University Hospitals
Geauga Medical Center

VOLUNTEER APPLICATION

Name: _____
Last first middle

Address: _____
Street City State Zip

Home Phone: ( ) _____ title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev. ☐ Other _____

Cell Phone # or other way to contact you _____ Birth date (year not required) _____

Email address: _____ Name you prefer to be called: _____

Emergency contact name and relationship _____

Phone: where this emergency contact can be reached ***during your volunteer hours*** _____

Physician's Name _____ Phone # _____

Are there any limitations that we should consider in your volunteer placement: _____

_____

Please circle last year completed in school Grade school 6 7 8 High School 1 2 3 4 College 1 2 3 4

Last (or current) school attended _____ Major _____

Current employer _____ Retired ☐ yes ☐ no

May we call you at work? If yes please list phone # _____ ☐ yes ☐ no

Occupation/current school _____ ☐ full time ☐ part time

Have you ever been convicted of any offense (other than traffic violation with a fine of $100 or less.)? ☐ yes ☐ no

If yes, please explain _____

A conviction will not necessarily disqualify a volunteer candidate; however, failure to disclose a conviction, regardless of how recent or severe, will be considered a falisification of this application.

Students Only:
Volunteer service is a requirement ☐ yes ☐ no
Required number of hours _____

Why do you want to volunteer?
- ☐ To help others
- ☐ Meeting religious beliefs
- ☐ To keep busy/something to do
- ☐ To make new friends
- ☐ Asked to volunteer by a friend
- ☐ Interest in health care field
- ☐ To gain work experience
- ☐ College/H.S. requirement
- ☐ Community service project
- ☐ Employer encouraged
- ☐ Court referred
- ☐ Other _____

How did you hear about us?
- ☐ Friend/relative another volunteer
- ☐ Friend/relative of an employee
- ☐ Visitor/relative of patient
- ☐ Former volunteer elsewhere
- ☐ Former employee
- ☐ Referred by physician
- ☐ School
- ☐ RSVP
- ☐ Volunteer Center
- ☐ Brochure
- ☐ Newspaper
- ☐ Radio
- ☐ Internet
- ☐ Community presentation
- ☐ Other _____

Previous and present volunteer experience

Agency: _____ Duties _____ from: _____ to: _____
Agency: _____ Duties _____ from: _____ to: _____
Agency: _____ Duties _____ from: _____ to: _____

Professional or community organizations of which you are a member: _____

Availability: On the chart below, please check any shift for which you would be able to accept a volunteer assignment. This gives us more options, but does not commit you to multiple assignments. **How many 3-4 hour shifts would you like per week** _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings							
Afternoons							
Evenings							

In order to maintain consistent staffing in all volunteer areas, please indicate how long you plan to volunteer here. As a reminder, all volunteers must agree to a minimum of 30 hours in the first year of volunteering.

The above information is accurate, complete and correct to the best of my knowledge. My signature indicates my approval for the hospital to call references I have provided and/or my physician regarding my physical and emotional health. The organization does not guarantee placement, and the volunteer is not obligated to accept the assignment offered. All placements of volunteers are at the sole discretion of the Manager of Volunteers.

_____ Date _____
Volunteer's signature

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex

Volunteers under the age of 18 must have the permission of a parent of guardian to become a volunteer.
I agree to have my child volunteer and understand that a 2-step Mantoux (TB) test is required. I also give my permission for the TB test.

_____ _____ _____
Parent/guardian signature Parent/guardian printed name today's date

I have the following skills and/or am interested in

Patient Care Services
- ☐ Assisting family
- ☐ Escort Service
- ☐ Patient Transport
- ☐ Mail delivery

Clerical Skills
- ☐ Alphabetizing
- ☐ Bookkeeping
- ☐ Collating/mailings etc
- ☐ Receptionist
- ☐ No clerical work

Office Machines
- ☐ Copier
- ☐ Computer
- ☐ Cash Register
- ☐ Calculator

Languages
- ☐ Spanish
- ☐ American Sign
- ☐ Braille
- ☐ French
- ☐ Hebrew
- ☐ Other _____

Communication skills
- ☐ Newsletter
- ☐ Public Relations
- ☐ Training/Teaching

Manual Skills
- ☐ Gardening
- ☐ Carpentry
- ☐ Elect/Mechanical
- ☐ Repair work

Other skills
- ☐ Fund Raising
- ☐ Special Events
- ☐ _____
- ☐ _____

University Hospitals
Geauga Medical Center

♦ STANDARDS OF BEHAVIOR FOR VOLUNTEER DEPARTMENT STAFF

♦ Volunteer Services Department

Excellent customer service is essential for Volunteer Department staff. We share the belief that all visitors to our department – staff, volunteers and the public in general - deserve to be received and treated with respect, kindness and professionalism.

VISITORS TO THE VOLUNTEER DEPARTMENT

Visitors to the Volunteer Department (including employees, volunteers & others) will be received and greeted with a smile and a warm friendly "Hello, how can I help you."

When current volunteers come into the office.

- Every attempt should be made to call them by name.
- Anything staff is working on should be set aside in order to give full attention to the volunteer.
- If a concern of complaint is shared, staff will make every effort to explain or address their concern.
- If staff is unable to resolve the volunteer's problem, a prompt detailed explanation will be made.

When a resident of the community comes into the office to explore volunteerism.

- All desk work will be stopped and set aside in order to give full attention to the visitor.
- All information given should be clear and truthful.
- Staff will make every effort to determine if openings in our hospital are well matched to the visitor's interest and ability.
- Staff will give the visitor a business card and note the dates and times of upcoming volunteer orientation.
- An application will be given to the visitor if they are prepared to accept one.
- We will note the name and phone number of the visitor so we can follow up within a week to see if a decision is made, if further information is needed, or simply to thank the visitor for stopping by.

TELEPHONE ETIQUETTE

- Initial calls from individuals requesting information concerning volunteering will be returned during the day the call is made, or Monday if message is received over the weekend. The message on the phone will remind callers that we are often out of the office, working in the hospital, but that all calls are important and will be returned promptly.
- Staff will be prepared to return calls during the evening if that is more convenient to the prospective volunteer.

GENERAL

- Dress for staff will be professional, clean, neat and unassuming.
- ID badges will be worn (face out) at all times.

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- When in the halls of the hospital, staff will assist visitors or patients who appear to be lost or in need of assistance. Whenever possible, take the visitor to their desired location, do not just point them to a destination.
- We are ambassadors of good will and whether in the Volunteer office of in the halls, or anywhere in the hospital we will be ready to offer help and assistance whenever needed.
- What we see and hear at UH Geauga Medical Center stays where you heard it! Confidentiality is of paramount importance, and when we have access to confidential information it will remain where it was found and will not be shared except on a direct need-to-know basis.
- Helping to identify problems will show our pride in the facility. If we see a spill on the floor we will clean it up or immediately get help to clean it. Pieces of paper etc. on the floor or in the waiting areas will be seen as our responsibility and will be disposed of properly.
- Conversations in public areas will be conducted in quiet appropriate voice levels. If the individual to whom we are speaking appears to be hard of hearing, we will raise our voice to make them comfortable and make it easier for them to understand the information we are sharing.

STANDARDS OF BEHAVIOR FOR VOLUNTEERS

- Volunteers will be in accordance with the current dress code and will be clean, neat and unassuming.
- ID badges will be worn at all times.
- When in the halls of the hospital, volunteers will assist visitors or patients who may be lost or in need of assistance. Whenever possible, take the visitor to their desired location, do not just point them to a destination.
- Volunteers are ambassadors of goodwill and when serving as a volunteer in the hospital they will be ready to offer help and assistance whenever needed.
- Though always being helpful, volunteers will not assume responsibility for a job until or unless directed by a staff member of the hospital.
- In order to maintain the highest possible level of safety and health, gloves will be worn when working directly with patients, their belongings, specimens or chemicals of any kind.
- Avoid making any comments about hospital staff, facilities, departments etc. Comments such as, "It's really hectic in surgery today," does not make patients or visitors feel comfortable. Remember that what may be a casual comment to you, may be upsetting to patients and visitors.
- Remember the 10-5 rule. When ten feet from someone try to catch their eye and smile. When you are 5 feet from someone speak. A simple "Hi" or "Hello" goes a long way to make people feel important.
- If you are working with a patient give them your full attention. If there are two volunteers working with a patient (transporting etc.) do not have a conversation with the other volunteer. This gives the appearance of rudeness to the patient.

_____ _____

Volunteer signature Date

_____ _____

Staff signature Date

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HIPPA Privacy Standard Handouts

Handout 1

What is Protected Health Information (PHI)?

HIPAA creates and defines the term Protected Health Information as individually identifiable health information that is transmitted or maintained in any form or medium. Health information becomes "protected" when it is combined with any piece of information that could identify who the patient is. Examples of these "identifiers" are the name of the physician treating the patient, medical record number, discharge date, date of birth, patient's address, telephone numbers, social security number, and, of course, the patient's name. For the most part, the majority of information we work with in health care would be classified as "protected" information.

Examples of PHI

- A medical chart or record and all the information contained within
- Lab test results printed on a fax sheet or viewed online on a computer screen
- An x-ray film with the patient's name or medical record number on it.
- A billing statement showing the patient's name and the service provided to them
- A surgery schedule listing patients and their procedures.
- Information telephoned or faxed to a home health provider indicating the patient's name and care required

What is the importance of the phrase "Treatment, Payment and Operations" (TPO)?

HIPAA permits health care workers to share PHI without the need for specific patient authorization as long as the workforce member is using the information for "Treatment, Payment and Operations." This means that we can share patient information openly with other persons who are directly involved in the patient's care. We can also share information as needed to get paid for the services we provide. In addition, UHHS can share information on patients when it needs the information to complete certain business "operations" – such as quality assessment, risk management, performance evaluations, employee training and development, and service improvement.

Examples of Communications Allowed Under "TPO"

- A discussion between a physician and a nurse about a patient's care
- A billing clerk's request for information on a patient so that a bill can be processed
- Analysis of a patient's PHI as part of a risk management inquiry
- Information passed from a nurse to a transporter to notify the transporter of any special needs the patient will have when being transported
- Patient information provided to an insurance company to clarify a claim for payment 1 c, 2a, 3d, 5b

What is Meant by "Minimum Necessary"?

"Minimum Necessary" is the term HIPAA uses to describe the level of information sharing that is appropriate when PHI is being communicated to others. It means that we should avoid giving out more information than really needs to be given out. The idea is to communicate only the information that is really needed by the person you are communicating with – no more and no less. Also, employees should be given access only to the information they really need to do their jobs. A computer screen, for example, should only show the patient information that the employee really needs to do their work and should not have other information on it that is not useful or relevant to the employee.

Handout 2

Personal Actions You Should Take to Protect the Privacy of Our Patient's Protected Health Information

- When someone asks you for information about a patient, make sure they have the right to receive the information they are asking for.
- When you give patient information out to others, give only the information the person really needs to have. Don't give them extra information they haven't asked for or aren't allowed to have.
- When you need to talk to another staff member about a patient's condition or treatment, you should lower your voice and do what you can to make sure that the conversation can't be overheard by other patients or visitors. For the most part, patient care should not be discussed in public areas, waiting areas, hallways, or elevators.
- Protect patient privacy by keeping documents and reports that have PHI on them in safe areas, out of the view of those who might happen to walk by.
- If you use the telephone, fax machine or email to share PHI with other facilities, organizations or employees, make sure that the information you send is going to the correct person and that they have the right to receive the information.
- Always follow proper procedures for logging in and out of computer systems. Never share your password with others.
- Sometimes our patients are also employees of UHHS. Their privacy, and the confidentiality of their PHI, must be respected just as we would with any patient.
- It is never appropriate to share private health information about our patients with our family, neighbors, friends, or clergy unless the patient has specifically told us it is okay to do so.

Who is allowed to have access to our patient's health information?

1. Patients have the right to have access to their own health information.
2. You are allowed to have access to the information that you need to do your job – no more, no less.
3. Other employees are allowed to have access to the information they need to do their jobs.
4. Family members, close friends of the patient, and Personal Representatives of the patient are allowed to have access to the patient's health information – but only to the extent that is appropriate given their relationship to, and involvement with, the patient.
5. At times, legal representatives, law enforcement workers and regulatory investigators have the right to have access to a patient's health information.
6. Employees (and other authorized persons) who are doing quality assurance reviews, risk management investigations or staff training have the right to access patient health information to do their work.

If you aren't sure that a person has the right to have access to the information they are asking you for, always check with your supervisor first before releasing the information. Then, give the person only the information that they really need – no more, no less.

Handout 4

Patient Rights Granted Under the HIPAA Privacy Standards

- Patients have the right to receive a copy of the UHHS Notice of Privacy Practices (NOPP). The Notice of Privacy Practices tells the patient what kinds of PHI we collect on them, how we use it and what their rights are for controlling, reviewing, copying, and amending this information.

- Patients have some rights to review, copy and amend the health care information we have on them. If a patient tells you they want to see their health care records, or obtain a copy of their health information, or add information to our charts or records, tell them you will advise management of their request. Then, notify your supervisor. Assure the patient that someone will get back to them about their request in a timely manner.

- A patient can ask to restrict the way we share their information with others, what information we can share, and also who we share their information with. All requests to restrict sharing of information need to go through the Privacy Officer. If the Privacy Officer agrees to the restriction, all employees will be expected to follow the restrictions.

- A patient has the right to file a complaint if they feel we have shared their health information with others in an inappropriate manner. If a patient tells you that they believe their privacy has been violated, or you believe you have observed a breach of patient privacy, notify your supervisor immediately.

- Patients have the right to expect us to provide them with an Authorization Form if we intend to use their health information for purposes other than the treatment, payment or operations uses summarized in the Notice of Privacy Practices. The authorization must describe how the PHI will be used, what is needed, the date the authorization expires, and who may disclose it and to whom.

- Patients are permitted to designate an individual to be their Personal Representative. Usually, a Personal Representative is a family member, relative or close personal friend. Sometimes the Personal Representative is a person who holds a Durable Power of Attorney for Health Care on behalf of the patient. They could also be a Guardian or an Executor of a deceased patient's estate. You can share the patient's PHI with their Personal Representative, but be sure to give them only the information they really need and are allowed to have. Ask your supervisor if you are unsure.

- Patients have the right to "opt out" of our patient registration system and/or facility directory. They may choose to do this if they don't want others to know that they are in a hospital or under a doctor's care. When a patient "opts out," they can be given an "alias" name in the system or directory. Be sure to use the patient's "alias" when discussing their care with other employees – especially if bystanders might be able to overhear.

Handout 3

Safeguarding Patient Information

Protection of patient health care information is a major goal of HIPAA. UHHS employees must take reasonable steps to maintain the confidentiality of patients' health information. These steps include common-sense practices such as keeping documents and charts with patient information out of view from casual onlookers, avoiding discussing patient information in public areas, and keeping computer screens turned away from public view when accessing patient information.

Patient confidentiality should also be protected in the following three situations:

Dealing with Phone Calls

- If you aren't sure that the person you are speaking with has the right to have information on the patient, it is best to take a message and tell the caller that you will have someone call them back (a nurse, doctor, family member or the patient).
- HIPAA allows you to give out certain information if the caller asks for the patient by name. You can:
  - Provide the patient's location in the hospital/facility
  - Provide a general statement of the patient's condition ("stable," "progressing well," etc.)
  - Provide the patient's religious affiliation if the caller is a member of the clergy

Using the FAX Machine

- Always use a cover sheet with a confidentiality reminder on it.
- If you need to send PHI through a FAX machine, verify that you have dialed the correct number before you press "send."
- If you have FAX numbers pre-programmed into your machine, make it a practice to periodically verify that the numbers are still correct.
- If you receive a FAX in error from someone else, and it has PHI on it, contact the sender and let them know they are faxing to the wrong number. Then, shred the FAX they sent you.
- Avoid leaving a FAX containing PHI sitting on the FAX machine where someone might be able to read it or take it.

Using Computers

- Always follow correct procedures for logging in and out of networks and computer systems.
- Never give your password to others or let others use your password to access a system.
- Make sure your screen is tilted away from the direct view of passersby or those who are standing nearby.
- Do not leave reports or documents containing PHI sitting on the printer where someone might be able to view them or take them.
- If you send PHI through Outlook email, make sure your message contains an appropriate confidentiality reminder.
- If you receive an email containing PHI from someone by mistake, reply to the sender to let them know that they have made a mistake, then delete the message they sent you.

HIPAA Privacy Standards Training

Participant Post-Test

UH Geauga Medical Center

Please PRINT your name: _____ Date: _____

Please PRINT your department's name: _____

Instructions: ***Read each question carefully and review the four possible answers given below the question. Decide which one of the four answers is the best one and circle the letter next to your answer. Choose only one answer.***

1. **What information does HIPAA always allow you to tell a person over the phone, assuming that they have asked for the patient by name? (except for behavioral health unit patients and except for patients who have "opted" out of the hospital directory).**
   a. The patient's diagnosis and general condition.
   b. No information can be given out.
   c. The location and general condition of the patient.
   d. Only the patient's location.

2. **Two nurses are eating lunch in a hospital's crowded cafeteria. Nurse A says to Nurse B, "Mr. Johnson, the cancer patient in Room 227, sure had a rough morning. He vomited three times." Did Nurse A violate the patient's right to privacy?**
   a. Yes, because someone could identify the patient from what Nurse A said.
   b. No, because the patient's first name wasn't mentioned.
   c. No, because nothing specific was said about what was wrong with the patient.
   d. No, because it is a private conversation, not meant to be overheard by others.

3. **What does the term *minimum necessary* mean?**
   a. Information can only be shared with the patient or their representative.
   b. Information obtained from UHHS patients should be shared only within UHHS, not with outsiders.
   c. Protected patient information should be shared with as few people as possible.
   d. Care should always be taken to give out only the information that the other person has a right to know, never more than is necessary.

4. **What is the *Notice of Privacy Practices*?**
   a. A statement that describes how a patient's medical information may be used and shared by UHHS, and how a patient can gain access to their health records.
   b. A UHHS form that authorizes a patient or facility to use and disclose information.
   c. Another name for the Patient Bill of Rights.
   d. A UHHS form signed by the patient that states they want to restrict sharing of their health information.

5. **What would be a reasonable action to take to protect patient privacy if you are talking with a patient about their care in a semi-private room, and the other bed in the room is occupied?**
   a. Write down the information and give it to the patient to read.
   b. Close the curtain between the beds and keep the volume of your voice as low as possible.
   c. Remind the patient in the other bed that your patient's information is private and ask them not to listen to your conversation.
   d. There is really nothing you can do to avoid being overheard, and the TPO exclusion in HIPAA says you don't need to be concerned about what the other patient might overhear.

University Hospitals
Geauga Medical Center

CONFIDENTIALITY FOR VOLUNTEERS

Confidentiality means trust – Confidence

- Patients and their families trust the caregivers at University Hospitals Geauga Medical Center to care for them as individuals. In providing this care we may be privileged to information about the patient and their family that we need to know in order to provide individualized care.

- To give out this information to the wrong people is violating the trust and confidence patients and families have in us as caregivers.

- Physicians, clergy, lawyers, nurses, social workers and all other professional educated staff take an oath to keep information confidential. Volunteers need to exercise the same professionalism when dealing with confidential information.

- Confidentiality has a high-value level. Patients and staff members, in order to feel secure, have to have trust and confidence in health care workers, volunteers and the leadership of these hospitals. To violate this trust may have legal consequences to the violator and to the organization. Since these hospitals holds confidentiality of patient and staff information in such high regard, the following policy is in effect.
  1. All hospital employees are restricted to the type of information they may give out concerning the patient and the institution. *Volunteers may not give out any information to family members and/or friends.*
  2. Only the physician, or nurses at the direction of the physician, may release information about patient's physical, mental or psychological condition.
  3. Medical records are confidential information. They are not released for review, summarizing or photocopying without proper authorization from the patient or responsible party. The medical record is the property of the hospital.

- There is some information that should be passed on. A patient may tell you something that will interfere with his/her care and treatment and the charge nurse should know. You should report this to the charge nurse. However, what the patient tells you has no bearing with or on his/her care, and the information is confidential.

- If another patient or family member asks you information about a patient, your answer should be directed to general information not medical (for example *instead of* "He is looking better," comment, "We had a nice conversation today"). This doesn't sound "stuffy" but allows you to make no reference at all to the patient's appearance, health and or progress.

I have read and understand the above statement about confidentiality of information noted above.

Date _____ Signature _____

Parental Signature is needed if volunteer is under the age of 18. Parents need to be aware of the importance of confidentiality required of our volunteers.

Date _____ *Parental Signature* _____

University Hospitals
Geauga Medical Center

CONSENT TO PARTICIPATE

University Hospitals Geauga Medical Center

Volunteer Services Department

While fulfilling your duties as a representative of University Hospitals Geauga Medical Center Hospital Volunteer Services Department, please remember that you are a representative of the hospital to our patients and visitors. Therefore we ask that you conduct yourself accordingly, in compliance with the following terms.

1. If you feel you have not been provided with adequate information about the purpose, time commitments, supervision and/or your anticipated responsibilities relative to the problem, please contact the Volunteer Services Department.

2. As a volunteer at either hospital, you are expected to comply with relevant hospital policies and not engage in activities that are detrimental to patient care or customer satisfaction.

3. You must also understand that in the performance of your duties as a hospital volunteer, you must hold in strict confidence any observations you may make, see or hear regarding the hospital patients, physicians and/or personnel.

4. Further, please understand that intentional or involuntary violation of confidentiality and/or other hospital policies may result in corrective action by the hospital and/or possible legal action by others, such as by patients and their families.

➢ All volunteers are accepted for **a required minimum of 32 hours** in their first year.

The hospital reserves the right to terminate your participation in the Volunteer program.

Date _____ Signature _____

Volunteers under the age of 18 need to have their parents' signature on this document to indicate that the parent understands and agrees to the commitment to volunteer.

Additionally, signing this statement indicates that as this volunteer's parent or guardian, I agree if any accident should occur while the minor child is volunteering at the hospital, the hospital has the permission to send that minor volunteer to our Emergency Department. The hospital would at that time make every effort to contact one of the parents or guardian.

Parental signature _____ *Date* _____

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Please print your name clearly:

University Hospitals
Geauga Medical Center

DEAR VOLUNTEER,

We need the names and full addresses of two individuals who know you and can complete a reference form that we will mail to them. These must be non-family members and those who have known you for three or more years. You can use friends of your family, neighbors, your friend's parents, school teachers and/or counselors or church references. *The important thing is that we need these returned to my office before you can start volunteering.* We suggest that you choose individuals who will quickly complete the references that we mail to them. Please clearly print the name and address of the individuals to whom we should mail reference forms.

Name (print clearly)	
Complete Address Phone #	

Name (print clearly)	
Complete Address Phone #	

University Hospitals
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Volunteer Mantoux Testing

An initial two-step Tuberculin skin testing is required for all new volunteers (and staff) at University Hospitals Geauga Medical. A one-step TB test is required annually thereafter during the month of your initial TB test. You will receive a reminder prior to your annual date of volunteering.

The procedure involves the injection of 5TU of Purified Protein Derivative (PPD) solution into the inner aspect of the forearm. You will need to return to the hospital 2-3 days later to have the TB test read. If you have had a past positive reaction, please make the individual administering the test aware prior to the completion of the test. If the first TB test is negative, a second test is administered one week later, again requiring you to return 2-3 days later to have the test read.

Either a physician or the applicant's county of residence TB clinic must evaluate those persons exhibiting a significant reaction. Annual documentation of review of signs and symptoms via a questionnaire will need to be completed after a positive test.

After the first year of testing persons converting from a non-significant skin test to significant results will receive a physician evaluation (your PCP or from the County Health Department where you reside). If the disease is present the volunteer will be off work until cleared by the Occupational Health Physician.

I give UH Geauga Medical Center authorization to give me a two-step TB skin test. I have read the above statement and understand its contents; therefore, I absolve the Institution(s) and the individual giving g the test of any and all responsibility.

_____ Date_____

Volunteer applicant's signature

If volunteer is under 18 years of age, parental consent is required:

As parent (or guardian) for _____ (print name of minor) I have read the statement above and give my approval for the administration of this test and the annual renewal TB test.

_____ _____

Parent's signature **Date**

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University Hospitals
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Volunteer Agreement

If accepted into Geauga Medical Center, I agree to:

1. Hold as absolutely confidential all information that I may obtain directly or indirectly concerning clients and staff and other volunteers and not seek to obtain confidential information from a client.
2. Become familiar with the organization's policies and procedures and uphold its philosophy and standards.
3. Donate my services to the organization without contemplation of compensation or future employment.
4. Be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
5. Furnish and maintain an appropriate uniform and maintain a well-groomed appearance during my volunteer time.
6. Attend orientation and in-service(s) as scheduled.
7. Carry out assignments and seek the assistance of the job supervisor when necessary.
8. Take any problems, criticism or suggestions to the Manager of Volunteer Services (allowing the Volunteer Department to decide on the most appropriate action for my concerns and/or suggestions).
9. Work a specified number of hours on a schedule acceptable to the organization and to me.
10. Adhere to the proper sign-in procedure.
11. Notify the Volunteer Office by phone if I am unable to work as scheduled (or using the appropriate "absent" forms kept in the Volunteer sign-in book).
12. Honor a minimum 3-month commitment towards volunteer service with the first month being a probationary period.
13. I understand that the Volunteer Department reserves the right to terminate my volunteer status as a result of
    a. failure to comply with organization policies, rules and regulations
    b. absences without prior notification
    c. unsatisfactory attitude, work or appearance, or
    d. any other circumstances which, in the judgement of the department Manager, would make my continued service as a volunteer contrary to the best interests of Geauga Medical Center.

14. **I agree to volunteer a minimum of 32 hours at UH Geauga Medical Center. If I require verification of my volunteer activity (for school, scouts etc.) and have not completed the required 32 hours, this failure to comply will be noted in the verification.**

I have read each of the above conditions and I agree to be bound by them.

Volunteer's signature_____ Date _____

Volunteer's printed name _____

Volunteers under the age of 18 need to have their parents' signature on this document to indicate that the parent understands and agrees to the commitment to which their youth has committed.

*Parental Signature*_____ *Date* _____

University Hospitals
Geauga Medical Center

In connection with my application to volunteer my services at University Hospitals (UH), I understand that investigative background inquiries will be made concerning me, including, potentially, consumer reports, investigative consumer reports, criminal, driving and other reports. These reports may include information as to my character, credit worthiness, general reputation, personal characteristics, mode of living and work habits, performance and experience, along with reasons for termination of past employment from previous employers. I have a right to request disclosure of the nature and scope of the report.

I understand these reports may contain negative information about background, character and personal reputation and they will be used solely for purposes of placement. I also understand that providing false and/or incorrect information in the application for volunteer services can result in immediate termination of my status as a volunteer.

By signing below, I hereby authorize, without reservation, any person or agency contacted by UH to provide information about the above areas of my life. This authorization is effective as of the date signed and it will remain effective until further notice.

I further release UH from any claims or liabilities of any kind resulting from its obtaining and using any such background information, including any consumer reports. I understand that I have rights under the Fair Credit Reporting Act, including the rights discussed in the Fair Credit Reporting Act Disclosure that UH provided for me in conjunction with this authorization.

_____ my initials indicate that I hereby acknowledged that I have received the Fair Credit Reporting Act Disclosure from University Hospitals.

Print full name _____

Social Security Number _____-_____-_____

Birth date: _____(month day year) ex. 01311999

Current address _____

City/state/zip code _____

Driver's license number (if applicable) _____ State _____

Ohio resident for the past five (5) years? ☐ Yes ☐ No

Applicant's signature _____ Date _____

University Hospitals
Geauga Medical Center

Name _____ VOLUNTEER DEPARTMENT

➢ TUBERCULIN SKIN TEST

SECTION A

Have you had TB	**no ☐**	**yes ☐**	**if yes, when**_____
Have you been treated for TB	**no ☐**	**yes ☐**	**if so, when** _____
Previous Skin test for TB	**no ☐**	**yes ☐**	

When? _____
Where ?_____
Negative ☐ **Positive ☐ ***IF POSITIVE COMPLETE SECTION C ***

SECTION B FIRST AND ANNUAL TB SKIN TESTING (test should be read between 48 & 72 hours after test is administered.)
Date placed _____ Type, lot & expiration _____

The TB test was given by _____
Site: **L. forearm ☐ R. forearm ☐**
Date read _____ Read by _____
Result: ☐ Positive **____mm induration** ☐Negative **____mm induration**
Comments _____

Comments _____
SECTION C YEARLY SURVEILLANCE FOR PPD REACTORS (positive Skin Test)

Have you had any of the following symptoms?

1. Chronic and/or productive cough? Yes ☐ No ☐
2. Night sweats? Yes ☐ No ☐
3. Unexplained fevers? Yes ☐ No ☐
4. Unexplained weight loss? Yes ☐ No ☐
5. Chronic fatigue? Yes ☐ No ☐
6. Blood tinged sputum production? Yes ☐ No ☐

If "YES" to any question, please describe your symptoms further. Include onset of symptoms, was treatment sought and what treatment was done?

_____*FOR OFFICE USE ONLY*

*Was this employee referred for further evaluation? Yes ☐ No ☐*If "yes", to whom? _____

Signature_____ Date_____

To arrange for TB reading and testing please contact Paula Leonette.

Paula's Geauga Medical Center Phone Number 285-6569