volunteertraining](http://www.stelizabeth.com/volunteertraining)
  - ➔ Answer sheet included in this packet
  - ➔ Orientation may take you 3-4 hours to complete and can be completed in more than one sitting
  - ➔ **Must be completed to attend Training**
  
- Provide a current copy of your **immunization record**
  - ➔ May be brought to training, faxed to: (859) 301-3943 or e-mailed to [volunteer@stelizabeth.com](mailto:volunteer@stelizabeth.com)
  - ➔ Must have proof of **2 MMR** vaccinations and **2 Varicella** vaccinations (or have had Chicken Pox)
  
- Complete the enclosed **forms**:
  - Confidentiality Agreement
  - Characteristics/Volunteer Agreement
  - Parent/Guardian Consent & Agreement
  - Initial Health Questionnaire
  - TB Testing Parent/Guardian Consent (*TB Tests will be provided by St. Elizabeth Volunteer Services on a later date*)
  - Reference (*must be completed by a current teacher, school administrator or guidance counselor*)

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*St. Elizabeth Volunteers are passionate about their role in making a positive difference in the patient experience.*

# Volunteer Hospital Orientation Training Modules Answer Sheet

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**1** Volunteer Handbook

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**2** HIPAA

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**3** Hospital Safety

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Hospital Safety (cont.)

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**4** Patient Safety

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Patient Safety (cont.)

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**5** Infection Control

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Office Use Only	
<input type="checkbox"/>	Mark History
<input type="checkbox"/>	Add Hours
<input type="checkbox"/>	Scanned

**Volunteer Hospital Orientation  
2017 Training Modules Answer Sheet**

Name: \_\_\_\_\_

**6** Safe Environment

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**7** Healthcare Security

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**8** Corporate Compliance

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**9** Ethics

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**10** Diversity

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**11** Wheelchair

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**St. Elizabeth Healthcare  
Associate / Volunteer  
Confidentiality  
/ Non-Disclosure Agreement**

As a St. Elizabeth healthcare participant, I am responsible for maintaining the confidentiality of information relating to patient/residents/clients and fellow associates. Unless it is necessary to complete my job responsibilities, information about the present condition, performance, or personal affairs of patients/residents/clients or other associates will not be repeated or discussed either inside or outside the St. Elizabeth Healthcare.

When confidential information must be discussed in the course of my work, I will use discretion to keep such conversation from being overheard by others who are not directly involved. I am aware that there are both state and federal laws that protect health information and other confidential information from unauthorized access. I also realize careless or thoughtless release of confidential information can result in disciplinary action, including termination and also could result in legal action being taken against St. Elizabeth Healthcare.

As a St. Elizabeth Healthcare associate, I will be obligated to attend/complete training courses directed at ensuring my understanding of St. Elizabeth Healthcare privacy policies in relation to protecting confidential information.

**Confidential information includes but is not limited to:** (1) information about patient/resident/client’s condition or treatment; (2) aggregate clinical data; (3) employee records; (4) employee patient/resident/client records; (5) marketing plans; (6) product or service plans; (7) strategies/forecasts; (8) patient/resident/client lists; and/or (9) financial information.

Confidential information can be obtained through hearing it, seeing it, viewing the medical record, or accessing it in the computer system.

**While creating, accessing and/or utilizing confidential information I agree to abide by the following:**

- I agree to keep confidential all information I access.
- I agree to access only the minimum necessary to perform my duty.
- I agree to access only that information for which there is a “Business Need to Know.” I understand that my access may be monitored.
- I understand that I may not use the St. Elizabeth Healthcare computer system to access the medical records or financial records of myself, my children, my spouse, my neighbor9s), my co-workers or anyone, without a business based reason to do so. I also understand I may not look at paper records of any of these individuals without a business-based reason to do so.
- I agree to keep my password confidential. I understand that providing my password to another individual may result in disciplinary action up to and including termination.
- I agree to protect data at all times, which includes data in electronic, paper, film, images, video or other forms. I will protect data during its creation, entry, processing, distribution, storage, and disposal.
- I agree to protect data from unauthorized access, modification, destruction or disclosure.
- I understand that upon my termination from St. Elizabeth Healthcare my ability access St. Elizabeth information will end. I agree that I will not attempt to access St. Elizabeth Healthcare systems or disclose any confidential information to any person or entity after my termination.

**I have read this document and understand that my signature constitutes my acceptance of the terms of the “Confidentiality/Nondisclosure” agreement.**

\_\_\_\_\_  
Name (Print)

Volunteer Services  
Department

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Characteristics of a St. Elizabeth Volunteer and Volunteer Agreement

Please carefully review the information provided below prior to signing.

### Characteristics of a St. Elizabeth Volunteer:

#### Committed

- Volunteers at St. Elizabeth take pride in giving their time and talents to the patient, guests and staff.
- Many volunteer positions require our Volunteers to commit to a regular volunteer shift, making them a reliable part of the St. Elizabeth team!

#### Cooperative

- Volunteers at St. Elizabeth are there to support the staff; partnering with them to better the experiences of our patients and guests.
- Volunteers are responsible, adaptable and responsive, with a desire to serve. Our Volunteers are an integral part of the SEH team!

#### Compassionate

- Volunteers at St. Elizabeth possess qualities essential to assisting patients and guests during a stressful and emotional time- friendly, compassionate, generous, honest, positive and responsive- They CARE!

#### Competent

- Volunteers are provided with extensive hospital orientation and training that is specific to their Volunteer position.
- Volunteers are expected to be responsive to the ever changing healthcare environment by learning new skills and adapting to new approaches.
- Typically, due to the amount of training and processing, it takes a new Volunteer 2-3 weeks from application to their first day of volunteering.

### Volunteer Agreement:

In signing this Agreement you are acknowledging your understanding of the characteristics that can be found in a St. Elizabeth Volunteer as outlined above and your willingness to fulfill these characteristics in your service at St. Elizabeth. I understand I am required to submit to an annual TB test during the period required by St. Elizabeth and also required to complete both the Annual Training review of St. Elizabeth's Policies and Flu Report Form. Your signature also acknowledges your recognition of and commitment to the minimum 6 months of volunteer service for Adult volunteers. 12 weeks of service for College volunteers and 10 weeks of service for Teen volunteers during the Fall and Spring programs; a shorter commitment of 8 weeks of service during the Summer Program. Failure to complete this commitment will result in dismissal from volunteer service, and the Volunteer Services department will not issue a volunteer hours report or letter of recommendation. Additionally, you understand that falsification or significant omission of any information provided in the application process may be considered justification for immediate dismissal when discovered.

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please carefully review the information provided below prior to signing.**

### Summer/Fall/Spring Program

#### Teen Volunteers Must:

- Be between 14 years old and a senior in High School
- Have appropriate and reliable transportation
- Have the time to commit to 3-4 hours of service generally once a week for a minimum of 10 weeks
- Maintain a clean uniform and abide by dress code – wearing uniform to all volunteer trainings and volunteer days/shifts (failure to do so results in inability to participate)
- Complete all required paperwork and health requirements prior to start date
- Complete an initial TB test & an annual TB test - a separate permission slip is required and may be obtained from a Volunteer Services office
- Abide by the policies, procedures and laws that govern the hospital(s)
- Understand and maintain patient confidentiality
- Complete Hospital Orientation/Training Modules
- If applicable, complete Nursing Unit Training or Emergency Department Training (offered 3 times per year)
- Notify the volunteer area supervisor when unable to volunteer

### High School Senior Internship Program

#### Senior Interns Must:

- Have appropriate and reliable transportation
- Maintain a clean uniform and abide by dress code – wearing uniform to all volunteer trainings and volunteer days/shifts (failure to do so results in inability to participate)
- Complete all required paperwork and health requirements prior to start including an initial TB test - a separate permission slip is required
- Abide by the policies, procedures and laws that govern the hospital(s)
- Understand and maintain patient confidentiality
- Complete Hospital Orientation/Training Modules
- Complete Nursing Unit Training and Emergency Department Training
- Notify the volunteer area supervisor and Volunteer Office when unable to volunteer

In signing this Agreement both the parent/guardian and teen are acknowledging understanding of the requirements for participating in a Volunteer Services teen program as outlined above. The parent/guardian signature also grants permission for, and acknowledges support of the teen named below to volunteer/intern at St. Elizabeth Healthcare. Additionally, both parties understand that falsification or significant omission of any information provided in the application process may be considered justification for immediate dismissal when discovered.

- Check here if the parent/guardian grants permission for St. Elizabeth Healthcare to use this teen's photo for publicity or recruitment purposes.**

\_\_\_\_\_  
Print Full name of Teen

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Teen Signature

\_\_\_\_\_  
Date

**Initial Health  
Questionnaire for  
Volunteers**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Have you had the following diseases?**

Yes	No	Unsure		Yes	No	Unsure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles (10 day/old fashioned)				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a positive TB skin test?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had close contact with anyone who has or has had TB?				

**Have you had the following immunizations?**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Tetanus/Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Measles, Mumps, Rubella (MMR)
<input type="checkbox"/>	<input type="checkbox"/>	Varicella (Chicken Pox)	<input type="checkbox"/>	<input type="checkbox"/>	Influenza

**Do you currently have any of the following symptoms?**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Productive Cough (3+ weeks)	<input type="checkbox"/>	<input type="checkbox"/>	Persistent weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Persistent low-grade fever	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain

IF you marked "yes" to any of these symptoms, please comment: \_\_\_\_\_

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Documentation Requirements:** Please review and obtain the necessary immunizations or records.

**Immunization Record**

- Birthdate prior to 1957: No immunization record required.
- Birthdate of 1957 or after: Obtain proof of immunizations and provide record to our office.
- *Specific immunizations are required for anyone volunteering at St. Elizabeth. If you do not have a record of these immunizations, we will work with you to complete this requirement.*

**All Volunteers are required to obtain an Influenza Vaccine each Flu Season (Sept. - April)**

- If you have already received the influenza vaccine for the current flu season, please provide a copy of this record to the Volunteer Services office.
- If you have **not** already received the influenza vaccine, Volunteer Services will provide you with information on how to receive one from St. Elizabeth Healthcare.
- If you **cannot** receive the influenza vaccine due a medical condition, please contact Volunteer Services to obtain the necessary Medical Exemption Statement which will need to be completed by your physician.

**For Internal Use Only**

Volunteer Office:              Edgewood                      Florence                      Ft. Thomas

Employee Health Recommendations: \_\_\_\_\_

If applicable, follow-up by Volunteer Services: \_\_\_\_\_

Signature of Employee Health RN: \_\_\_\_\_ Date: \_\_\_\_\_



**Parent/Guardian Consent  
for TB Testing of  
Teen Volunteers**

All active volunteers are required by the State of Kentucky to receive an initial and an annual TB test. Volunteers under the age of 18 must bring this completed form to receive the test at St. Elizabeth Healthcare.

- Check here to give permission for your student to receive the required TB test**

\_\_\_\_\_

Print Full name of Teen

\_\_\_\_\_

Parent/Guardian Signature

Date \_\_\_\_\_



**TEEN VOLUNTEER REFERENCE FORM**

volunteer@stelizabeth.com

\_\_\_\_\_ is considering volunteering at St. Elizabeth Healthcare. As a part of their application, a school/adult reference is required. Your name and email address have been supplied by the student as being willing to provide this reference. Please complete the form below.

**ALL INFORMATION IS CONFIDENTIAL**

Name of person completing reference \_\_\_\_\_

Position \_\_\_\_\_ School \_\_\_\_\_

Relationship to teen \_\_\_\_\_ Length of time known teen \_\_\_\_\_

Please briefly describe why you are recommending this teen to be a volunteer at St. Elizabeth:

\_\_\_\_\_  
 \_\_\_\_\_

Please tell us what your experience with the applicant has been by checking the appropriate box below.

<i><b>Applicant....</b></i>	<i><b>Superior</b></i>	<i><b>Good</b></i>	<i><b>Fair</b></i>	<i><b>Poor</b></i>	<i><b>Comments</b></i>
<b>is dependable</b>					
<b>uses good judgment</b>					
<b>relates well to others</b>					
<b>presents neat appearance</b>					
<b>has patience with others</b>					
<b>accepts instruction</b>					
<b>gets the job done</b>					
<b>does quality work</b>					
<b>respects confidentiality</b>					

Would you recommend this teen for volunteer placement in a hospital setting? \_\_\_yes \_\_\_no

Comments: \_\_\_\_\_

***Thank You!***