Dear Prospective Member:

We welcome you as an applicant to the Parrish Medical Center Volunteer Services. The following information will aid you in completing your applications and answer any questions you may have concerning our organization. Orientation is held monthly to acquaint prospective members with our hospital's mission, vision, values and healing environment.

Volunteer membership is open to men and women interested in volunteer services with the hospital and who qualify for membership. Most of our members work on services within the hospital or at off-site facilities. The services include the Welcome Desk, Courier/Escort, Gift Shop,Surgical Waiting Room, Support Services and Courtesy Shuttle. Some of our services have direct patient contact, while others offer only minimal or no patient contact.

We work a seven-day week with the workday divided into three shifts--mornings, afternoon and evening. Each shift is generally four hours long and most members work one shift per week. Applicants who want to contribute more hours are urged to work on special projects as they arise or as a substitute. We try to assign volunteers to the service, day and time preferred, but this is not always possible. Volunteers may be asked to select an alternate schedule and/or service. We hope you will understand our need to fulfill service commitments to the hospital.

Uniforms are required and polo shirts will be provided. If you have any questions or concerns, please do not hesitate to contact the Volunteer Services department at 321-268-6111 extension 7183 or also by email at <u>Volunteerservices@parrishmed.com</u>

Sincerely,

Parrish Medical Center Volunteer Services

Volunteer Service Application

Name:	Spouse's Name:	
Address:		
City:	State: Zip Code:	
Phone (H):(C):	Birthday:	
	Employer:	
Previous work experience:		
As a volunteer:		
As a paid employee:		
Organizations that you are, or were, a member of	(Please indicate any offices you held.):	
Write or speak a foreign language? DVes DNo	Please list:	
General health condition?	ricuse fist.	
Any physical limitations that prohibit pushing a w Any other limitations?	wheelchair or walking 2-3 hours? □Yes □No	
Have you ever been a hospital Auxiliary member	? □Yes □No	
What are your reasons for joining Volunteer Servi	e? ices?	
What are your reasons for joining volunteer Servi	ices:	
References: Please provide at least 3 (references Name:	Telephone:	
Address:		
Email Address:		
	Telephone:	
Address:		
Email Address:		
Name:		
Address:		
Email Address:		
	e requirements, rules and regulations of Parrish	
Medical Center.	ionto mbrigiologo and applications of this beautiful in	
 I will hold all information concerning pat confidence. 	ients, physicians and employees of this hospital in	
• I agree to work a minimum of 25–50 hour	rs a year to maintain an active membership.	
Signature of Applicant:	Date:	

PLEASE RETURN APPLICATION TO:

Human Resources Department Parrish Medical Center Auxiliary 951 North Washington Avenue Titusville, FL 32796

CONFIDENTIAL PERSONAL PROFILE

Please take a few moments to complete your personal profile sheet for your file folder. This will assist us in identifying special skills and talents of our membership.

Name:	Date:
Address:	
Telephone:	Email:
Emergency Contact:	
Name	Phone Relationship
Are you retired? ☐ Yes ☐ No	Are You a Year-Round Resident? ☐ Yes ☐ No
Special Interests:	
Special Skills (please mark all that a Accounting Computer Secretarial Special Events Writing Other:	
Hobbies and/or Talents:	
Do you speak a language other than If yes, what language(s)?	English? Yes No
Experience in Other Organizations:	:

Thank you for taking the time to complete this form so that we may better serve you.

CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

As an employee, regular staff or contracted, volunteer, physician, physician office personnel, student, or vendor at Parrish Medical Center, I have the duty to protect the confidentiality of all patients, medical, financial, employee, organizational, and other forms of information as outlined in this agreement. I also understand that each and every patient, visitor, guarantor, employee and other individual associating or interacting with Parrish Medical Center has the legal right to confidential treatment of information about him/herself.

Therefore, any and all information I am exposed to in the course of performing my professional duties or that I come onto contact with in the course of my interactions with Parrish Medical Center will be treated as highly confidential, and will not be disclosed to anyone who does not need that information to perform his/her professional or medical care duties. Physicians, nurses and other patient care personnel should never disclose patient information to anyone not directly involved in that patient's current care, including, but not limited to the patient's spouse, family and relatives, friends, or other physicians or caregivers who treat the patient for other reasons.

The security and confidentiality of information accessed through electronic information systems is protected through the use of personal user IDs and passwords. The following statement describes your understanding of the significance of accessing protected health information electronically and the implications of any misuse:

I understand that personal user IDs and passwords are the equivalent of my legal signature and I am responsible for their use. I will never knowingly allow anyone to use my user IDs and passwords or leave a system unattended without signing out. I will not disclose my user IDs and passwords to anyone or attempt to gain knowledge of another person's user IDs and passwords to obtain access to any system. In the event that I have any reason to believe the confidentiality of my user IDs and passwords have been compromised, I will immediately notify Information Systems or the appropriate system administrator of the violation and have my password changed. Any misuse of my user IDs and passwords to obtain clinical, financial or business information that is not in the direct performance of my duties or responsibilities is a violation resulting in disciplinary action up to and including termination.

Accordingly, I pledge and assure that I will protect the confidentiality of any and all patient, medical, financial, employee, organizational, and other types of information and methods of communication, including but not limited to computer systems, paper documents, email, telephone, direct verbal, and all other forms of communication.

I further agree that except as permitted or required by this agreement or by law, I expressly agree to comply with the Health Information Portability and Accountability Act (HIPAA) in all respects, including the implementation of necessary safeguards to prevent such disclosure.

I have read and fully understand the above and agree to be bound by each and every term and condition of this agreement with Parrish Medical Center.

	/	
Print First Name	MI	Last Name
Signatura	Doto	Talanhana Numban
Signature	Date	Telephone Number

Consent to Photograph, Videotape, Film or Interview

	rish Medical Center (PMC) is committed to protecting the privacy and fidentiality of our patients/community and their information.
I,	,
	rase print: patient or his/her legal representative name)
here	eby authorize and grant permission to PMC, and/or its representatives to:
	To photograph/videotape//film me (or my minor child) to document the progress of my medical care.
	To release pertinent medical and other information to the media about me (or my minor child's name) beyond the one word condition description (Good, Fair, Poor, Critical, Serious, or Undetermined).
	To interview me (or my minor child's name) for use by the news media: newspapers, magazines, radio, television, etc.
	To interview me (or my minor child's name) for use within PMC's marketing or publicity materials.
	To photograph/videotape/film me (or my minor child) for use in marketing or publicity materials.
In s	igning this agreement, I understand that:
1.	Editing of these materials by individual media (<i>i.e.</i> television, newspaper, magazine) representatives will be done so at their discretion, and that this discretion is beyond PMC's control.
2.	I have agreed to participate without monetary compensation.
3.	I can revoke my consent at any time in writing, but if I do, it will not have any effect on any actions taken prior to my revocation.
4.	I may refuse authorization and that this is strictly voluntary.
(Sig	nature) (Date)
(Wi	tness)
Pho	ne Number:
Mai	ling Address:

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics that binds the employees at Parrish Medical Center and its off-site family of services. Like them, I assume certain responsibilities and expect to account for my actions based on the organization's expectations. I will keep confidential matters confidential. As a volunteer I have agreed to work with no monetary compensation. But, once accepted as a volunteer worker, I expect to do my work according to the high standards expected of paid care partners.

I believe that all work should be carefully analyzed so work methods can be standardized. I believe that people should be studied in order to determine what jobs they can do and like to do, and that as far as possible, they should be assigned to jobs they can do well and enjoy.

I promise to be open-minded in my work, to be trained for it, and bring interest and attention to it. I realize that I may have assets that my co-workers may not have andthat I should use these to enrich the projects we are working on together. I also realize I may lack assets that my co-workers have. I will not let this make me feel inadequate, but will endeavor to assist in developing good teamwork.

I will learn how I can best serve the activity for which I have volunteered, and offer as much as I am sure I can give, but no more. I realize that I must live up to my promises and, therefore, will be careful that my agreement is simple and clear so that it cannot be misunderstood.

I believe my attitude toward volunteer work should be professional. I believe that I have an obligation to my work, to those who direct it, to my colleagues, to those for which it is done, and to the public.

Being eager to contribute all I can to Parrish Medical Center's healing environment,I accept this Code of Ethics for Volunteers as my code, to be followed carefully and cheerfully.

Signed_	Date
Print Name	

VOLUNTEER SERVICES REQUEST FOR LOCAL LAW ENFORCEMENT CHECK FOR APPLICANTS

Last Name	Middle	First	
Social Security Numbe	r		
Date of Birth	Race	Sex	
Please document the	findings of this check and retu	irn the information to:	
Parrish Medical Cente	_	irn the information to:	
Parrish Medical Cente Human Resources	r	irn the information to:	
Parrish Medical Cente Human Resources 951 N. Washington Av	r	irn the information to:	
Parrish Medical Cente Human Resources 951 N. Washington Av Titusville, FL 32796	renue	irn the information to:	
Please document the Parrish Medical Center Human Resources 951 N. Washington Av Titusville, FL 32796 Phone: (321) 268-6878	renue	irn the information to:	
Parrish Medical Center Human Resources 951 N. Washington Av Titusville, FL 32796 Phone: (321) 268-6111 Fax: (321) 268-6878	r renue 1 Ext. 7741 evard County Sherriff's Departr	ment to check any and all recoragency to release to Parrish M	•

VOLUNTEER SERVICES WORKERS' COMPENSATION VERIFICATION FORM AND STATEWIDE CRIMINAL HISTORY BACKGROUND CHECK

RESEARCHERS ASSOCIATES, INC. (850) 893-2548 / (850) 893-9518

Name of Applicant:
Social Security Number:
Date of Birth:
Has this person had a workers' compensation claim filed in the state of Florida in the lastyears? ☐ Yes ☐ No
If Yes, Employer:
Date:
Type of Injury:
Time Lost:
Person Providing Information:
Checked By Date