

BACKGROUND CHECK RELEASE FORM

| | |
|--|-----------------------------------|
| NAME (First, Middle, Last): _____ | |
| FORMER/MAIDEN NAME(S) (If applicable): _____ | EMAIL: _____ |
| CURRENT ADDRESS: _____ | DATE OF RESIDENCY (MM/YY): _____ |
| CITY, STATE, ZIP: _____ | PHONE: (____) _____ |
| PREVIOUS ADDRESS (IF CURRENT IS LESS THAN 7 YEARS): _____ | |
| CITY, STATE, ZIP: _____ | DATES OF RESIDENCY (MM/YY): _____ |
| *APPLICANT'S SOCIAL SECURITY NUMBER: _____ - _____ - _____ | *DATE OF BIRTH: ____/____/____ |
| DRIVER'S LICENSE NUMBER AND STATE ISSUED: _____ | |
| YEAR AND SCHOOL NAME OF MOST RECENT GRADUATION: _____ | |
| TYPE DEGREE/DIPLOMA RECEIVED: _____ | DATE RECEIVED (MM/YY): _____ |
| CITY AND STATE: _____ | NAME AT TIME OF GRADUATION: _____ |

* This information will be used only for background screening purposes and will not be taken into consideration in any employment decisions.

Authorization of Background Investigation

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency such as HireRight, Inc., and to the release of such background reports to Novant Health and its designated representatives and agents, for the purpose of assisting Novant Health in making a determination as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention or for other lawful employment purposes. I understand that if Novant Health hires me or contracts for my services, my consent will apply, and Novant Health may obtain background reports, throughout my employment or contract period.

I understand that information contained in my employment or contractor application, or otherwise disclosed by me before or during my employment or contract assignment, if any, may be used for the purpose of obtaining and evaluating background reports on me. I also understand that nothing herein shall be construed as an offer of employment or contract for services.

I hereby authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requested by the consumer reporting agency.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate and complete. I agree that this form in original, faxed, photocopied or electronic (including electronically signed) form will be valid for any background reports that may be requested by or on behalf of Novant Health.

| | | |
|------------------------------|--|----------------|
| _____ | | ____/____/____ |
| APPLICANT'S SIGNATURE | | DATE |

*****To reduce any delays in the process, please provide as much detailed information as possible for each applicable field.*****



CONDITIONS OF EMPLOYMENT

I certify that the statements made in this application are true and correct to the best of my knowledge and understand that falsification of this information could result in termination of my employment. Permission is hereby granted to obtain references listed herein to release any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing or receiving same. I hereby authorize any educational institution which I have attended to release transcript data upon receipt of a signed copy of this document.

In making this application for employment, I understand that an investigation may be made in which information is obtained through personal interviews with my neighbors, former employers, friends, associates, others with whom I am acquainted and/or others who may have knowledge of me. This inquiry includes information regarding my character, general reputation, personal characteristics and mode of living.

All applicants are required to successfully complete interviews, reference checks, health screen and drug screen. Successful completion of the aforementioned requirements is no guarantee of employment or job availability. I further understand that should I be hired, I may be requested to submit to a drug screen during the course of my employment.

I understand that if I am employed, my employment will not be for a definite duration and can be terminated at any time by either myself or my employer. I further understand that none of the companies personnel

policies should be construed as a contract or as a guarantee of continued employment. No representatives of Novant Health or any of its affiliates, other than the President/CEO of Novant Health or his designee, has authority to enter into or approve any agreement for employment for any specified period of time or to approve any agreement contrary to the foregoing.

Should my services terminate after accepting employment, it is understood that Novant Health or any of its affiliates may supply, in confidence, to any prospective employer my record, with no liability attaching to the company or any of its staff.

The Immigration Reform and Control Act of 1986 requires all employees to verify United States citizenship or, for aliens, authorization to work in the United States.

I hereby authorize Novant Health, and any other affiliate company with which I may become employed to deduct from my paycheck any amount of money that I may now or hereafter owe Novant Health, or any other affiliates of Novant Health. I understand that I will be notified of the amount of any such deduction at least 7 days in advance, and that I will have the opportunity to withdraw this authorization before the deduction is made. I acknowledge that a condition of my employment shall be the making of satisfactory arrangements for the payments of any debt that I may owe Novant Health, or any other affiliates of Novant Health.

This application and any material accompanying it shall become the sole property of Novant Health.

Applicant Signature

Date

NOTE: Successful job applicants will be officially notified only by a representative of the Human Resources Department.

CUSTOMER SERVICE STANDARDS

We, the employees of Novant Health and our physician partners, will deliver the most remarkable patient experience, in every dimension, every time. Every staff member commits to the highest level of patient satisfaction and customer service. Following are specific expected behaviors by which all employees are measured both daily and during their annual evaluation. If you can follow these standards, then Novant Health is the right place for you to work.

Courtesy

- Smile, make eye contact with and acknowledge each person you pass in hallways and public areas.
- Immediately acknowledge customers in your work area.
- Allow customers to exit and enter doorways and elevators first, and hold doors for them. Offer to exit elevators to make room for staff transporting patients.
- Say “Please” and “Thank You.”
- At the conclusion of each patient interaction, always ask, “Before I go, is there anything else I can do for you?”

Customer Waiting

- Respond to requests for help, including call lights, doorbells, intercom systems and telephone requests immediately.
- When possible, provide customers with expected wait times for appointments or procedures.
- Provide regular updates on the current status of waits or delays to customers located in waiting rooms.
- If delay occurs, take responsibility and apologize.
- Keep waiting areas clean and comfortable.

Professionalism

- Keep your promises. If you tell a customer you are going to do something, make sure that you follow through. Never say “It isn’t my job.”
- Speak positively of our facilities, fellow employees, physicians, and support services to patients and visitors.
- Good communication between staff leads to improved patient care.
- End every conversation by asking, “Is there anything else I can do for you?”

Peer Relationships

- We are committed to working together as a team. Collaboration and professionalism are musts.
- Respect and appreciate cultural differences.
- Display common courtesy.

Service Recovery

- Anticipate
- Acknowledge.
- Apologize.
- Amend.

Directions

- Be familiar with physical layout of our campuses.
- Offer to help anyone who looks lost or hesitant.
- Escort customers to their destinations. If they don’t know where they are going, escort them to the nearest information desk.
- Use patience when helping patients, families and guests find their destinations.

Providing Information/Communication

- Introduce yourself by stating your full name, role and department.
- Make eye contact to show interest and concern.
- Listen, without interrupting, to what customers and co-workers have to say.
- Clarify what you heard the customer say before you take action.
- If you don’t have the answer, take responsibility and find someone who can help.
- Tell customers and co-workers what to expect before, during and after they receive services.

Environment & Cleanliness

- Take ownership of any environmental problem you see.
- Never walk past trash – always stop and pick it up.
- Clean up spills and/or report them to Environmental Services.
- Keep work area neat, clean and orderly.
- Do not make unnecessary noise in patient areas.

Telephone Courtesy

- Answer phones within 3 rings. Use your most pleasant voice.
- Offer a greeting, identify yourself, your department and offer assistance. Answer every call this way.
- Ask for permission before placing a caller on hold. Provide updates every 30-45 seconds if placed on hold.
- Prior to transferring a caller, state where they are being transferred to and give them the extension.

Privacy, Respect & Dignity

- Knock and wait for an answer before entering a patient’s room, exam room or workspace.
- Conversations or discussions that offend or hurt customers and/or co-workers will not be tolerated.
- Patient and co-worker information is confidential.

**My number one job responsibility is to provide a remarkable patient experience, in every dimension, every time.
Signing this pledge shows my personal commitment to honoring service excellence.**

Employee’s Signature _____ Date _____

Print Name _____

Human Resource’s Signature _____ Date _____

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT



I, _____ hereby authorize
Employee Name (please print)

Novant Health Inc. to initiate credit entries or debit corrections to my

Checking Account Savings Account

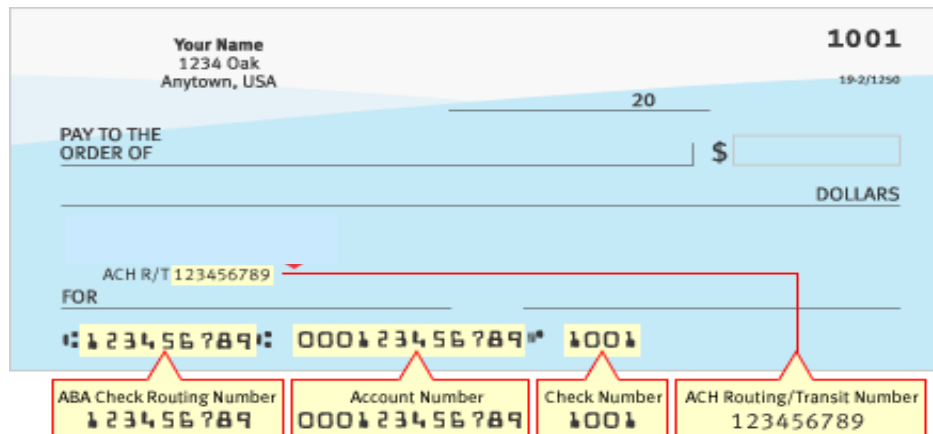
indicated below and the depository (bank) named below.

Depository (Bank) Name _____

City _____ State _____ Zip _____

Routing Number _____

Account Number _____



This authority is to remain in full force and effect until I leave employment with Novant Health Inc. If it becomes necessary for me to change banking institutions or bank account numbers, I will submit a new Direct Deposit Authorization Agreement form with the new banking information at the same time that I cancel the Direct Deposit to my current bank account number.

Employee Signature _____ Date _____

Employee SSN _____ Employee ID # _____

Daytime Telephone Number _____

Department Name & Number _____

To Begin your Automatic Direct Deposit fax this completed form and a copy of a voided check to Payroll at either 336.277.1015 or 336.277.9350

EQUAL OPPORTUNITY EMPLOYMENT INFORMATION FORM

The information requested in this form is required for equal opportunity reporting and will be maintained as a separate document from your application.

LAST NAME FIRST NAME MIDDLE NAME

POSITION APPLIED FOR: _____

SEX: (F) (M)

CIRCLE ALL THAT APPLY – CHECK ONE AS PRIMARY

RACE: AMERICAN INDIAN/ALASKA NATIVE ASIAN
BLACK/AFRICAN AMERICAN HISPANIC/LATINO
NATIVE HAWAIIAN/OTH PAC ISLAND WHITE

EMPLOYEE SIGNATURE DATE SIGNED

CONFIDENTIALITY AGREEMENT



In consideration of new or continued employment, or my association with Novant Health, Inc. ("Novant"), I agree that:

PROPER USE AND/OR DISCLOSURE OF CONFIDENTIAL INFORMATION

- I will use and/or disclose **protected health information (PHI)** or other confidential information only for the purposes of treatment, payment, or health care operations, or as otherwise required by law, as these terms are defined and set forth in Novant policy. I will not use or disclose **PHI** or other confidential information other than as permitted by this agreement, applicable Novant policy or as allowed by law.
- I will not attempt to access or use information that I am not authorized and required to access to use to perform my duties. This includes accessing information about any patient, including fellow employees or family members.
- I will avoid discussions about specific patients with or around those who are not directly involved in the patient's care.
- Any requests for patient information from persons not directly involved in the patient's care should be sent to the appropriate nursing or other supervisor.
- I will refer all media requests for information to Novant's Marketing and Public Relations department. I will refer all other outside requests for information to the appropriate Administrator on Call, nursing or other supervisor.
- I understand that non-public information regarding business contracts and/or other business relationships between a Novant entity and others is also confidential, and will not be disclosed to other parties.

MEASURES TO PROTECT CONFIDENTIAL INFORMATION

- I will follow all Novant policies and procedures, applicable laws and regulations, and other appropriate measures to maintain the security of **PHI** and other confidential information, and to prevent unauthorized use and/or disclosure of this information. The Novant policies and procedures for safeguarding **PHI** and other confidential information are available on the Novant intranet site.
- I will not leave confidential printed, written or electronic information visible in areas accessible by unauthorized individuals except in emergencies.
- When granted an identification badge and/or access to Novant systems, I agree to comply with Novant's policies and procedures regarding use of same.

REPORT OF IMPROPER USE AND/OR DISCLOSURE

- I will immediately report to the Alert Line or The Privacy Office any security breach in which unauthorized disclosure of or access to **PHI** may have occurred, as well as any other use or disclosure of **PHI** that is not permitted by law.

TERMINATION AND PENALTIES

- I understand that if I violate Novant's confidentiality policies or this agreement that I may be subject to disciplinary action, including termination of employment/relationship and criminal charges.
- I hold Novant harmless from any legal liability for the actions I commit that violate Novant's confidentiality policies or this agreement.
- I have been provided access to Novant's confidentiality policies. I agree to review the confidentiality policies and to abide by them.

Name (please print)

Signature

Date

Tobacco-Free Campus Acknowledgement Form

I acknowledge that I have received education on and will comply with the Novant Health Tobacco-Free Environment policy (HR # 6045). Additionally, I understand that employees who use tobacco products on Novant Health premises are in violation of this policy and will be subject to the Progressive Discipline policy (HR # 6040).

I understand that effective April 2, 2007, this policy prohibits smoking and the use of smokeless tobacco products is prohibited:

- In Novant Health facilities, including, but not limited to, hospitals, physician practices, outpatient clinics, and office buildings. Smoking and the use of tobacco products is prohibited in facilities leased by Novant Health.
- In company-owned vehicles at any time and in private vehicles on Novant property.
- Anywhere on Novant Health grounds, sidewalks and parking lots/decks.

I further understand that this policy applies to all persons, including, but not limited to, employees, non-employed workers, medical staff, volunteers, inpatients, outpatients, visitors, students, contractors, vendors and other guests on Novant Health premises.

Employee Signature

Employee ID Number

Date

PICTURE ID INFORMATION

Name: First: _____
Last: _____
Preferred Name: _____

- You may use your first *or* preferred name.
- Your last name is mandatory (with the exception of Emergency Services and Behavioral Health).

Credential(s)/Degree(s): _____

(Ex.- B.S., RN, MSN, BSN, MBA, LPN, CNA, CMA, MOA, PA, NP, etc.)

*The Talent Acquisition and Employment Department
will verify education, licenses, and certifications.*

Signature: _____ Date: _____