



Dear Potential Volunteer:

Thank you for your interest in becoming a volunteer with the Central Florida Regional Hospital Auxiliary. Volunteers are very special members of our hospital's team. Volunteer positions include:

- Information Desk
- Gift Shop
- Trolley
- Emergency Department
- Post Anesthetic Care Unit (PACU)
- Outpatient Surgery
- Surgical Waiting Room
- ICU/NSICU Waiting Room
- Sunshine Cart
- Medical/Surgical/Peds Units
- Open Heart/Cardiac Cath/ICU Waiting Room

Attached you will find a volunteer application packet. Please complete and return the forms, along with any reference letter(s) to the Volunteer Services office at the hospital.

After reviewing your application we will contact you to schedule an interview.

Again, thank you for inquiring about the volunteer program at Central Florida Regional Hospital. We look forward to having you join our team. If you have any questions, please feel free to call **407-302-7385**.

Sincerely,

Auxiliary Membership Committee



AUXILIARY MEMBERSHIP APPLICATION

First Name _____ Last Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email _____ Do you check it regularly? Yes No

Are you a Florida resident? Yes No Gender: Male Female

Education (Highest Level Completed) _____

Areas Studied/Special Skills _____

Community Affiliations/Experience: _____

Why are you interested in volunteering at this hospital? _____

Have you ever been a hospital volunteer? Yes No

If yes, where? _____

Are you currently seeking employment at the hospital or any other company? Yes No

If yes, where? _____

What is your expected time commitment to the Auxiliary?

3-6 months One year or more

How did you hear about the CFRH Auxiliary? _____

Personal References (please give two):

Name _____ Phone (____) _____

Name _____ Phone (____) _____

Have you been convicted of a crime and/or released from confinement following a conviction for any criminal offense? No Yes If yes, give date, place, & nature of each such conviction:

Are you presently charged with any violation of the law?

No Yes *If yes, give date, place, and nature of each such charges:*

Auxiliary Services (please mark your preference):

- Gift Shop *(operate cash register, assist customers with purchases, etc.)*
- Information Desk *(give directions, answer telephone, deliver flowers, etc.)*
- Emergency Room *(help nurses, run errands, prepare patient charts, refill stock, etc.)*
- Surgical Waiting Room *(act as liaison between family members and medical staff, etc.)*
- Sunshine Cart/SNU Visitor *(deliver patient mail, water patient plants, sell candy, etc.)*
- Outpatient Surgery *(assist nurses, make beds, prepare patient charts, etc.)*
- PACU *(keep families informed of patients' status, answer telephone, etc.)*
- ICU/NSICU Waiting Room *(act as liaison between family members & medical staff, etc.)*
- Med/Surg/Peds Units *(assist nurses, read to patients, deliver snacks to patients, etc.)*
- Trolley *(drive the golf cart to pick up and drop off visitors in the parking lot)*
- OH/CCL/ICU Waiting Room *(act as liaison between family members and medical staff, etc.)*

Days Available or Other Comments _____

Yearly dues: \$8.00 (Central Florida Regional Hospital Auxiliary, Inc., is operated independently by its Board of Directors and members; dues are collected by the Auxiliary, not the Hospital.)

I HEREBY APPLY FOR MEMBERSHIP AND AGREE TO COMPLY WITH ALL RULES, BY-LAWS, AND POLICIES OF THE AUXILIARY.

Signature

Date

EMERGENCY CONTACT INFORMATION



APPLICANT'S

First Name _____ Last Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Social Security No. _____

1st Emergency Contact:

Name: _____

Home Phone _____ Work Phone _____

Relationship _____

2nd Emergency Contact:

Name: _____

Home Phone _____ Work Phone _____

Relationship _____

Service Areas:

1. _____

2. _____

3. _____

4. _____

5. _____



EMPLOYEE/CONTRACT EMPLOYEE/VOLUNTEER
CONFIDENTIALITY STATEMENT POLICY & PROCEDURE

ACKNOWLEDGEMENT OF POLICY

It is the policy and obligation of Central Florida Regional Hospital to keep in strict confidence all that pertains to any patient and any patient's affairs. Every person holding any employment or voluntary position with Central Florida Regional Hospital shares this obligation. Therefore, information regarding the diagnosis, condition and treatment of patients is confidential and may be disclosed only by persons specifically authorized to do so. Non-medical information of a personal nature is equally as confidential. Discussions of such information by Employees, Contract Employees and Volunteers are prohibited. Any Employee, Contract Employee or Volunteer who violates this confidentiality policy may be immediately dismissed.

All patient related communication between Employees, Contract Employees, Volunteers and Medical Staff should be respected and held with the same degree of confidentiality as information regarding patients.

I understand and acknowledge the policy statement of Central Florida Regional Hospital regarding confidentiality. I recognize the importance of this statement, and I understand that a copy of this document will be signed and kept on file.

Print Name of Volunteer

Signature

Date

Confidentiality and Security Agreement

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.

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|---|--|
| <ol style="list-style-type: none"> 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. | <ol style="list-style-type: none"> 13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards. 14. I will: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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. |
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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.

Volunteer Signature	Facility Name and COID	Date
Volunteer Printed Name	Business Entity Name	



Credentiaing and Background Investigation

CENTRAL FLORIDA REGIONAL HOSPITAL VOLUNTEER DISCLOSURE & RELEASE (CLIENT # 1494)

FULL NAME _____

Any Other Names Used _____

Social Security No. ____ / ____ / ____ Date of Birth¹ _____

Current Address _____

City _____ State _____ Zip _____

My present employer may be contacted for a job reference. Yes No

Will you be driving the trolley? Yes No

Driver's License State _____ No. _____

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

Table with 5 columns: City, State, Dates, From:, To: and 4 rows of residential history.

Pursuant to the requirements of the Fair Credit Reporting Act, I acknowledge that a credit report, consumer report² and/or investigative consumer report³ may be made in connection with my application to volunteer with prospective organization.

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 _____

Parent/Guardian Signature _____ 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.



Name: _____
(Last) (First) (Middle)

PREVIOUS WORK HISTORY (PREVIOUS **7 YRS)**

<u>From</u>	<u>To</u>	<u>Name of Company</u>	<u>Job Title</u>	<u>City & State</u>	<u>Contact Number</u>

SIGNED: _____ DATE: _____

(Volunteer)