New Volunteer Packet- Checklist

Thank you for your interest in becoming a Volunteer at St. Elizabeth Healthcare! Please use this checklist as a guide to complete the required documents for volunteer service found in this packet.

☐ **Volunteer Agreement**
- Please read and sign

☐ **Confidentiality Agreement**
- Please read and sign

☐ **Initial Health Questionnaire**
- Please complete and sign

☐ Review the following **Immunization** requirements, obtaining the necessary immunizations or records.

MMR
- **Born 1956 or before:** Presumed immune to Measles, Mumps, Rubella.
- **Born 1957 or after:** Need written proof of **2** Measles, Mumps, Rubella Vaccines. If written proof is not available, a blood test will be completed to determine vaccination need.

Chicken Pox (for Everyone):
- Must have proof of **2** Varicella Vaccines or have had Chicken Pox. If unsure of having had Chicken Pox and do not have written proof of vaccinations, a blood test will be completed to determine vaccination need.

Influenza (Flu) vaccine (for Everyone):
- Required annually (September - April).
- 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.

Tdap (for Everyone):
- Required - will need to provide documentation of previous vaccine given after 2005.

☐ **Complete the Online Volunteer Application**

☐ **Call to schedule a Placement Appointment at your preferred facility:**

- **Dearborn, IN**: (812) 496-8658
- **Edgewood, KY**: (859) 301-2140
- **Florence/Grant, KY**: (859) 212-5375
- **Ft. Thomas/Covington, KY**: (859) 572-3166
- **Hospice** (*Edgewood, KY*): (859) 301-4622

St. Elizabeth Healthcare Volunteer Agreement

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

St. Elizabeth Volunteers are 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! ***Because of this:***

- **Adult** volunteers are asked to commit to a minimum 6 months of service
- **College** volunteers are asked to commit to a minimum of 12 weeks of service, or 8 weeks during the summer months (June through mid-August)
- **High School** volunteers are asked to commit to a minimum of one "*Session"* within the High School Volunteer Program
- *Failure to complete this commitment will result in dismissal from volunteer service or denial to return to volunteer service later. Additionally, the Volunteer Services department may not issue a volunteer service report or letter of recommendation.*

St. Elizabeth Volunteers are Compassionate

Volunteers at St. Elizabeth possess qualities essential to assisting patients and guests during a stressful and emotional time; they are friendly, compassionate, generous, honest, positive, and responsive - they CARE! ***Because of this:***

- In signing this agreement, you are acknowledging your understanding of these characteristics that should be found in a St. Elizabeth Volunteer and your willingness to fulfill these characteristics in your service at St. Elizabeth.

St. Elizabeth Volunteers are 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! ***Because of this:***

- Notification of end of service, changes in availability or inability to volunteer for a scheduled shift should be communicated in a timely manner and to the appropriate staff, whether that be the Volunteer Services department or assigned department.
- 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.

St. Elizabeth Volunteers are Competent

Volunteers are expected to be responsive to the ever-changing healthcare environment by learning new skills and adapting to new approaches. Volunteers are provided with extensive hospital orientation and training that is specific to their Volunteer position. ***Because of this:***

- An annual TB test is required of certain volunteers during a designated month; this requirement is determined by volunteer position
- Completion of Annual Training, a review of Hospital Orientation, and a Volunteer Self-Review is required of all volunteers during a designated month
- An annual Influenza vaccine is required of all volunteers by a designated date; those who chose not to receive an Influenza vaccine may take a leave of absence from volunteering during Flu Season

_____

Print Full Name

_____ _____

Signature Date

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 neighbors), 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.

_____	Volunteer Services
Name (Print)	Department
_____	_____
Signature	Date

St. Elizabeth HEALTHCARE Volunteer Services

Initial Health Questionnaire for Volunteers

Name: _____ **Date of Birth:** _____/_____/_____

Have you had the following diseases?

Yes	No	Unsure	
☐	☐	☐	Chicken Pox
☐	☐	☐	Have you had a previous positive TB skin test?

Have you had the following immunizations?

Yes	No		Yes	No	
☐	☐	Influenza	☐	☐	Measles, Mumps, Rubella *(MMR)*
☐	☐	Varicella *(Chicken Pox)*	☐	☐	Tdap *(Pertussis/Whooping Cough)*

Do you currently have any of the following symptoms?

Yes	No		Yes	No	
☐	☐	Productive Cough *(3+ weeks)*	☐	☐	Persistent weight loss
☐	☐	Persistent low-grade fever	☐	☐	Loss of appetite
☐	☐	Night sweats	☐	☐	Coughing up blood
☐	☐	Shortness of breath	☐	☐	Chest pain

If you marked "yes" to any of these symptoms, please comment on the back of this form.

Volunteer Signature: _____ **Date:** _____

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

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For Internal Use Only

Volunteer Office: **Edgewood** **Florence** **Ft. Thomas** **Hospice** **Dearborn**

Signature of Volunteer Coordinator: _____ Date: _____