GRIFFIN HEALTH

Dear Future Volunteer,

Thank you for your interest in volunteering at Griffin Hospital. We truly value our volunteers as they assist in nearly every department of the hospital. Many assignments are based on interest and skills which best match the needs of our program.

Our program requires you to commit to a minimum of 100 hours for adults and 50 hours for junior volunteers (students must be at least 15 years old to volunteer). Many of our volunteers develop long-lasting friendships with hospital staff and look forward to coming to Griffin Hospital **weekly all year round** in order to meet the minimum yearly commitment.

Outlined below are the steps in becoming a volunteer at Griffin Hospital. Volunteers are on-boarded on an as needed basis. We strive to find the best placement for all our volunteers. Meeting the needs of the Hospital as well as the volunteers is our goal.

- Submit completed application to Volunteer Services
- Your placement as a volunteer is based on skills, interests, and availability. When a volunteer position becomes available, an interview will be scheduled to discuss possible placement in Griffin Hospital Volunteer Services. Acceptance and placement as a volunteer is not guaranteed to any applicant. The availability of volunteer positions is dependent upon the needs of the hospital.
- Complete medical requirements (health assessment, immunization record, TB blood test, and yearly flu vaccine)
- Background check
- Attend a two-hour Volunteer Orientation

If you have any questions, please call the Volunteer Services Department at (203) 732-7555 or email kbrowne@griffinhealth.org.

Sincerely,

Kathy Browne

Kathy Browne
Volunteer Program Supervisor

Interviewed:_____ Assignment(s):_____
Starting:_____ _____
Orientation:_____ _____

Griffin Hospital

130 Division Street
Derby, CT 06418 (203)732-7555

Volunteer Application

Name:_____
Last First Middle initial

Street:_____City:_____ State & Zip:_____

Home phone:_____ Work phone:_____ Cell:_____

E-mail address:_____ Sex: _____Male _____ Female

Marital status: Married:_____ Single:_____ Widow/widower:_____ Divorced:_____

Date of birth:_____ Social Security #: _____ - _____ -_____
(month, day & year)

Driver's license #:_____ State issued:_____

High School_____ College_____

Place of employment:_____ Occupation:_____

Health problems/physical limitations:_____

Do you speak a language(s) other than English – if so, which one(s)?:_____

Community affiliations:_____

Have you ever been convicted of a crime?_____

Signature_____ Date:_____

How did you hear about volunteering opportunities at Griffin Hospital?

____Another volunteer - if so, who? _____

_____School _____ Comcast TV channel _____ Griffin Hospital Website _____Newspaper

_____Religious institution _____Advertisement

Other- please describe_____

Please list your hobbies, skills and interests (music, artistic or other) _____

_____

Is there a particular type of volunteer work in which you are interested? (Check all that apply):

_____working with patients _____assisting with general office duties _____Baking

_____Complimentary Therapies _____Dining Services _____Gift Shop

_____ Ambassador _____Golf Cart Shuttle Driver _____Candy Striper

Other_____

Availability:

Days available: (circle) **M** **T** **W** **Th** **F** **S** **Su**

Mornings:_____ Afternoons:_____ Evenings:_____ Flexible:_____

In case of an emergency involving you, who would you like us to call?

Name:_____ Phone:_____

Business phone:_____ Relationship:_____

Please list names and phone numbers of two personal references:

1. Name:_____ Phone:_____
2. Name:_____ Phone:_____

GRIFFIN HOSPITAL CONSENT FOR RELEASE OF INFORMATION

This consent acknowledges that Griffin Hospital, Griffin Health Services Corporation or its agent, Employers Reference Source, may conduct a verification of my education, previous employment, work history, military service, or motor vehicle records and contact personal or business references and receive any criminal history record information pertaining to me which may be in the files of federal, state or local criminal justice agencies in any state and/or other information as deemed necessary to fulfill the requirements of this application.

I have read and understand this consent, and I authorize the background verification. I authorize persons, schools, current and former employers and military agencies to release any information that is requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I also release and discharge Griffin Hospital, Griffin Health Services Corporation and its agent Employers Reference Source and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses arising from the retrieving and reporting of such information.

I understand the information below will be used solely for the purpose of conducting a background check in connection with my application as a volunteer with Griffin Hospital, Griffin Health Services Corporation.

I agree that a copy of this document is as valid as the original.

APPLICANT:_____
Name typed or printed

Have you used any other last name? Yes ( ) No ( )

If yes, what name did you use?_____

HIPAA CONFIDENTIALITY STATEMENT AND AGREEMENT FORM (attached)

I have received and completed a copy of the "Griffin Hospital Confidentiality Statement and Agreement Form". I have read the form and agree to comply with all the confidentiality, privacy regulations regarding protected health information (PHI); and I will report any suspected privacy violations to the hospital's Vice President of Legal Affairs.

GRIFFIN HOSPITAL PHOTOGRAPHY/MEDIA CONSENT FORM

As a volunteer, Griffin Hospital has my consent to interview me and take photographs, video and audio of me in connection with my role as a volunteer at the hospital and I understand that I release the hospital from all liability connected with the taking, distribution and publication of the same.

_____ _____
Date Signature (if minor – parent or guardian signature)

GRIFFIN HOSPITAL VOLUNTEER AGREEMENT

If accepted into the volunteer program, I agree to:

1) Comply with all Griffin Hospital Volunteer Health Assessment requirements.
2) Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff and not seek to obtain confidential information from the patient.
3) Become familiar with the hospital's policies and procedures and uphold its philosophy and Standards.
4) Be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
5) Wear the appropriate uniform and maintain a well-groomed appearance during my volunteer time, abiding by the specified dress code.
6) Attend orientation and in-service training as scheduled, where I will receive information concerning Griffin Hospital's a) general procedures, philosophy, history and objectives b) Planetree c) confidentiality d) Infection Control e) Fire and Safety Management f) Wheelchair usage g) Hazardous materials.
7) Carry out assignments and seek the assistance of the job supervisor when necessary; and not attempt any task for which I have not been trained.
8) Take any problems, criticism or suggestions to my service area supervisor or to the Planetree Services Assistant.
9) Work a specified number of hours on a schedule acceptable to the hospital and to me.
10) Adhere to the sign-in procedure.
11) Notify the volunteer office if unable to work as scheduled.
12) Honor a minimum of fifty (50) hour commitment toward volunteer service for students.
13) Honor a minimum of one hundred (100) hour commitment toward volunteer service for adults.
14) Report to my supervisor IMMEDIATELY any accident or injury sustained while volunteering to assure that I am treated promptly and covered by hospital insurance.
15) Obtain a physician's permission form to return to volunteer duties if I have been absent for one week or more because of injury, illness, surgery or a communicable disease.
16) I understand that my services are donated to the Hospital without obligation of compensation or future employment, and provided with humanitarian or charitable reasons.
17) I understand that the Volunteer Services Department reserves the right to terminate any volunteer status as a result of (a) failure to comply with organizational policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude work, or appearance, or (d) any other circumstances which, in the judgment of the department director, would make my continued service as a volunteer contrary to the best interests of the hospital.
18.) Mandatory flu shots are required annually. Flu shots can be obtained at Occupational Medicine Center free of charge (for those 18 or older), or you can have your physician or facility administer the vaccine – documentation is required.

I have read each of the above conditions, and I agree to be bound to them.

Volunteer's signature_____ Date:_____

Parent's or Guardian signature if under 18 Years old _____

GRIFFIN HOSPITAL – POLICIES AND PROCEDURES

TOPIC: BACKGROUND CHECK

BACKGROUND CHECK

It is my understanding, that my volunteer service is contingent upon a satisfactory passing of a criminal and sexual abuse background check.

I authorize Griffin Hospital to perform such checks.

_____ _____

Applicant's Name Date

_____

Applicant's Signature

GRIFFIN HEALTH

Information Services

Phone: 732-1200 • Fax: 732-1469

- HIPAA Confidentiality Statement and Agreement Form -

As an employee, volunteer, student or physician at Griffin Hospital, you will have access to confidential information. If you are a contracted consultant, a vendor, a physician, a laboratory or other entity whose relationship requires access to hospital information or who has been permitted access to patient identifiable information (PHI), you will also acknowledge the terms of the Griffin Hospital HIPAA Confidentiality Statement and Agreement.

Confidential information includes patient information, financial information or other information relating to Griffin Hospital or its affiliated entities, its employees, patients and/or business interests. During your employment or contractual relationship activities, you may learn of or have access to some or all of this confidential information. Griffin Hospital, its employees, Medical Staff, students, volunteers and any affiliated partners or vendors will maintain the confidentiality of patient information and the security of medical records whether in hard copy, film or computerized form. To assure that the maximum level of confidentiality is maintained, employees and others with access to confidential information are required to sign the HIPAA Confidentiality Statement and Agreement Form and follow department policies and procedures as related to job functions. Violation of the terms of this agreement will subject you to penalties, which might include, but is not limited to, termination of employment or contractual agreement. Accordingly, by signing this agreement you agree;

To respect a patient's right to privacy and confidentiality by not disclosing their admission or use of outpatient services of which you might become aware by virtue of your relationship with the hospital. You will access confidential information that is reasonably necessary to perform a job function or related to patient care on a "need to know" basis. Records pertaining to patient care or other hospital activities are confidential, whether in hard copy, film, or computerized form. Unauthorized access, use, copying or disclosure is strictly prohibited. Access to other than authorized information is restricted without specific written authorization

To access records pertaining to patient care only when your job functions require access to information related to the current episode of patient care. Access to other patient information is strictly prohibited without specific written authorization. If you are a Meditech Patient Care Information (PCI) user, you are not authorized to access your own record. Additionally, you are not authorized to access the record of a friend or relative or any other patient except in the performance of duties related to patient care

That access to the system will be monitored on a regular and random basis. You will not attempt to access any information to which you have not been granted access.

To safeguard your access rights and will not disclose passwords or other access codes for use by other individuals. You are the only individual authorized to utilize your assigned password. Report to Information Services, immediately, any breach of security if your password has been disclosed accidentally or otherwise. You will not utilize anyone else's to gain access to other information

That the combination of your User ID (in Meditech, the User Mnemonic) and Password is intended to be the legal equivalent of your traditional handwritten signature when creating or modifying the electronic medical record

To respect the confidentiality of printed reports, and handle, store or dispose of these reports accordingly

Not to install or use any remote access software (i.e. VPN, PACS, Citrix, etc.) on Griffin Hospital computers without prior approval from Information Services. Not to install or use any remote access software (i.e. VPN ,PACS, Citrix, etc.) to access Griffin Hospital patient information on a computer at an outside facility unless that computer was specifically approved for that use by Griffin Hospital

To access the Internet for official business only and only with prior authorization of Information Services

Signature: _____ **Date**: ____ / ____ / ____

Printed Name: _____ **Dept.** _____

☐ **Employee** ☐ **Volunteer** ☐ **Doctor** ☐ **Other**: _____