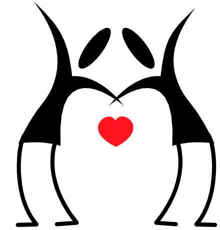

# About Volunteering
# at Ogden Regional Medical Center

*(Please remove these sheets for your information. Return the completed application)*

Thank you for your interest in volunteering at Ogden Regional Medical Center. We have approximately 150 volunteers ages 17 and older. We look forward to the opportunity to work with you.

Following are answers to frequently asked questions that are intended to simplify the application process for you. Court ordered community service or attendance credit hours cannot be worked off or signed off at Ogden Regional

Bringing on a new volunteer entails financial and resource commitments from ORMC in preparing, orienting, and training. For this reason, applicants must be willing to make a service commitment of 100 volunteer hours. We find that as volunteers gain experience, their social relationships and service experience become enjoyable and they frequently stay long-term.

Our volunteer opportunities are flexible. During the interview, we will discuss current openings and time commitment. As a general rule, volunteers are asked to work a minimum 4- to 5-hour shift, one day per week. Of course, volunteers are welcome to add more hours/days if desired. For those with career objectives, we offer limited openings in clinical areas; however, these positions are peripheral support in nature, as volunteers are not permitted to offer patient care. Listed below is the process we follow:

**Assignments-** Volunteer assignment possibilities are listed on page 2 of the application. Review the opportunities before you fill out the rest of the application.

**Application** - Complete an application, answering all questions fully, including the health record. You must include drivers license and social security number for the background check. Return application to the volunteer office, fax or mail it to:

**Attn: Sally Gale, Volunteer Director**
**5475 South 500 East**
**Ogden, UT. 84405**
**Phone - 801-479-2075 FAX - 801-479-2164**
**sally.gale@mountainstarhealth.com**

**Interview** - After an application review, you will be contacted for an interview appointment. At this time, the objective is to determine a good service match for you from current openings.

**TB Test** - This simple Tuberculosis test is mandatory before beginning service. The test will be administered on your interview day at our expense. Remember to return within 48-72 hours to have the test read and recorded.

**Badge** - Human Resources will take your photo and prepare a volunteer badge on your interview day.

**Orientation** - Allow at least 2 weeks after submitting your application for the background check to clear. You will then be scheduled for mandatory hospital orientation. Sessions are scheduled once monthly, always on a Monday 8am-2pm. Further training and supervision is offered in your assigned department by a fellow volunteer or by a department employee.

**Uniform** - Working within the hospital requires a volunteer uniform. Select one of three styles tops, our complements. The remainder of the uniform consists of tan/kakki slacks, closed toed shoes and socks (volunteer responsibility).

**Immunize – History** Most people can use the following guidelines to approximate their immunization history. For Utah students who started school after 1960, at five-years of age, before entering kindergarten most had the polio, MMR, and DP(Tetanus). At age12, before entering Junior High school, most Utah students had an MMR and Tetanus booster. If you do not have a written immunization record, use this information to jog your memory. Simply record the year according to your best memory.

**Communicable – Disease** If you cannot recall the exact year you had a communicable disease such as chicken pox, estimate how old you were and fill in the year. Do not leave this page blank. We need as much health history as you can recall.

**Commitment** –Due to the resources and time invested in your training, we require a minimum commitment of **100 hours**. This can be accomplished by volunteering in one department weekly for 6 months, or through a more intense schedule serving in more than one area. Should you discover your original assignment is not a good match, please do not terminate service. Visit with the Volunteer Director to discuss additional openings for which you qualify. There is a system in place that allows for absence, vacation and family time off.

**Volunteer Defined:** A volunteer is an individual who donates services without contemplation of payment for a public spirited or charitable purpose.

Time spent in these preparatory steps is necessary and informative. You will feel more at home in the hospital atmosphere, and you will be well prepared to serve. We expect you will enjoy your volunteer service and benefit personally from this fulfilling experience. We are anxious to get acquainted with you and put your talents to use.

An appointment will be made after we receive your application. If you have further questions contact: **Sally Gale, Volunteer Director at 479-2075.**

# OGDEN REGIONAL MEDICAL CENTER

## VOLUNTEER APPLICATION

**Attn: Sally Gale, Volunteer Director**
**5475 South 500 East, Ogden, Ut. 84405**
**PH: (801) 479-2075 FAX: (801) 479-2164**
**Sally.gale@mountainstarhealth.com**

Name ______________________________________ Date _____________________________

Address ______________________________ City ______________ St. _____ Zip __________

Birth Date __________________ Home Phone # _______________ Work/Cell# ______________

E-mail address _________________________________________________________________

1. Volunteer positions generally require a minimum commitment of one day per week, for 4-6 hours. The minimum commitment is 100 service hours. Are you willing to accept such an assignment? ________________________

2. Most volunteer positions require the ability to walk the distance of the hospital/parking lot, adequate vision and hearing, and the ability to read, write, and communicate effectively. Are you able to perform the essential functions of the volunteer service area(s) for which you are applying without accommodations? ___________________
If no, explain accommodation: ______________________________________________

3. Describe employment, school or community experience and skills applicable to the volunteer position(s) for which you are applying? ________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

4. What goals or need do you wish volunteering to fill in your life? ____________________
_________________________________________________________________________

5. Have you ever been convicted of a misdemeanor or felony? ______________________
If so, explain ______________________________________________________________
_________________________________________________________________________

6. How did you hear of us? ___________________________________________________

# ORMC VOLUNTEER ASSIGNMENT PREFERENCE

Please indicate service area(s) of interest to you. Check day(s) and time(s) you are available to volunteer on a regular weekly basis.

- ☐ **Information/Reception** (*day & evening*) *(includes Ronald McDonald Family Room))*
- ☐ **Gift Shop**
- ☐ **Nursing Station** (*flexible schedules avail)*
- ☐ **Mail Delivery/Materials Management** *(daytime only)*
- ☐ **General Clerical** *(flexible schedules available)*
- ☐ **Radiology** *(students in this career field)*
- ☐ **Cancer Resource Center/Support**
- ☐ **Emergency Room** *(21 yrs. & older)*
- ☐ **Anything available**

| Day Available | Morn-ing | Mid-Day | Eve 4 –8 pm |
|---|---|---|---|
| ☐ **Sunday** | ☐ | ☐ | N/A |
| ☐ **Monday** | ☐ | ☐ | ☐ |
| ☐ **Tuesday** | ☐ | ☐ | ☐ |
| ☐ **Wednesday** | ☐ | ☐ | ☐ |
| ☐ **Thursday** | ☐ | ☐ | ☐ |
| ☐ **Friday** | ☐ | ☐ | ☐ |
| ☐ **Saturday** | ☐ | ☐ | ☐ |

*Positions are filled based on qualifications, current openings and the applicant's availability.*

In case of illness or personal emergency during my volunteer assignment, please contact:

1)____________________________________________________________

Name Relationship Phone(s)

2)____________________________________________________________

Name Relationship Phone(s)

3) Under age 18, parental permission required. Parent's signature:____________________________

# I AM ORMC

As a volunteer at Ogden Regional Medical Center I commit to:

**OWN**
**O**ffer solutions to problems. Offer help to others, even if it is not my job. Accept ownership of my concerns.
**W**ork area – Keep clean and organized. Care for all equipment and return to proper storage.
**N**egativity is unacceptable – Be positive with all patients, visitors, customers, all hospital staff, employees, volunteers and physicians.

**RESPECT**
**R**ecognize and acknowledge the good in my fellow co-workers.
**E**ach of us is responsible: I am accountable for my attitude and actions.
**S**tay informed.
**P**roper tone of voice. Use appropriate verbal and nonverbal language. Be non-judgemental.
**E**mployees manage up – "Manage up" everyone!
**C**ore Values–Maintain honesty, integrity, compassion, trustworthiness, kindness, hospital loyalty, professional image (includes dress code).
**T**eamwork.

**MESSAGE**
**M**ake sure patients, families, and physicians are kept informed.
**E**scort patients and visitors to their destination.
**S**cripts! I will use them!
**S**ave personal conversations for a time away from patients – Never complain to a patient
**A**lways say what I CAN do, not what I can't do.
**G**reet each patient with a smile and maintain eye contact.
**E**veryone - Use the ICARE model.

**CARE**
**C**ommunication - Complete and maintain the whiteboard at all times.
**A**ctively LISTEN to the patient without interrupting.
**R**elationships are very important – Build them with customers and patients.
**E**nvironment – Keep the noise level down and check the comfort level of patients & guests.

.

__________________________________ ____________________
Volunteer Signature Date

For HIPAA purposes, if I am hospitalized at Ogden Regional Medical Center, I grant permission to my volunteer colleagues, hospital staff and leadership to acknowledge my visit with a remembrance or visit during my stay. This authorization applies to all future admits including those while I am volunteering, and those following my volunteer service.

__________________________________ ____________________
Volunteer Signature Date

# Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g*., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    a. Share/disclose user-IDs, passwords or tokens.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

**The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):**

17. I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.
18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

| Employee/Consultant/Vendor/Office Staff/Physician Signature | Facility Name and COID<br>**06030** | Date |
|---|---|---|
| Employee/Consultant/Vendor/Office Staff/Physician **Printed Name** | Business Entity Name<br>**Ogden Regional Medical Center (OGMC)** | |

# OGDEN REGIONAL MEDICAL CENTER

NAME ________________________________________ DATE OF HIRE ________________________________

ADDRESS ____________________________________ PHONE ______________________________________

City, St. Zip___________________________________

SOCIAL SEC. NUMBER _________________________ DATE OF BIRTH ______________________________

DEPARTMENT ________VOLUNTEER_________ JOB TITLE ___________________________________

## YEARLY HEALTH TEST RESULTS

*For Office Use Only.*

| DATE | BP | WBC | HGB | HCT | UA | PPD (mm) | FOLLOW-UPON ABNORMALITIES |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

**COMMUNICABLE DISEASE HISTORY**

(Give approximate date)

Chicken Pox _____Year

Red Measles (Rubeola) _____Year

Mumps _____Year

German Measles _____Year

Rubella Titer _____Year

Rubeolla Titer _____Year

Hep BsAB Titer _____Year

Varicella Titer _____Year

Other _____Year

Allergies ☐ Yes ☐ **No**

_______________________________________________

Latex Allergy: ☐ Yes ☐ No

**IMMUNIZATION HISTORY**

(Give approximate date)

Tetanus Toxoid _____Year

Polio _____Year

Measles _____Year

Mumps _____Year

Rubella _____Year

MMR Vaccine _____Year
(Measles, Mumps, Rubella)

Hepatitis B _____Year
(3 injections completed)

Hepatitis A _____ Year
(2 injections completed)

Varicella Vaccine _____Year

I certify that all the above is true to the best of my knowledge.

_______________________________________________ ____________________ HR-1012-1

Signature Date

# CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of HCA Management Services, LP (hereafter referred to as HCA) may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with HCA's consideration of me for employment, promotion or position re-assignment, and give my full consent for this information to be obtained.

II. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

III. I understand that if I am a resident of **Minnesota/Oklahoma/California (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box □.

IV. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by GIS to furnish the information described in Section I.

V. Upon proper identification, you have the right to make a request to GIS, within a reasonable period of time, as to the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that GIS has previously furnished. Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

**CANDIDATE COMPLETE THE FOLLOWING:**

______________________________ Signature

______________________ Today's Date

______________________________ Please print full name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

______________________________ Month, Day and Year of Birth

______________________________ Social Security Number

______________________________ Driver's License Number and State

______________________________ Name as it appears on License

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide city and state of conviction and details of conviction.

________________________________________________________________________________

Other (maiden) names used: ______________________________

**FAIR CREDIT REPORTING ACT NOTICE:**
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state . Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

Please provide all home addresses for the past (7) years, starting with your present address:

| Street Address | City | State | Zip | Dates Mo/Yr |
|---|---|---|---|---|
| 1) | | | | |
| 2) | | | | |
| 3) | | | | |
| 4) | | | | |