Dear Prospective Member:

We welcome you as an applicant to the Parrish Medical Center Auxiliary. The mission of the Auxiliary is to work with compassion and integrity, in partnership with Parrish Healthcare to fulfill the Parrish Medical Center mission. We do this through volunteerism, educational scholarships and fundraising.

Auxiliary membership is open to all men and women, interested in volunteer services who meet the membership criteria. Auxiliary volunteers perform a variety of services within the Medical Center or at off-site Parrish Health Care facilities. Some of these services include guest and escort services, Pink Angel gift shop, surgical waiting, fitness center,courtesy shuttle, spiritual care, office support and other support services. Some of our services have direct patient contact, while others offer only minimal or no patient contact.

The Auxiliary works primarily Monday-Friday, although some services or special events may occur on the weekend. Shifts typically are four-hours long, and are available mornings, afternoons, and some evenings. Through the application and placement process, you will have the opportunity to learn more about the variety of positions and work shifts available.

We do wear uniforms to designate our volunteer status. Various choices of attire are available and will be explained during the interview process.

Dues for active members are $5.00 per year. General meetings and service meetings are scheduled regularly to keep our Volunteers updated.

For more information, please contact Carlos Diaz at 321-268-6683.

Thank you for your interest,
Parrish Medical Center Auxiliary

APPLICATION FOR VOLUNTEER SERVICE

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

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:**_____________________________________

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.

F: Groups\SPE\Community Services\Art Files\Flyers_Misc\Auxiliary
5/23/17

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**

F: Groups\SPE\Community Services\Art Files\Flyers_Misc\Auxiliary
5/23/17

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

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**

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**

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

<u>RESEARCHERS ASSOCIATES, INC.</u>
(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**