PARRISH MEDICAL CENTER AUXILIARY

Dear Prospective Member:

We welcome you as an applicant to the Parrish Medical Center Auxiliary. The following information will aid you in completing your application and answer a few of the questions you may have concerning our organization. Orientation is held each month to thoroughly acquaint prospective members with our hospital's mission, vision, values, and healing environment.

Auxiliary membership is open to all men and women who are interested in volunteer service to the hospital and who qualify for membership. Most of our members work on services within the hospital or at an off-site facility. The services include Information Desk, Courier/Escort, Gift Shop, Surgical Waiting Room, Lifeline, Tender Touch, Support Services and Courtesy Shuttle. Some of our services have direct patient contact, while others offer only minimal or no patient contact.

We work a seven-day week with the workday divided into three shifts—morning, afternoon and evening. The shifts are generally four-hours long, and most members work one shift per week. Applicants who want to contribute more hours are urged to work on special projects as they arise, or as a substitute. We try to assign you to the service, day, and time you prefer, but this is not always possible. We may ask you to select an alternate schedule and/or service. We hope you will understand our need to fulfill service commitments to the hospital.

Uniforms are required. Uniform choices will be explained during the interview.

Dues for active members are $5.00 per year. General meetings are held twice a year, and service meetings are scheduled quarterly to update Auxilians on hospital programs and services.

Volunteer service in the hospital and its off-site facilities requires compassion and integrity.

For more information, contact Membership Chairman Diane Brown at 268-6333, ext. 7182.

Parrish Medical Center Auxiliary

PARRISH MEDICAL CENTER AUXILIARY

APPLICATION FOR VOLUNTEER SERVICE

Name _____ **Spouse's Name** _____

Address _____

City_____ **State**_____ **Zip Code**_____

Home # _____ **Cell #**_____ **Birthday** _____

Email _____ **Employer** _____

Previous work experience:

As a volunteer: _____

_____

As a paid employee: _____

_____

Organizations that you are, or were, a member of (please indicate offices you held).

_____

_____

- Write or speak a foreign language? ❑ Yes ❑ No Which ones? _____
- General health condition? _____
- Any physical limitations that prohibit pushing a wheelchair or walking for 2–3 hours? ❑ Yes ❑ No
- Any other limitations? _____
- Have you ever been a hospital Auxiliary member? ❑ Yes ❑ No
- When? _____ Where? _____
- Why do you want to join this Auxiliary? _____

_____

References: <u>No relatives or doctors. Give Auxilians if possible</u>.

1st Name _____ Daytime Phone _____

Address _____

2nd Name _____ Daytime Phone_____

Address _____

- I understand and agree to comply with the requirements of the Parrish Medical Center Auxiliary, its rules and regulations, and the rules and regulations of Parrish Medical Center.
- I will hold all information concerning the patients, physicians and employees of this hospital in confidence.
- I agree to work a minimum of 25–50 hours a year to maintain an active membership.

Applicant's Signature _____ **Date** _____

PLEASE RETURN APPLICATION TO:

Membership Chairman
Parrish Medical Center Auxiliary
951 North Washington Avenue
Titusville, FL 32796

F:\Groups\Auxiliary\Applications
2/99, 9/01, 1/05, 6/09, 3/10, 5/13

PARRISH
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CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics similar to the one that binds the employees at Parrish Medical Center and its off-site family of services. Like them, I assume certain responsibilities and expect to account for my actions based on the organization's expectations. I will keep confidential matters confidential. As a "volunteer" I have agreed to work with no monetary compensation. But, once accepted as a volunteer worker, I expect to do my work according to the high standards expected of paid care partners.

I believe that all work should be carefully analyzed so work methods can be standardized. I believe that people should be studied in order to determine what jobs they can do and like to do, and that as far as possible, they should be assigned to jobs they can do well and enjoy.

I promise to be open-minded in my work, to be trained for it, and bring interest and attention to it. I realize that I may have assets that my co-workers may not have and that I should use these to enrich the projects we are working on together. I also realize I may lack assets that my co-workers have. I will not let this make me feel inadequate, but will endeavor to assist in developing good teamwork.

I will learn how I can best serve the activity for which I have volunteered, and offer as much as I am sure I can give, but no more. I realize that I must live up to my promises and, therefore, will be careful that my agreement is simple and clear so that it cannot be misunderstood.

I believe my attitude toward volunteer work should be professional. I believe that I have an obligation to my work, to those who direct it, to my colleagues, to those for which it is done, and to the public.

Being eager to contribute all I can to Parrish Medical Center's healing environment, I accept this Code of Ethics for Volunteers as my code, to be followed carefully and cheerfully.

Signed _____ Date _____

Print Name _____

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VOLUNTEER SERVICES
REQUEST FOR LOCAL LAW ENFORCEMENT CHECK FOR APPLICANTS

Pursuant to Chapter 85-54, Laws of Florida, Parrish Medical Center requests a local records check on the applicant listed below:

_____ _____ _____
Last Name Middle First

_____
Social Security Number

_____ _____ _____
Date of Birth Race Sex

Please document the findings on this check and return the information to:

Parrish Medical Center
Human Resources
951 N. Washington Avenue
Titusville, FL 32796
Phone: 321-268-6111 ext. 7741
Fax: 321-268-6878

I hereby authorize Brevard County Sheriff's Department to check any and all records pertaining to criminal convictions, and for any law enforcement agency to release to Parrish Medical Center information regarding convictions under Florida Statutes or statutes of other jurisdictions.

_____ _____
Signature of Applicant Date

PARRISH
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VOLUNTEER SERVICES
WORKERS' COMPENSATION VERIFICATION FORM
and
STATEWIDE CRIMINAL HISTORY BACKGROUND CHECK

RESEARCHERS ASSOCIATES, INC.
850-893-2548 / 850-893-9518

Applicant's Name _____

Social Security Number _____

Date of Birth _____

Has this person had a workers' compensation claim filed in the state of Florida in the last _____ years? ❑ **Yes** ❑ **No**

If Yes, Employer _____

Date _____

Type of Injury _____

Time Lost _____

Person Providing Information _____

Today's Date _____

Checked By _____

Confidential Personal Profile

PARRISH MEDICAL CENTER AUXILIARY

Please take a few moments to complete your personal profile sheet
for your file folder. This will assist us to identify members' special skills and talents.

Name _____ **Date**_____

Address _____

Telephone _____ **Email** _____

Are you retired? ❑ Yes ❑ No

Are you a year-round resident? ❑ Yes ❑ No

Special Interests: _____

_____

Special Skills (please mark all that apply):

____ Accounting
____ Computer
____ Secretarial
____ Special Events
____ Writing
Other: _____

Hobbies and/or Talents _____

_____

Do you speak a language other than English? ❑ Yes ❑ No

If yes, what language(s)? _____

Experience in other organizations:_____

_____

Are you interested in serving on a committee (please check all that interest you)**:**

____ Executive Board
____ Nominating Committee
____ Scholarship
____ Service Chairman
____ Service Assistant Chairman
____ Special Events

Thank you for taking the time to complete this form so we may better serve you.

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CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT

As an employee, regular staff or contracted, volunteer, physician, physician office personnel, student, or vendor at Parrish Medical Center, I have the duty to protect the confidentiality of all patient, medical, financial, employee, organizational, and other types of information as outlined in this agreement. I also understand that each and every patient, visitor, guarantor, employee, and other individual associating or interacting with Parrish Medical Center has the legal right to confidential treatment of information about himself or herself.

Therefore, any and all information I am exposed to in the course of performing my professional duties or that I come into contact with in the course of my interactions with Parrish Medical Center will be treated as highly confidential, and will not be disclosed to anyone who does not need that information to perform his or her professional or medical care duties. Physicians, nurses, and other patient-care personnel should never disclose patient information to anyone who is not directly involved in that patient's current care, including, but not limited to the patient's spouse, family and relatives, friends, or other physicians or caregivers who treat the patient for other reasons.

The security and confidentiality of information accessed through electronic information systems is protected through the use of personal user IDs and passwords. The following statement describes your understanding of the significance of accessing protected health information electronically and the implications of any misuse:

> I understand that personal user IDs and passwords are the equivalent of my legal signature and I am responsible for their use. I will never knowingly allow anyone to use my user IDs and passwords or leave a system unattended without signing out. I will not disclose my user IDs and passwords to anyone or attempt to gain knowledge of another person's user IDs and passwords to obtain access to any system. In the event that I have any reason to believe the confidentiality of my user IDs and passwords has been compromised, I will immediately notify Information Systems or the appropriate system administrator of the violation and have my password changed. Any misuse of my user IDs and passwords to obtain clinical, financial, or business information that is not in the direct performance of my duties or responsibilities is a violation resulting in disciplinary action up to and including termination.
>
> **Accordingly, I pledge and assure that I will protect the confidentiality of any and all patient, medical, financial, employee, organizational, and other types of information to which I am exposed. This pledge of confidentiality applies to all sources of information and methods of communication, including but not limited to computer systems, paper documents, email, telephone, direct verbal, and all other forms of communication.**

I further agree that except as permitted or required by this agreement or by law, I expressly agree to comply with the Health Information Portability and Accountability Act (HIPAA) in all respects, including the implementation of necessary safeguards to prevent such disclosure.

I have read and fully understand the above and agree to be bound by each and every term and condition of this agreement with Parrish Medical Center.

_____/_____/_____

Print: *First Name MI *Last Name

_____ _____

*Signature *Contact Phone Number

_____ _____

*Date Email Address

*Required Fields