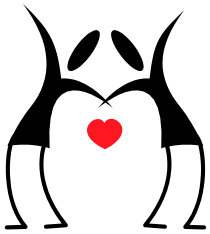
About Volunteering
at Ogden Regional Medical Center



(Please keep these sheets for your information. Return the completed application only)

Thank you for your interest in volunteering at Ogden Regional Medical Center. We have approximately 150 volunteers ages 17 and older. We look forward to the opportunity to work with you. Following are answers to frequently asked questions that are intended to simplify the application process. Court ordered community service, attendance credit hours, internships and shadowing cannot be signed off at Ogden Regional. After reviewing this process, if you feel Ogden Regional Medical Center is a good match for your service, please complete and submit the attached application.

Application - Complete an application, answering all questions fully. It is imperative that we are able to contact you by e-mail, so include an e-mail address. Incomplete applications are not considered. Please thoughtfully respond to each question. Phrases such as "I want to give back to the community," need to be followed with deeper reflection. Return application to the volunteer office:

Ogden Regional Medical Center
Attn: Sally Gale, Volunteer Director
5475 South 500 East, Ogden, UT. 84405
Phone - 801-479-2075 FAX - 801-479-2164
sally.gale@mountainstarhealth.com

Immunize – Disease History Most people can use the following guidelines to approximate their immunization/ and communicable disease history. For Utah students who started school after 1960, before entering kindergarten, most had the polio, MMR, and Tdap (Tetanus/diphtheria) vaccine. At age 12, before entering Junior High school, most Utah students had an MMR and Tetanus booster. If you do not have a written immunization record, use this information to jog your memory and record the year according to your best memory. **Do not leave this section blank.** Write "No" in the year if you did not have the vaccination/disease. **If you are selected** for a position, those age 19-64 without memory or record of the vaccination/disease will be required to have a Tdap booster and Varicella (chicken pox) vaccine. Our Infection Control Nurse will counsel you if needed. *(Applicants do not need to get vaccinations. We will address vaccinations if you are selected for a position.)*

Background – A background check is required. You must be willing include driver's license, social security number and former addresses. Any offense revealed on a background check that has not been fully taken care may disqualify applicant.

Commitment –Due to the resources and time invested in volunteer training, **we require a minimum commitment of 100 hours.** This can be accomplished by volunteering in one department weekly for 6-months, or through a more intense schedule. Please do not apply if you are unable to make the commitment. There is a system in place that allows for reasonable absence, vacation and family time-off.

As a general rule, volunteers are asked to serve a minimum 4- to 5-hour shift, one day per week. Students are encouraged to increase the pace. We offer limited openings in clinical areas; however, these positions are peripheral support in nature as volunteers are not permitted to offer patient medical care.

Interview - After an application review, you may be contacted for an interview appointment. Interviews are scheduled based on current openings. **It may take up to 4-8 weeks before you are contacted.** The interview objective is to determine if this is a good match for you and us. For those offered a position, you can expect the following:

TB Test - This simple Tuberculosis test is mandatory before beginning service. The test is administered to those selected for a position, on the interview day, at our expense. Remember to return within 48-72 hours to have the test read and recorded.

Badge - Human Resources will take a photo and prepare a volunteer badge for new volunteers.

Flu Vaccine As a volunteer, we want to protect you and our patients. Therefore, volunteers are required to have the annual flu vaccine. If you have not had the vaccine, it will be offered to you at no cost by the hospital.

Uniform - Select a uniform top, our complements. The remainder of the uniform consists of tan/kaki ankle length slacks, closed-toed shoes and socks (volunteer responsibility). Facial jewelry is limited to one pair of earrings. Those who accept an assignment in a clinical area may not wear artificial nails.

Orientation - Orientation sessions are scheduled once a month, on a Monday, 7:45 am-1:30 pm. New volunteers must attend the entire orientation. Further training and supervision is offered in the assigned department.

Volunteer Defined: A volunteer is an individual who donates services without contemplation of payment for a public spirited or charitable purpose. Volunteer must have: the ability to traverse long distances; acceptable visual and audio acuity; possess excellent interpersonal and communication skills; be alert and able to problem-solve; have the ability read/write English legibly; be of sound mental and emotional health; and be flexible.

Time spent in these preparatory steps is necessary and informative. You will feel more at home in the hospital atmosphere, and you will be well prepared to serve. We expect you will enjoy your volunteer service and benefit personally from this fulfilling experience. We are anxious to get acquainted with you and put your talents to use.

OGDEN REGIONAL MEDICAL CENTER

VOLUNTEER APPLICATION

Attn: Sally Gale, Volunteer Director
5475 South 500 East, Ogden, Ut. 84405
PH: (801) 479-2075 FAX: (801) 479-2164
Sally.gale@mountainstarhealth.com

Name _____Date_____

Address_____City_____St._____Zip_____

Birth Month/day_____Home Phone #_____Work/Cell#_____

E-mail address_____

1. Volunteer positions generally require a minimum commitment of one day per week, for 4-6 hours. The minimum commitment is 100 service hours. Are you able to fulfill this commitment? _____

2. Volunteer positions require the ability to traverse long distances; acceptable visual and audio acuity; excellent interpersonal and communication skills; alertness, ability to problem-solve; ability read/write English legibly; sound mental and emotional health; and flexibility. Are you able to perform the essential functions of volunteer service for which you are applying without accommodations? _____If no, explain accommodation: _____

2. Describe employment, school or community experience and skills applicable to the volunteering_____

   _____

   _____

4. What specifically brought you to volunteer at this time in your life?_____

   _____

5. What desire can volunteering fulfill in your life? _____

   _____

6. Have you ever been convicted of a misdemeanor or felony? _____

   If so, explain the charge, the date and current status (fines paid/outstanding) etc.

   _____

   _____

7. How did you hear of us? _____

ORMC VOLUNTEER ASSIGNMENT PREFERENCE

Please indicate service area(s) of interest to you. Check day(s) and time(s) you are available to volunteer on a regular weekly basis.

- ☐ **Information/Reception** *(day & evening) (includes Ronald McDonald Family Room))*
- ☐ **Nursing Station**
- ☐ **Mail Delivery/Materials Management** *(daytime only)*
- ☐ **Radiology** *(students in this career field)*
- ☐ **Total Joint Center** *(knee/hip replacement experience preferred)*
- ☐ **Emergency Room** *(21 yrs. & older)*
- ☐ **Pet Therapy** *(Certified pet teams)*
- ☐ **Anything available** *(clerical, gift shop etc)*

Day Available	Morn-ing	Mid-Day	Eve 4 –8 pm
☐ **Sunday**	☐	☐	N/A
☐ **Monday**	☐	☐	☐
☐ **Tuesday**	☐	☐	☐
☐ **Wednesday**	☐	☐	☐
☐ **Thursday**	☐	☐	☐
☐ **Friday**	☐	☐	☐
☐ **Saturday**	☐	☐	☐

Positions are filled based on qualifications, current openings and the applicant's availability.

In case of illness or personal emergency during my volunteer assignment, please contact:

1)_____
Name Relationship Phone(s)

2)_____
Name Relationship Phone(s)

3) Under age 18, parental permission required. Parent's signature:_____

I AM ORMC

As a volunteer at Ogden Regional Medical Center I commit to:

OWN
Offer solutions to problems. Offer help to others, even if it is not my job. Accept ownership of my concerns.
Work area – Keep clean and organized. Care for all equipment and return to proper storage.
Negativity is unacceptable – Be positive with all patients, visitors, customers, all hospital staff, employees, volunteers and physicians.

RESPECT
Recognize and acknowledge the good in my fellow co-workers.
Each of us is responsible: I am accountable for my attitude and actions.
Stay informed.
Proper tone of voice. Use appropriate verbal and nonverbal language. Be non-judgemental.
Employees manage up – "Manage up" everyone!
Core Values–Maintain honesty, integrity, compassion, trustworthiness, kindness, hospital loyalty, professional image (includes dress code).
Teamwork.

MESSAGE
Make sure patients, families, and physicians are kept informed.
Escort patients and visitors to their destination.
Scripts! I will use them!
Save personal conversations for a time away from patients – Never complain to a patient
Always say what I CAN do, not what I can't do.
Greet each patient with a smile and maintain eye contact.
Everyone - Use the ICARE model.

CARE
Communication - Complete and maintain the whiteboard at all times.
Actively LISTEN to the patient without interrupting.
Relationships are very important – Build them with customers and patients.
Environment – Keep the noise level down and check the comfort level of patients & guests.

.

_____ _____

Volunteer Signature Date

For HIPAA purposes, if I am hospitalized at Ogden Regional Medical Center, I grant permission to my volunteer colleagues, hospital staff and leadership to acknowledge my visit with a remembrance or visit during my stay. This authorization applies to all future admits including those while I am volunteering, and those following my volunteer service.

_____ _____

Volunteer Signature Date

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of a11 patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINS, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

☐ *General Rules*

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

☐ *Protecting Confidential Information*

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available
5. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

☐ *Following Appropriate Access*

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

☐ *Using Portable Devices and Removable Media*

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data ***(e.g.,*** Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Company network.

❑ *Doing My Part - Personal Security*

1. I understand that 1 will be assigned a unique identifier ***(e.g.,*** 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. I will:
   a. Use only my officially assigned User-ID and password (and/or token *(e.g.,* SecurID card)).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.
3 I will never:
   a. Disclose passwords, PINS, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Company network.
4 I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5 I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

❑ *Upon Termination*

1. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Volunteer Signature	Facility Name and COID Ogden Regional Medical Center 34415	**Date**
Volunteer Printed Name	Business Entity Name Ogden Regional Medical Center	

OGDEN REGIONAL MEDICAL CENTER

NAME _____ DATE OF HIRE _____

ADDRESS _____ PHONE _____

_____
(City, State, Zip)

SOCIAL SEC. NUMBER _____ DATE OF BIRTH _____

DEPARTMENT VOLUNTEER SERVICE AREA _____

YEARLY HEALTH TEST RESULTS *For Office Use Only. Leave Boxes Blank.*

Go to Disease/Immunization History

DATE	BP	WBC	HGB	HCT	UA	PPD (mm)	FOLLOW-UPON ABNORMALITIES

COMMUNICABLE DISEASE HISTORY

*(Volunteers – see page 2 instructions. Give approximate date or "No" if you have not had disease. **Don't leave blanks**)*

Chicken Pox _____Year

Red Measles (Rubeola) _____Year

Mumps _____Year

German Measles _____Year

Rubella Titer _____Year

Rubeolla Titer _____Year

Hep BsAB Titer _____Year

Varicella Titer _____Year

Other _____Year

Allergies ☐ Yes ☐ **No**

_____

Latex Allergy: ☐ Yes ☐ No

IMMUNIZATION HISTORY

*(Volunteers-see page 2 instruction Give approximate date or "No" if you have not had immunization. **Don't leave blanks)***

Tetanus Toxoid _____Year

Polio _____Year

Measles _____Year

Mumps _____Year

Rubella _____Year

Tdap _____Year

MMR Vaccine _____Year
(Measles, Mumps, Rubella)

Hepatitis B _____Year
(3 injections completed)

Hepatitis A _____ Year
(2 injections completed)

Varicella Vaccine _____Year

Previous TB skin test _____Year

I certify that all the above is true to the best of my knowledge.

_____ _____

Signature Date

CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of HCA Management Services, LP (hereafter referred to as HCA) may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with HCA's consideration of me for employment, promotion or position re-assignment, and give my full consent for this information to be obtained.

II. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

III. I understand that if I am a resident of **Minnesota/Oklahoma/California (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box □.

IV. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by GIS to furnish the information described in Section I.

V. Upon proper identification, you have the right to make a request to GIS, within a reasonable period of time, as to the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that GIS has previously furnished. Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETE THE FOLLOWING:

_____ _____
Signature Today's Date

_____
Please print full name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

_____ _____
Month, Day and Year of Birth Social Security Number

_____ _____
Driver's License Number and State Name as it appears on License

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide city and state of conviction and details of conviction.

_____

Other (maiden) names used: _____

FAIR CREDIT REPORTING ACT NOTICE:
In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state . Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

Please provide all home addresses for the past (7) years, starting with your present address:

Street Address City State Zip Dates Mo/Yr

1)_____

2)_____

3)_____

4)_____