



## 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. 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 new volunteers. 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 remain long-term.

During the interview, we will discuss current openings and time commitments. As a general rule, volunteers are asked to serve a minimum 4- to 5-hour shift, one day per week. Students are encouraged to increase the pace. 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 and indicate your interest(s).

**Application** - Complete an application, answering all questions fully, including the health record. You must include driver's license and social security number for the background check. Incomplete applications will not be considered. Return application to the volunteer office:

**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 may be contacted for an interview appointment. Interviews are scheduled per current openings. Sometimes it takes several weeks before you are contacted. The interview 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 to those selected for a position, on the interview day, at our expense. Remember to return within 48-72 hours to have the test read and recorded.

**Badge -** Human Resources will take a photo and prepare a volunteer badge for new volunteers.

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

**Orientation -** Orientation occurs only once monthly and is mandatory for all new volunteers. Sessions are generally scheduled the first Monday, 8am-2pm. New volunteers must attend the entire orientation. Further training and supervision is offered in the assigned department by a fellow volunteer or by a department employee.

**Immunize – History** – Most people can use the following guidelines to approximate their immunization history. For Utah students who started school after 1960, at age five, before entering kindergarten, most had the polio, MMR, and DP(Tetanus) vaccine. At age 12, 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. 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.

**Commitment** –Due to the resources and time invested in volunteer 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. Please do not apply if you are unable to make the weekly commitment. There is a system in place that allows for reasonable 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.

After reviewing this process, if you feel Ogden Regional Medical Center is a good match for your service, please complete and submit the attached application. Remember, you must adequately address every question/field in order to be considered for service.

# 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? \_\_\_\_\_



# I AM ORMC

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

## OWN

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

## RESPECT

Recognize and acknowledge the good in my fellow co-workers.  
Each of us is responsible: I am accountable for my attitude and actions.  
Stay informed.  
Proper tone of voice. Use appropriate verbal and nonverbal language. Be non-judgemental.  
Employees manage up – “Manage up” everyone!  
Core Values–Maintain honesty, integrity, compassion, trustworthiness, kindness, hospital loyalty, professional image (includes dress code).  
Teamwork.

## MESSAGE

Make sure patients, families, and physicians are kept informed.  
Escort patients and visitors to their destination.  
Scripts! I will use them!  
Save personal conversations for a time away from patients – Never complain to a patient  
Always say what I CAN do, not what I can't do.  
Greet each patient with a smile and maintain eye contact.  
Everyone - Use the ICARE model.

## CARE

Communication - Complete and maintain the whiteboard at all times.  
Actively LISTEN to the patient without interrupting.  
Relationships are very important – Build them with customers and patients.  
Environment – Keep the noise level down and check the comfort level of patients & guests.

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Volunteer Signature

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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.

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Volunteer Signature

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Date

# Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that 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 information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINS, encryption keys, credit card or other financial account numbers (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 or Company systems.

## **General Rules**

1. 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.
2. 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 email, in order to manage systems and enforce security.
3. 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.

## **Protecting 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. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available
5. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

## **Following Appropriate Access**

1. 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.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

## **Using Portable Devices and Removable Media**

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (e.g., Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
  - a. Require the use of only encryption capable devices.
  - b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
  - c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
  - d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
  - e. Restrict access to any mobile application that poses a security risk to the Company network.

**Doing My Part - Personal Security**

1. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. 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.
3. I will never:
  - a. Disclose passwords, PINS, or access codes.
  - b. Use tools or techniques to break/exploit security measures.
  - c. Connect unauthorized systems or devices to the Company network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
  - a. my password has been seen, disclosed, or otherwise compromised;
  - b. media with Confidential Information stored on it has been lost or stolen;
  - c. I suspect a virus infection on any system;
  - d. I am aware of any activity that violates this agreement, privacy and security policies; or
  - e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

**Upon Termination**

1. 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.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By 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 Signature	Facility Name and COID Ogden Regional Medical Center 34415	Date
Employee/Consultant/Vendor/Office Staff Printed Name	Business Entity Name Ogden Regional Medical Center	

# OGDEN REGIONAL MEDICAL CENTER

NAME \_\_\_\_\_ DATE OF HIRE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

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

### 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

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

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) \_\_\_\_\_