SHERIDAN MEMORIAL HOSPITAL

Youth Volunteer Application

Volunteer Services -- Patty Forister (307) 675-2620

Date:______________________________ Date of Birth: ___________________________

Name:____
(Last) (First) (Middle)

Preferred Name (if any): ____________________________ Home Phone: ________________________

Home Address:____

Cell Number: __________________________________ E-Mail Address: ________________________

Special training, trade, interests: ____

Do you speak a foreign language? If yes, what language: ________________________________

Any physical limitations? Briefly explain: ____

PREVIOUS EMPLOYMENT AND/OR VOLUNTEER WORK:

Employer/Organization	When/How Long	Job Title/Scope of Work

References: Please provide **two (2) letters of reference** (not immediate family). Thank You.

Junior Volunteers (under age 19) School: ______________________ Grade: ______
Parents Names & Phone Numbers Mom: ______________________ Phone: __________
Dad: ______________________ Phone: __________

Parental Permission: All answers to the above questions are true and correct. I hereby give my son/daughter permission to participate in the Junior Volunteer Program at Sheridan Memorial Hospital, Sheridan, WY and I will assume responsibility for his/her actions, if my child is accepted for the program. I also give permission for my son/daughter to receive the required TB test administered through employee health and for a mandatory drug screen, with no personal cost associated to me. Questions about TB testing? Call Sheridan Memorial Hospital employee health at 672-1144.

Parent signature: ______________________________________ Date: __________

Thank you for your interest in volunteering at Sheridan Memorial Hospital!

4/07

VOLUNTEER AGREEMENT

As a Volunteer at Sheridan Memorial Hospital, I will be punctual and conscientious in the fulfillment of my duties and will accept supervision graciously.

I agree to dress neatly and have a pleasant rapport with the people I work with and others with whom I come in contact.

I will ask the Director of Volunteer Services or the personnel of the department if I do not understand an assignment.

If unable to fill my placement commitment, I understand it is my responsibility to try to find a substitute. If unable to do so, I will contact my Department Director or the Director of Volunteer Services 24 hours in advance except in case of emergency.

I will conduct myself with dignity, courtesy and consideration, honoring the volunteer policies whenever I am on duty.

I will consider CONFIDENTIAL, all information which I may hear directly or indirectly concerning a patient, doctor or any member of personnel.

I will not seek information in regard to a patient.

I will take any problems, criticism or suggestions to the Director of Volunteer Services.

____

Signature   Date

Sheridan Memorial Hospital

CONFIDENTIALITY AGREEMENT

Sheridan memorial Hospital (SMH) recognizes the importance of the protection of confidential information concerning patients, their families, medical staff, co-workers and the operations of the Hospital. It is the intent of Sheridan Memorial Hospital and the undersigned individual to maintain the privacy of Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the privacy regulations published by the U.S. Department of Health and Human Services (DHHS), and any other applicable State and Federal laws and/or regulatory agency rules and regulations.

"Confidential Information" denotes **all information** acquired by an individual in the course and scope of their employment and/or their association with Sheridan Memorial Hospital whether that information is obtained by discussion (direct or overheard), consultation, examination, treatment, and or direct access to records.

It is the obligation of the undersigned individual to maintain the confidentiality and privacy of PHI to the best of their ability and to divulge/share only the minimum amount of PHI necessary for another authorized individual with a valid "need to know" to do their assigned tasks.

As a member of Sheridan Memorial Hospital's workforce and/or volunteer program, I

(Print Name) ____ do hereby agree that I will:

1. Protect the confidentiality of patient and hospital information.
2. Not divulge/share unauthorized information to any source.
3. Not access or attempt to access information other than that information which I have authorized access to, and a need to know, in order to complete my assigned tasks.

Report breaches of this confidentiality agreement by others to Sheridan Memorial Hospital's Privacy Officer. I understand that failure to report breaches in an ethical violation which may subject me to disciplinary action up to and including termination.

I have read and agree to adhere to the conditions of this confidentiality agreement. I also acknowledge that any violation of the above conditions can result in disciplinary action up to and including termination.

________________________________ ______________
SIGNATURE DATE

________________________________ ______________
WITNESS DATE