PARRISH
MEDICAL CENTER
AUXILIARY

Dear Prospective Member:

We welcome you as an applicant to the Parrish Medical Center Auxiliary. 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.

Auxiliary 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 Information 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 members to the service, day and time preferred, but this is not always possible. Members 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. Uniform choices will be explained during the interview. Dues for active members are $5 per year. General meetings are held twice a year, and service meetings are scheduled quarterly to update the Auxiliary on hospital programs and services. If you have any questions or concerns, please do not hesitate to contact our Patient Experience Team at 321-268-6685 or 321-268-6683.

Sincerely,

Parrish Medical Center Auxiliary

PARRISH MEDICAL CENTER
AUXILIARY

Name:_____ Spouse's Name: _____
Address:_____
City:_____ State:_____ Zip Code: _____
Phone (H):_____ (C):_____ Birthday:_____
Email:_____ 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? ❑Yes ❑No Please list: _____
General health condition? _____
Any physical limitations that prohibit pushing a wheelchair or walking 2-3 hours? ❑Yes ❑No
Any other limitations? _____
Have you ever been a hospital Auxiliary member? ❑Yes ❑No
When?_____ Where?_____
What are your reasons for joining this Auxiliary? _____
_____

References: No relatives or doctors. Give Auxilian references if possible.
Name:_____ Telephone:_____
Address:_____
Email Address: _____
Name:_____ Telephone:_____
Address:_____
Email Address: _____

- I understand and agree to comply with the requirements of the Parrish Medical Center Auxiliary, its rules and regulations; and the rules and regulations of Parrish Medical Center.
- I will hold all information concerning patients, physicians and employees of this hospital in confidence.
- I agree to work a minimum of 25–50 hours 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

PARRISH MEDICAL CENTER
AUXILIARY

CONFIDENTIAL PERSONAL PROFILE

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 apply):
❑ Accounting
❑ Computer
❑ Secretarial
❑ Special Events
❑ Writing
Other**:** _____

Hobbies and/or Talents: _____

Do you speak a language other than English? ❑ Yes ❑ No
If yes, what language(s)? _____

Experience in Other Organizations: _____

Are you interested in serving on a committee (please check all that interest you**):**
❑ Executive Board
❑ Nominating Committee
❑ Scholarship
❑ Service Chairman
❑ Service Assistant Chairman
❑ Special Events

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

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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**

_____ _____

Signature **Date** **Telephone Number**

PARRISH MEDICAL CENTER AUXILIARY

Consent to Photograph, Videotape, Film or Interview

Parrish Medical Center (PMC) is committed to protecting the privacy and confidentiality of our patients/community and their information.

I,_____,
(Please print: patient or his/her legal representative name)
hereby 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 signing this agreement, I understand that:

1. Editing of these materials by individual media (*i.e.* 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.

_____ _____
(Signature) (Date)

_____
(Witness)

Phone Number: _____

Mailing Address: _____

Email Address: _____

Distribution: (1) Chart; (2) Communications & Service Excellence; (3) Client/Patient Rev. 11-2013

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CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics similar to the one 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. 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, like to do, and that as far possible should be assigned to do.

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 and that 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 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 my work, to my colleagues, to those for which my work 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.

_____

Print Name

_____ _____

Signature **Date**

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VOLUNTEER SERVICES
REQUEST FOR LOCAL LAW ENFORCEMENT CHECK FOR APPLICANTS

Pursuant to Chapter 85-54, Laws of Florida, Parrish Medical Center requests a local records check on the applicant listed below:

_____

Last Name Middle First

_____

Social Security Number

_____ _____ _____

Date of Birth Race Sex

Please document the findings of this check and return the information to:

Parrish Medical Center
Human Resources
951 N. Washington Avenue
Titusville, FL 32796
Phone: (321) 268-6111 Ext. 7741
Fax: (321) 268-6878

I hereby authorize Brevard County Sherriff's Department to check any and all records pertaining to criminal convictions and for any law enforcement agency to release to Parrish Medical Center information regarding convictions under Florida Statutes or statutes of other jurisdictions.

_____ _____

Signature of Applicant **Date**

PARRISH MEDICAL CENTER
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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 last_____years? ❑ Yes ❑ No

If Yes, Employer: _____

Date: _____

Type of Injury: _____

Time Lost: _____

Person Providing Information: _____

_____ _____
Checked BY **Date**