Volunteer Application- Adult

Volunteer Department
Centennial Medical Center. 2300 Patterson Street. Nashville. TN 37203
615.342.1753 FAX 615.342.1759

Name____ SSN _____________________

Address____

Home Phone____________ Cell ____________ Work ____________ Birthday ____/____/____
Optional

Email:

Education: circle highest year of completion
Grade 6 7 8 HS 1 2 3 4 College 1 2 3 4 Graduate 1 2 3 4

Completed degree (s) ____

Business Experience: begin with most recent

Employer _____________________ Supervisor ______________________ Phone __________

Address ____

Employer _____________________ Supervisor ______________________ Phone __________

Address ____

Volunteer Experience: Begin with most recent

Organization _____________________ Supervisor _____________________ Phone _________

Address ____

Organization _____________________ Supervisor _____________________ Phone __________

Address ____

Please list special skills/ hobbies: ____

Do you speak a foreign language? Y N If yes, what language? ___________________________

How were you referred to our volunteer program? ___________________________________

Volunteer area of interest __________________ Length of commitment: 3 mo. 6 mo. Other ___

Motivation for volunteering? ____

____

Adult Application continued

References: Excluding relatives

Name ___________________________ Phone ________________ Relationship ___________________

Name ___________________________ Phone ________________ Relationship ___________________

Name ___________________________ Phone ________________ Relationship ___________________

Have you ever been convicted of a crime? Y N If yes, please explain _______________________

____

Emergency Contacts:

Name ___________________________ Phone ________________ Relationship ___________________

Name ___________________________ Phone ________________ Relationship ___________________

Name ___________________________ Phone ________________ Relationship ___________________

Special needs/ concerns: ____

Schedule Preferences:

Preferred days/ times ____

Willing to be on-call? Y N If yes, best days/times ____

I have read the forms and understand an investigative report will be made to include information as to character, general reputation, personal characteristics, criminal history, and verification of social security.
I hereby authorize prior employers to provide such information concerning my employment with them as may be requested, and organizations indicated to release information related to volunteer services provided.

Signature ____ Date _____________________

For office use only:

Assigned Department _______________________________________ Start Date ________________

VOLUNTEER DISCLOSURE & RELEASE

Credentialing and background investigation

FULL NAME ______________________________

Any Other Names Used ______________________________

Social Security No. ____/____/__________ Date of Birth[1] ______________________________

Current Address ______________________________

City ______________________________ State __________ Zip ______________

Driver's License State ______________________ No. ______________________

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.

	City	State	Dates From:	To:
1.		/		
2.		/		
3.		/		
4.		/		

Pursuant to the requirements of the Fair Credit Reporting Act, **I acknowledge that a credit report, consumer report[2] and/or investigative consumer report[3] may be made in connection with my application to volunteer with prospective organization.** I understand that these investigative background inquiries may include credit, consumer, criminal, driving, prior employment and other reports. These reports may include information as to my character, work habits performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that a prospective organization and PreCheck, Inc. may be requesting information from various federal, state, and other agencies which maintain records concerning my past activities relating to my educational/school records, driving, credit, criminal, civil and other experiences, as well as claims involving me in the files of insurance companies.

I authorize, without reservation, any party or agency contacted by PreCheck, Inc. to furnish the information mentioned above. A photocopy of this authorization shall have the same effect as the original.

I understand the information obtained will be used as one basis for volunteering for services or denial of volunteering. I hereby discharge, release and indemnify the prospective organization, PreCheck, Inc., their agents, servants and employees, and all parties that rely on this release and/or the information obtained with this release from any and all liability and claims arising by reason of the use of this release and dissemination of information that is false and untrue if obtained from a third party without verification.

It is expressly understood that the information obtained through the use of this release will not be verified by PreCheck, Inc. The authorization granted herein shall be effective throughout the term of my volunteering.

I have read and understood the above information, and assert that all information provided by me is true and accurate.

Signature ______________________________ **Date** ______________

If you are under the age of eighteen, the signature of a parent or guardian must be obtained.

Parent/Guardian ______________________________ **Date** ______________

Upon your written request within a reasonable period of time, the investigative agency compiling a report will make a complete and accurate disclosure of the nature and scope of the investigation. In addition, if you are denied volunteering, either wholly or partly because of information contained in a consumer report, a disclosure will be made to you of the name and address of the investigative agency making such a report.

[1] *The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.*

[2] *A "Consumer Report" may consist of employment records, educational verification, licensure verification, driving record, previous address and public records relative to criminal charges.*

[3] *An "Investigative Consumer Report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with persons having knowledge.*

800.999.9861
713.861.5959
info@precheck.com
www.precheck.com

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all 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, communications, computer systems and management information (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.

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.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. 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.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. 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.
9. 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.
10. 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.
11. 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 e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. 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.
15. I will never:
    a. Share/disclose user-IDs, passwords or tokens.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):

17. I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.
18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.
19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.

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

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name and COID	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	