Application for Volunteer Services and Internships

☐ Adult Volunteer ☐ Teen Volunteer ☐ Internship ☐ AHU

(Check Selected Program Above)

Personal Information

Last Name:	First Name:	M.I.:
Mailing Address (**Local**):		
City:	State:	Zip Code:
Cell Phone:	Secondary Phone:	
E-Mail Address:		

Emergency Contact Information

Name:	Phone number:	Relationship:
Name:	Phone number:	Relationship:

Volunteer Experience:

Organization:	Start:	End:
Organization:	Start:	End:

Work Experience

Organization:	Start:	End:
Organization:	Start:	End:

Do you currently or have you ever worked for Adventist Health System / AdventHealth? ☐ Yes ☐ No

☐ I am currently employed by AdventHealth	Department:	Location:	
☐ Past employee	Location:	Start:	End:

Preferred Area of Service: (List 3 Choices)

Availability for Service

☐ **Sunday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Monday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Tuesday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Wednesday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 – 8
☐ **Thursday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Friday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Saturday**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8	☐ **Events**	☐ 8 - 12 ☐ 12 - 4 ☐ 4 - 8

Personal & Professional References (Attach with Application)

Please provide two (2) letters of reference, made out to program coordinator or manager. Letters must be ***signed*** by the person providing the recommendation. Letters must be from an individual who is ***Not Related*** to the candidate and can attest to your commitment and character as a volunteer. The references will need to contain contact information for each person(s) providing the reference and will need to be provided at the time of interview (*before service can begin*).

Acknowledgement of Information

- I certify that the information presented in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or omission of facts on this application will be sufficient cause for disqualification of this application.

- I give my permission to AdventHealth to verify any information provided in this application and I authorize my past references or any other persons to answer all questions concerning my ability, character, reputation and previous employment record. I release all such persons from any liability damages resulting from having furnished such information.

- I am aware that if I should sustain injury while volunteering at AdventHealth that AdventHealth is not liable. I understand that in the event of an injury, I must report any injuries, regardless of severity, to the department which I serve, and Volunteer Services in order to properly document my injury.

_____ _____ / _____ / _____

Volunteer Signature Date of Signature

Pledge of Commitment

CONFIDENTIALITY

I will consider all information confidential which I may hear directly or indirectly concerning a patient, physician or any member of the hospital staff and I will not seek information in regard to a patient, visitor, or employee. I am aware of and will abide by the patient information privacy law of HIPAA.

COMMITMENT

I will uphold the standards and traditions of AdventHealth hospital as they are expressed in the mission, & Service Standards presented in the orientation.

EXPERIENCE

The purpose of the volunteer program is to provide an opportunity to experience a hospital environment and provide needed services and assistance to the hospital staff, patients, and visitors. The program is not intended for the purposes of acquiring hired positions within the hospital or career training, nor is it meant to lead into a paid position with AdventHealth.

_____ _____ / _____ / _____

Volunteer Signature Date of Signature

Parental Consent for Volunteer Services

To be completed by parents / guardians of minors

I give permission for my son / daughter, _____, who is at least 16 years old, to participate as a teenage volunteer at AdventHealth.

- I understand that my son / daughter is making a commitment to serve as a volunteer and that I will support his / her participation, which includes reporting for duty as scheduled, except in the event of illness.

- I understand that he / she will be assigned to an available service suitable to his / her age and capabilities.

I grant my consent

_____ ___ / _____ / _____

Parent or Guardian (please print) Date

_____ ___ / _____ / _____

Signature of Parent or Guardian Date

CONFIDENTIALITY STATEMENT

Please read and initial each statement

Sign-On:

☐ I understand access to the system needs to be protected and will not reveal the Password to anyone.

☐ I understand that an individual ID/Password is an electronic signature and will not intentionally use someone else's or leave a system unattended where mine is signed-on.

Confidential Information.

☐ I understand that I may have the right to access confidential information but will take care only to access what I need for performing my job.

☐ I will adhere to ethical standards in protecting confidential information both on and off the job.

☐ I will not intentionally give out confidential information to those who don't have a legitimate need-to-know, and I will take reasonable care to make sure that unauthorized people do not see/overhear it, that reports are stored in a safe place, and that unneeded information is properly disposed.

☐ I understand that any inappropriate or unauthorized retrieval/review/sharing of private patient or employee information with unauthorized people may result in disciplinary action which could include termination.

☐ I will not give confidential information to anyone who is not authorized to have it.

☐ I will not discuss confidential information when unauthorized people might overhear it.

☐ I will not leave confidential information where unauthorized people might see it.

☐ I will access confidential information only during my tour of duty.

☐ I will not access confidential information which is not needed to perform my job.

☐ I will not take confidential information out of my authorized work area.

☐ I will store confidential reports in a locked secure area.

☐ I will destroy unneeded confidential information by having it shredded, burned, or returning it to the area that produced it.

I have read and do understand my responsibilities and obligations under this policy, and have signed my acknowledgment to adhere to its terms:

Volunteer Name (Print): _____Op ID _____

Department Name: _____

Volunteer Signature: _____ Date_____

Privacy of Patient Information

HIPAA Acknowledgement Form

(Health Insurance Portability and Accountability Act)

HIPAA is the Health Insurance Portability and Accountability Act (Federal Law) that was developed in order to implement a national, uniform system of keeping patients records secure and private, as well as implementing a faster way to process health care claims. Below is a brief description of important aspects of this law that you should be aware of, even if you have not or will not deal directly with these types of issues.

PATIENT INFORMATION
Only access, use, or disclose, on a legitimate "need to know" basis information for activities related to treatment, payment, and healthcare operations on behalf of the company. Always maintain the privacy of patient information. Only access, use, or disclose the minimum information necessary to perform your designated role regardless of the extent of access provided.

NOTICE OF PRIVACY PRACTICE
Employees will provide patients with a Notice of Privacy Practices, which will inform patients of their rights with respect to protected health information, as well as AdventHealth's legal responsibilities.

RELEASE OF INFORMATION
Never release information for the purposes other than treatment, payment, and healthcare operations without written authorization from the patient, except as required by applicable federal, state, or local laws and regulations.

I agree to abide by the HIPAA Federal law and the rules and regulations associated with patient privacy instituted by AdventHealth and any affiliated organizations and programs.

_____ _____
Print Applicant Name Applicant Signature

_____ / _____ / _____
Date

Volunteer Services / Intern Badge Form

☐ Adult Volunteer ☐ Teen Volunteer ☐ Internship ☐ AHU

(Check Selected Program Above)

Personal Information		
Last Name:	First Name:	M.I.:

Please choose AdventHealth location:

☐ Altamonte ☐ Apopka ☐Celebration ☐ Children's ☐ East Orlando

☐ Kissimmee ☐ Orlando ☐ Winter Park ☐ Winter Garden

Return of Your Badge

The badge that you have been entrusted with is property of AdventHealth and as such:

- Badge must be returned at the end of your service time.
- Volunteers are also required to bring their badge upon taking a leave of absence.

Employee ID	
Badge No.	
OPID	

Acknowledgement

I understand and agree that should I take a leave of absence or cease to volunteer or finish my internship, I must immediately return my badge to AdventHealth volunteer services. I understand that if I do not return my badge I will not receive documentation of my service hours.

_____ _____

Volunteer Signature Date

☐ Hold Badge for volunteer services

☐ Give Badge to volunteer/ intern

Program Competency Checklist

Please complete the below checklist to ensure program competency prior to the start of service.

Volunteer Name: _____ Department: _____

I have been educated on the following items as part of my volunteer role:

- ☐ I know where the time clock is; I know how to clock in and out.
- ☐ I have been informed what to do if I forget to clock in and out.
- ☐ I know how to contact my department if I am not able to come in.
- ☐ I know how to get to my area of service.
- ☐ I understand I must adhere to the uniform and image standards of AdventHealth.
- ☐ I understand the meal ticket policy and where and how to my meal ticket.
- ☐ I know how to use a wheelchair if I need to transport a patient and I know that I cannot assist patients in or out of a wheelchair.
- ☐ I understand and commit to AdventHealth's Patient Experience program: using ICare and ACT, and our Service Standards.
- ☐ I understand I must use my personal devices OFF STAGE and agree to adhere to this policy.
- ☐ I understand AdventHealth has a Non-Smoking Policy.
- ☐ I can Locate Fire Alarm, Extinguisher, and Fire Exit Map.

I have been instructed on and comprehend all the above listed items.

_____ _____

Volunteer Signature: Trainer Signature:

Date Completed: _____/_____/_____