Today's Date_____________

Have you ever volunteered at NWH?

____

How did you hear about Northern Westchester Hospital?

____

Please complete information requested on BOTH sides of application and sign application on reverse side.

Do you have any relatives employed here? (please provide the name and department) ____

Were you previously employed at NWH?____________

INFORMATION

Last Name First Name Middle Date of Birth

Street Address City State Zip E-Mail

____

Are you at least 14 years of age? Yes No Home Telephone Number:_________________________ Social Security Number: _________________

Cell Phone Telephone Number:______________________ Emergency Telephone Number:________________________

VOLUNTEER AVAILABILITY

I am willing to Volunteer:

Days: Hours:

____

*Please Note: the volunteer office is not open on weekends, please talk to the volunteer director for more information.

ADDITIONAL INFORMATION

Personal Interests/Skills/Organizations/Affiliations:

Federal and/or New York State Law prohibit discrimination in employment because of age, race, creed, color, marital status, religion, sex, national origin, disability, sexual orientation, or Vietnam era veteran

Do you speak a foreign language other than English?____ If so, what language?__________ Read/Write/Speak

If education is still in process, please indicate "Still Attending". In diploma Column.

School	Name of School & Location	Years Completed	Course of Study	Diploma Degree
High School				
College				
Graduated				
Other				

Were you ever convicted of a Crime? Yes /No. If you were please give date(s) and State(s) in which conviction occurred?

Note: A conviction record will not be necessarily be a bar to employment. Factors such as age at time of offense, date, seriousness, nature of violation and rehabilitation will be taken into account.

VOLUNTEER/EMPLOYMENT HISTORY

List most recent positions first.

From Mo. Yr.	Name of Employer		Name/Title Last Supervisor	Telephone No.
To Mo. Yr.	Address Street City	State Zip	Position Held	

Briefly describe the work you performed:

____

____

From Mo. Yr.	Name of Employer		Name/Title Last Supervisor	Telephone No.
To Mo. Yr.	Address Street City	State Zip	Position Held	

Briefly describe the work you performed:

____

____

From Mo. Yr.	Name of Employer		Name/Title Last Supervisor	Telephone No.
To Mo. Yr.	Address Street City	State Zip	Position Held	

Briefly describe the work you performed:

____

____

HEALTH STATEMENT

In order to assure proper placement of all volunteers, we do request that you answer the following question: Do you have a disability which might affect your performance or create a hazard to yourself or others in connection with the job for which you are applying? If so, please state the following: (1) the skills and performance you use or intend to use or intend to use perform the job notwithstanding the disability and (2) the accommodations we elimination of certain duties relating to the job or other accommodations.

Explain____

PRE-VOLUNTEER STATEMENT

By my signature below, I confirm that I have not withheld any information requested and that the statements I have made are correct and complete to the best of knowledge. I understand that any false statements or misrepresentation this application will be cause of rejection of my application or dismissal from my volunteer position.

______________________________ ______________________

Applicant Signature Date

ADDITIONAL COMMENTS:

Northern Westchester Hospital
Northwell Health℠

INFORMATION NEEDED BEFORE BECOMING A VOLUNTEER

Northern Westchester Hospital is required to comply with New York State Public Health Law and the Joint Commission for Accreditation of the Hospital Organizations as it relates to employees and volunteers. Therefore, certain testing and documents will be required of you ***before you may begin as a volunteer***. This includes medical information from your private physician indicating, that in their opinion, you are physically able to serve as a volunteer.

As a volunteer, you may be assigned to work directly with patients. Therefore, we recommend that if you are not immune to Hepatitis B, you receive this vaccination series from your primary doctor, prior to volunteering. OSHA (Occasional Safety and Health Administration) requires that this be suggested to you. If at any time during your volunteering, you get injured or become ill you must immediately notify the supervisor for your area. Employee Health should be notified immediately as well so that the proper action can be taken in a timely manner.

All services tests, x-rays, and vaccinations must be complete and accurate PRIOR to starting as a volunteer. The hospital is not responsible for completing the pre-volunteer requirements. We are a mode of checking that all proper steps are taken to ensure the health and safety of the hospital patients, staff and volunteers.

Thank you in advance for your cooperation!

Confidentiality and Non-Disclosure Agreement

As a condition to receiving a computer sign-on code and being allowed access to a system, and/or being granted authorization to access and form of confidential information I, the undersigned, agree to comply with the following terms and conditions:

1. I will not disclose my password to anyone or allow anyone to access the system using my password.

2. I am responsible and accountable for all entries made and all retrievals accessed under my sign-on. Any data available to me will be treated as confidential information.

3. I will not attempt to learn or use another user's password.

4. I will not access or request any information I have no responsibilities for. In addition, I will not access any other confidential information, including personal, billing or private information.

5. If I have reason to believe that the confidentiality of my User Sign-On Code and/or password has been compromised, I will ask that my password be changed and notify the Stellaris Support Desk immediately.

6. I understand that my use of the system will be periodically monitored to ensure compliance with this agreement.

7. I will not disclose protected health information or other that is considered proprietary, sensitive, or confidential.

8. I will comply with my hospital's confidentiality policy and all appropriate laws and regulations.

I further understand that if I violate any of the above terms, I may be subject to loss of privileges and/or corrective action, including suspension or dismissal from employment.

Volunteer's Name_________________________ Date_________________
(Please Print)

Volunteer's Signature______________________________________

Northern Westchester Hospital
Northwell Health℠

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI) STATEMENT

It is the policy of Northern Westchester Hospital (N.W.H.) to maintain confidentiality regarding Protected Health Information for all patients treated/seen at the hospital. This information is to be privileged and confidential and is to be treated accordingly.

The Health Insurance Portability and Accountability Act of 1996 "HIPAA" requires the Hospital to adhere to certain rules when using and disclosing the "Protected Health Information" or "PHI" of its patients. "Protected Health Information" is defined by HIPAA as information, in any form or medium (including oral, written and electronic communications), that:

- Is created by a health plan, health care provider, or a health care clearinghouse;
- Relates to an individual's physical or mental health, the provision of health care to an individual, or the payment for the provision of health care to an individual; and
- Identifies, or could be reasonably expected to be used to identify, an individual.

Protected Health Information includes anything from a patient's name, address and telephone number to the patient's clinical and billing records, etc.

1. Every patient has the right to confidentiality of all PHI regarding his/her care and treatment at Northern Westchester Hospital. N.W.H. and all the employees/physicians/volunteers/contracted/private duty patient care staff/ students and interns involved in the services offered have an obligation to protect the confidentiality of PHI concerning all patients. This information includes the (paper) medical record, any document that can be reproduced in paper format i.e., microfilm/microfiche, faxed documents, all information within the Hospital Information System (HIS), and verbal/telephone conservations. All the above applies to staff who may have access to PHI while working from any site off campus.
2. Only persons involved in the care and treatment of the patient or whose job duties require review of the PHI shall have the right to review the medical record either in hard copy or on the computer on a need to know basis. Personnel who have the right to review records are expected to review only those sections of the hard copy or computerized record, which are pertinent to their responsibilities.
3. All employees/physicians/volunteers/contracted/private duty patient care staff/students and interns that obtain PHI, whether as part of their responsibilities or by any other means, have an obligation to treat such information confidentially. Some discussion concerning patients by personnel involved in their care is a necessary part of any plan of care. Any unnecessary discussion concerning a patient and his/her care is a direct violation of medical ethics, HIPAA regulations and of the patient's right to privacy/confidentiality.
4. **Such violations of a patient's rights are considered to be a serious offense and constitute grounds for disciplinary action up to and including termination.**

Unauthorized review, discussion and or copying of the medical record (either on paper or computerized) and/or portions of the same are strictly prohibited. This includes any

unauthorized access to areas within the HIS that are not related to job responsibility or the sharing of computer security code. (See HR Policy Discipline, 2-23).

5. Any employee/physician/volunteer/contracted/private duty patient care staff/student or intern who becomes aware of an incident involving a violation of this policy as noted above has an obligation to report such incident to his/her immediate supervisor and/or the Manager of the Health Information Management Department (Medical Records Department), and the Privacy Officer.

I ____ have read The Confidentiality of Protected Health Information Statement and understand that any violation to the rights of confidentiality constitutes grounds for disciplinary action up to and including termination. It is also my responsibility as an employee/physician/volunteer/contracted/private duty patient care staff/student/intern of Northern Westchester Hospital to report any violation that I am aware of to my immediate supervisor. I am responsible to read and sign this confidentiality statement (if applicable) annually at the time of my performance review.

Signature:______________________________ Date:_______________

VOLUNTEER PRE-PLACEMENT CONSENT

I understand that my service at NWH is a subject to satisfactory completion of the medical information from by my physician including a skin test for TB. I understand that the above is **required by New York State Public Health Law** and medical clearance for volunteer service. I release NWH from any liability that may result from misrepresentation or withheld information.

Signature (confirms you have read, understand, & consent to below)

____ _____/_____/______
Date

Parental Consent (if volunteer applicant is under 18)

____ ____/_____/______
Date

Pre-Placement Checklist:

______ **Volunteer Pre-Placement medical clearance**

______ **PPD placed and read within 48-72 hours.**

MEDICAL CLEARANCE FORM

Applicant: ____________________________________ Date of Birth: ___/___/___
Address: _____________________________________ City: _____________ State: ______
Zip Code: ________ Telephone: (___) _____________

Dear Physician,
Your patient has applied for a volunteer/intern/students position at Northern Westchester Hospital. Pursuant to New York State Public Health Law, all POTENTIAL volunteers/interns are required to provide medical information. Kindly complete this medical questionnaire at your earliest convenience.

1. Does this applicant have any medical conditions that would restrict him/her from a volunteer assignment? Medicatio– Yes ☐ No
____ Allergies:
____

2. In your opinion, may this applicant transport patients in wheelchairs or on stretchers if properly trained? Yes ☐ No

3. Would you recommend this applicant for volunteer services? ☐ Yes ☐ No

4. Please provide documentation of immunization/ disease or titers for the following:

IMMUNIZATION TYPE	DATE OF DISEASE/ IMMUNIZATION	TITER RESULTS/DATE
Td/Tdap		
Measles		
Mumps		
Rubella		
Varicella		
Hepatitis B		
Flu Vaccine		

5. Date of PPD (Mantoux) Skin Test (**MUST BE WITHIN PAST YEAR):**
Date Planted: _________
Date Read: __________
Results: ☐ Positive ☐Negative

If positive, date of last CXR: ________________ Results: ___________________________

Physicians Signature: _____________________________________ Date: ____________________
(Please print name): ______________________________________

Z:\Vol medical information form for volunteers revised 2012