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HERITAGE VALLEY
HEALTH SYSTEM

Adult Volunteer Application

Today's Date: _____ Campus: Sewickley Beaver

Age Group: 18 - 25 26 - 35 36 - 49 50 - 65 65 +

Please select: Mr. Mrs. Ms. Miss Dr. Other

 Last Name (Please print) First Name Middle Initial

 Street Address Apt. Number

 City State Zip Code

 Home Phone

 Email Address Fax No. Cell Phone No.

Please list current employer. If no longer employed, list your last employer. PLEASE PRINT

 (Current – Last) Employer Position Dates of Service

 Business Telephone Email Supervisor/Title

 Street Address City State Zip Code

Education: High School (Name) _____ (Year Graduated) _____

College: (Name) _____ (Year Graduated or Years Completed) _____

Other Post High School Training: _____

Post Grad Education: School/Major/Degree/Year Received: _____

Special Training/Skills/Hobbies: _____

Volunteer Experience (When/Where): _____

Referral Source: Volunteer Employee Physician Friend Newspaper Hospital Publication Other

Are you a U.S. Citizen? YES NO If no, what type of visa do you hold? _____

Have you ever been convicted for abuse or neglect? YES NO

Have you ever been convicted of a felony? YES NO If yes, please explain: _____

Do you have any relatives currently employed by Heritage Valley Health System? YES NO

If yes, please list the following: Relative/Relationship and Department in which he/she works. _____

Reference: List someone, other than a friend or relative, who knows your work record. Your application will not be considered without completing this section in full.

Name: _____ Phone: _____

Business (if applicable): _____ Title: _____

Address: _____

In case of emergency:

Name: _____ Relationship: _____

Telephone: _____ Work Phone: _____

Address: _____

Company Name: _____ City/State/Zip: _____

What type of volunteer work are you looking for? (Please be specific) _____

When are you available to volunteer?

NOTE: Mornings in offices normally start at 8:30/9:00 a.m.; some clinical areas may begin as early as 6:30 a.m.; Afternoons normally run from Noon to 4:00 p.m.; Evenings in most areas run 4:00 p.m. to 8:00 p.m. Please be as specific as possible with the actual times you are able to volunteer and list those under the appropriate days.

	M	TU	W	TH	F	S	SU
Morning							
Afternoon							
Evening							

My signature is your authorization to check the accuracy of the above information. It also indicates that I understand, if accepted, the need for regular attendance and punctuality in service. I am offering my services to Heritage Valley Health System willingly and without pay.

Signature

Today's Date

All information requested on this application including dates, addresses and phone numbers must be completed in full prior to formal processing. Please be aware that your reference and/or employer may be contacted to verify your information.

EQUAL OPPORTUNITY

Volunteer Services believes that all persons are entitled to equal opportunities, and does not discriminate against applicants for volunteer service because of race, creed, color, religion, national origin, age, or sex. The hospital policy of non-discrimination prevails throughout all aspects of the volunteer relationship.

CONFIDENTIALITY

Heritage Valley Health System has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health and social information. Additionally, HVHS must ensure the confidentiality of its human resources, payroll, fiscal, computer systems, management, and other non-public information.

"Confidential information" includes but is not limited to all previously listed information. In the course of your professional association with HVHS, you will come in contact with confidential information. In order to volunteer within HVHS you will receive a copy of the Confidentiality Agreement at the interview session and will be asked to sign and comply with all of its terms.

ORIENTATION/ANNUAL EDUCATION

Prior to placement, all volunteers will be given a resource manual. This manual will contain all of the general information needed in order to be sufficiently aware of the policies and procedures of the health system and volunteer services. Posttests are also required and will be included with the manual. These posttests must be completed and returned to the volunteer department for inclusion in one's personnel file. Additionally competencies are required for key service areas and will also be provided for completion. The director will inform the volunteer which competencies are required. Yearly, all volunteers must complete an annual education update.

UNIFORMS/IDENTIFICATION BADGE

All volunteers will receive a uniform and a picture identification badge that must be worn at all times while volunteering. Upon permanent departure from the program, the identification badge must be returned.

CONFIDENTIALITY AGREEMENT

I understand Heritage Valley Health System (HVHS) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health and social information. Additionally, HVHS must ensure the confidentiality of its human resources, payroll, fiscal, computer systems, management, and other non-public information.

“Confidential Information” includes, but is not limited to, all previously listed information. In the course of my professional association with HVHS, I will come in contact with Confidential Information; and I understand that the following are my responsibilities in protecting such information.

I further understand I must sign and comply with this agreement in order to be authorized to access any HVHS Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends, family or other HVHS affiliates, who do not have a need to know the information.
2. I understand that my personal access code, user ID(s) and password(s) used to access computer systems are also an integral aspect of this Confidential Information. I am responsible for all activity performed under my access code. I will not willingly inform another of my computer password or knowingly use another person's user ID instead of my own for any reason, (except as necessitated by department manager or Information Systems to address system issues). I will log off all applications prior to leaving a computer unattended.
3. I will not access or view any Confidential Information, or utilize equipment, other than what is required to do my job.
4. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such information.
5. I will not make any unauthorized transmissions, inquiries, modifications (intentional or accidental), of Confidential Information in any format, (written, printed or electronically recorded); nor will I purge such information. These unauthorized transmissions include, but are not limited to, removing and/or transferring Confidential Information from HVHS computer systems to unauthorized locations.
6. The approved disposal of information must ensure the continued protection of Confidential Information. Hard copy form must be shredded and/or torn before being discarded or confidentially recycled. Electronic media, which does not contain the primary data source must be erased before being discarded or reused.
7. I understand all computer access activity is subject to audit.
8. I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, or in other places outside of HVHS). It is not acceptable to discuss Confidential Information in public areas even if a patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.
9. I will immediately report to appropriate management any activity, by any person, including myself, which is in violation of this Agreement.
10. I agree that my obligation to keep information confidential continues outside of work hours and even after the termination of my professional association with HVHS.
11. Upon termination of my professional association with HVHS, I will immediately return any documents or other media containing Confidential Information to HVHS.
12. Security and privacy policies of HVHS were adopted to protect the security and privacy of Confidential Information. As an employee, I will read and comply with all such policies. As an affiliate, I can access these policies for my information on legal and ethical compliance.
13. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my professional association, in accordance with corrective action policies, as well as legal liability.

By signing this document, I understand and agree that I have read and will comply with all its terms.

Signature of employee/physician/resident/student/intern/volunteer/contracted worker or other affiliate:

Signature _____

Print name _____ Date _____