ISLAND HOSPITAL

For Office Use Only:

Date Rec'd_____

WSP_____

VOLUNTEER APPLICATION

Name:_____ Ph: Hm:_____

Mailing Address:_____ Cell:_____ □ text ok

_____

E-mail address_____ *required

Emergency Contact:_____
(Name) (Phone) (Relationship)

Do you have any physical limitations or are you under any course of treatment that might limit your ability to perform certain types of work/tasks? (i.e. lifting boxes, pushing wheelchairs, etc) □ Yes □ No

Please explain:_____

Medication(s) allergies:_____

Food allergies (to accommodate at luncheons):_____

Availability:
All day shift hours are between 6am – 5pm; dependent on position.

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Hours Preferred: _____

Please list three non-family references whom we might contact (required):

1. _____ Phone:_____
2. _____ Phone:_____
3. _____ Phone:_____

How did you learn about our program?

Neighbor/Volunteer Saw Advertisement Volunteer Center

Website Agency/School

Other_____

I certify that the information provided herein is true and correct to the best of my knowledge, and I agree to update this information in the event that anything changes.

_____ _____
Volunteer Signature Date

ISLAND HOSPITAL

VOLUNTEER SKILLS

As a Volunteer you will have the opportunity to offer many of your skills and work in areas of interest to you. To better place you, and to know just what wonderful gifts you have to offer we would like you to fill out this inventory of skills. This information will assist us in placing you in just the right volunteer position.

Skills you have that you would like to share:_____

_____

_____

_____

Other Volunteer Activities: _____

_____

Educational/Occupational Background:_____

_____

Any other information that may help us to know you and your abilities?

_____

_____

_____

ISLAND HOSPITAL

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer you are privileged to become a member of the Island Hospital family. Once you become a member of the Volunteer team, you become a representative of the institution, and as such, your behavior at all times reflects upon the institution. It is expected that you will be worthy of the trust given to you, and that you will perform your duties to the best of your ability with intelligence, courtesy, tact, and cheerfulness.

The Hospital assumes an obligation to keep in strict confidence ***ALL*** information about patients. Each person who works here in any capacity shares this responsibility. Discretion cannot be too strongly emphasized. Keep confidential any information acquired through your volunteer service in the hospital. Never refer to the identity of a patient, his/her diagnosis, condition, or treatment. It is the obligation of each and every volunteer to respect a patient's privacy. **Do not discuss any information regarding a patient with any individual in or out of the hospital**. Do not seek information regarding a patient. It is well to forget even a patient's name when you leave the hospital, or while you are on breaks.

REMEMBER:

What you see here,
What you hear here,
Must remain here,
When you leave here.

I have read and understand the "Code of Ethics for Volunteers."

_____ _____

Volunteer Signature Date

ISLAND HOSPITAL

VOLUNTEER SERVICES
NON-DISCLOSURE/CONFIDENTIALITY AGREEMENT

I, _____, understand and agree that I must hold patient information/records, employee personnel records, hospital financial and operating data, computer information (including my password, if applicable) and ANY OTHER information of a private or sensitive nature, in the strictest confidence.

I also understand that if I am found to have violated this policy, I will be subject to disciplinary action up to and including discharge.

_____
Volunteer Signature

_____
Print Name

_____
Date

ISLAND HOSPITAL

CONFIDENTIALITY

POLICY:

One of the primary responsibilities of every employee (encompasses volunteers), physician and staff person is confidentiality. This is defined as "any information, written or spoken or computer-generated, that its unauthorized or indiscreet disclosure may be harmful to the interest of a patient, an employee or the hospital district".

Confidential Information:

- All patient Protected Health Information (PHI) which includes patient medical and financial information)
- Employee personnel records
- Hospital financial and operating data
- Computer information (including an individual's access password)
- Any other information of a private or sensitive nature

Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements.

Examples of unauthorized disclosures include:

- Discussing or revealing PHI or other confidential information to friends or family members.
- Discussing or revealing PHI or other confidential information to other employees without a need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility - without the patient's consent - to an unauthorized party who has no legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.
- Photographs of PHI and/or patients or other confidential information. Photographs related to clinical documentation of disease processes are permitted.

Responses to requests for information from outsiders (such as the press) about a patient, an employee, the hospital district or any hospital district-related activities are to be given only by authorized personnel, according to hospital policy.

PHI will not be disclosed to a patient's employer except as permitted or required by HIPAA, and RCW 70.02. Inquiries regarding patients from third party employers are to be directed to the Director of Quality/Risk or the Privacy Office.

Confidential written information shall be protected, and destroyed by shredding when no longer needed. Island Hospital utilizes an authorized contractor for confidential shredding, with locked bins available for disposal of confidential material.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the organization to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

The use of personal and/or Hospital provided camera is prohibited in patient areas or around PHI. Photographs for the purpose of clinical documentation are permitted.

_____ _____

Employee/Volunteer Signature Date

_____

Print Name

Island Hospital Non-Employee Confidentiality Agreement

Maintaining confidentiality for patients is of the utmost importance to Island Hospital. Unauthorized disclosure of protected health information (PHI) is a violation of the respect for the privacy of our patients and a violation of the ***Health Insurance Portability and Accountability Act of 1996*** (HIPAA). I understand that I may have access to PHI and Island Hospital wishes to insure that I maintain the confidentiality of all PHI to which I may gain access in accordance with all applicable state and federal laws, including without limitation the HIPAA Privacy Rules.

I understand that I may be given an Island Hospital computer access password, User ID(s) or other authorization which will allow me to access the Island Hospital computer network upon signing this Agreement and agree to comply with its terms. I understand and agree that I must hold PHI, my Island Hospital computer access password and any other information of a private or sensitive nature, in the strictest confidence and in accordance with HIPAA regulations and agree as follows:

1. I understand that computer access passwords used to access computer systems are the equivalent of my signature and should not be shared with anyone, including other office staff.

2. I will use PHI only as needed by me to perform my legitimate duties relating to and for the benefit of Island Hospital and its patients. This means that:

    a. I will not access or view PHI or utilize equipment containing such information other than what I have a legitimate need to know or utilize;

    b. I will not in any way divulge copy, transmit, release sell, revise, alter, or destroy any PHI except as properly authorized within the scope of my activities relating to Island Hospital. This includes, but is not limited to; removing and/or transferring PHI from Island Hospital's computer systems to unauthorized locations (e.g. home).

    c. I will not make inquiries about PHI for other individuals that do not have the proper authorization to access such information.

3. I will not misuse or carelessly fail to safeguard PHI. This means that:

    a. I will not disclose my access code, user ID(s), and password(s) or any other authorization I have that allows me access to confidential information. I accept responsibility for all activities undertaken using my access code, user ID(s), and/or password(s).

    b. I will log out of the computer system after accessing confidential files.

    c. I will not leave unattended a computer terminal to which I have logged on.

    d. I will not discuss confidential information where others can overhear the conversation.

4. If I have reason to believe that PHI or the confidentiality of my access code, user ID(s), and/or password(s) have been compromised, I will immediately report any known or suspected breach of confidentiality to the Privacy Officer even if such actions were made by another due to my intentional or negligent act.

5. I understand that I will be unauthorized to access PHI and that my access code, user ID(s), and Password(s) will be inactivated upon notification that I no longer have a legitimate need for access to the information.

6. I will return any documents or other media containing confidential information upon request or termination.

7. A periodic audit of patient access will be conducted by Island Hospital.

I understand that violating this agreement may result in computer access denial and/or termination of my relationship with Island Hospital and that I am responsible for any legal action resulting from my misuse of PHI.

The undersigned hereby acknowledges reviewing this Agreement and agrees to comply with its terms.

_____

Name (Last, First, Middle Initial)

_____ _____

Signature Date

Island Hospital_____

Employer

Volunteer_____

Position

Witness (REQUIRED) _____ Office Phone Number _____

ISLAND HOSPITAL

Confidentiality Statement

All patient Protected Health Information (PHI—which includes patient medical and financial information), employee records, financial and operating data of the Hospital, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his/her specific job requirements. Examples of unauthorized disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members.
- Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the Hospital to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Employee Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records, and data to which I have knowledge and access in the course of my employment with Island Hospital is to be kept confidential, and this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at Island Hospital pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Island Hospital is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Island Hospital are grounds for disciplinary action, up to and including termination.

_____ _____

Date Signature of Volunteer

_____ _____

Supervisor Print Name of Volunteer

MEMORANDUM

To: New Volunteers

Fr: Director of Volunteer Services

Re: Child and Adult Abuse Information Act

In 1987, the Washington State Legislature passed the Child and Adult Abuse Information Act. This law requires that employees and volunteers hired on or after January 1, 1988, who will or may have unsupervised access to and who will or may be directly responsible for the care, supervision or treatment of children or developmentally disabled persons, must make a written disclosure of certain civil adjudications, convictions, records of crimes against persons and, for licensed personnel, disciplinary board final decisions. Background inquires on these matters will be made to the appropriate state or federal law enforcement agencies. In compliance with this law, we are required to obtain disclosure statements from newly hired employees and volunteers as outlined above. We keep all information received in the strictest confidence.

Have you ever been convicted of a crime against persons? (A crime against persons includes any of the following offenses: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second or third degree statutory rape; first or second degree robbery; first or second degree arson; first or second degree manslaughter; first degree burglary; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; or any of these crimes as they may be renamed in the future.)

☐ Yes ☐ No

Have you ever been found in (a) disciplinary action, (b) domestic proceeding, or (c) disciplinary board final decision to have sexually assaulted or exploited a minor or to have sexually abused a minor?

☐ Yes ☐ No

If you answered "YES", please describe and provide the date(s) of the finding(s) and the penalty (penalties) imposed.

_____

_____

WASHINGTON STATE PATROL BACKROUND CHECK

We require your legal name (first, middle initial and last), alias/maiden name(s) (if applicable) and date of birth, to obtain from the Washington State Patrol Criminal Identification System a report of your record and criminal convictions for offenses against persons, civil adjudications of child/adult abuse, and disciplinary board final decisions.

We will be notified of the State Patrol's response within 5 – 7 business days after they receive the report. We will make a copy of the report available to you upon request. All information will be confidential.

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that I can be discharged from volunteering for any misrepresentation or omission in the above statement. I also understand that my volunteer status is conditioned on your receipt of a satisfactory report from the Washington State Patrol.

Signature: _____

Print Name: _____

Date: _____