



SHERIDAN MEMORIAL HOSPITAL

Volunteer Application

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

Date: _____

AUX: _____

Name: _____
(Last) (First) (Middle)

Home Address: _____ Phone: _____

Business Address: _____ Phone: _____

Birthday: _____ Referred by: _____

Prior Experience:

Volunteer: _____

Employment: _____

Special Interests & Hobbies: _____

If there is a special request for volunteer help would you like to be called? Yes No

Person to call in the event of an emergency: _____
Address _____ Phone: _____

What is your use of drugs/alcohol? _____

Are you currently under a doctor's care? If so, with whom and for what reason?

What medications are you taking? _____

Have you ever been convicted of a felony? If yes, please explain: _____

Why do you want to be a volunteer? _____

How did you learn of the Sheridan Memorial Hospital Volunteer program? _____

What skills or training do you have which might be utilized in your volunteer assignment? _____

What would you NOT be willing to do? _____

What days and hours are you willing to designate for volunteer work at Sheridan Memorial Hospital?

Do you like patient contact? Yes No Remarks: _____

List three references. Please include addresses and telephone numbers.

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



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 Volunteer Services Coordinator 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 Manager or the Volunteer Services Coordinator 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 Volunteer Services Coordinator.

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, 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.
4. Report breaches of this confidentiality agreement by others to Sheridan Memorial Hospital’s Privacy Officer. I understand that failure to report breaches is 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

Approved: 02-15-06