



Sheridan  
Memorial  
Hospital

Taking  
Your Health  
to Heart

# SHERIDAN MEMORIAL HOSPITAL Volunteer Application

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

Date: \_\_\_\_\_

AUX: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

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 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.

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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 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

# Sheridan Memorial Hospital

## Background Investigations Consent

I, \_\_\_\_\_, hereby authorize Sheridan Memorial Hospital and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualification for employment or volunteering.

I release Sheridan Memorial Hospital and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge:

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
\* Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
\* Maiden Name or other Names used

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
State Issued

Security: Have you ever been convicted of an offense against the law (other than a minor traffic violation), or are you now under charges for any offense against the law? Yes \_\_\_\_\_ No \_\_\_\_\_  
Listed criminal offenses will not necessarily bar you from employment or volunteering with SMH. If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Please list all Residence Addresses for the past 7 years; use a separate sheet if needed:

\_\_\_\_\_  
Present Residential Address

\_\_\_\_\_  
How Long?

\_\_\_\_\_  
City / State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Former Address #1

\_\_\_\_\_  
How Long?

\_\_\_\_\_  
City / State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*NOTE: The above information is required for identification purposes only, and is in no manner used as qualifications for employment or volunteering. Sheridan Memorial Hospital is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Religion, Age (40 and over), Handicap or National Origin.