



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:

- CVICU Waiting Room
- Company Care Office
- Emergency Department
- Human Resources Department
- Information Desk
- Gift Shop
- ICU/NSICU Waiting Room
- Medical Staff Office
- Medical/Surgical Units
- Outpatient Surgery
- Post Anesthetic Care Unit (PACU)
- Sunshine Cart
- Surgical Waiting Room
- Transportation and Discharge
- Trolley

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.

The purpose of the volunteer program is to provide an opportunity to experience working in a hospital environment and provide needed services and assistance to the hospital staff, patients and visitors. The program is not meant for the purpose of job or career training, nor is it meant to lead to paid employment at Central Florida Regional Hospital.

We prefer applicants commit to a minimum of one year to the Auxiliary.

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? _____

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):

- CVICU Waiting Room (*act as liaison between family members and medical staff, etc.*)
- Company Care Office (*copying, filing, general clerical duties*)
- Emergency Department (*help nurses, run errands, prepare patient charts, refill stock, etc.*)
- Gift Shop (*operate cash register, assist customers with purchases, etc.*)
- Human Resources Department (*copying, filing, folding, creating packets, labeling, etc.*)
- ICU/NSICU Waiting Room (*act as liaison between family members & medical staff, etc.*)
- Information Desk (*give directions, answer telephone, deliver flowers, etc.*)
- Med/Surg Unit (*survey patient's hospital experience*)
- Medical Staff Office (*copying, filing, faxing, general clerical duties*)
- Outpatient Surgery (*assist nurses, make beds, prepare patient charts, etc.*)
- PACU (*keep families informed of patients' status, answer telephone, etc.*)
- Sunshine Cart/SNU Visitor (*deliver patient mail, water patient plants, sell candy, etc.*)
- Surgical Waiting Room (*act as liaison between family members and medical staff, etc.*)
- Transportation/Discharge (*assist nurses in discharging patients to the lobby, transport patients from registration and the front desk to the floors*)
- Trolley (*drive the golf cart to pick up and drop off visitors in the parking lot*)

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

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, information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (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 and in the scope of 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. Disclose passwords, PINs, or access codes.
 - 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.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

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



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

CENTRAL FLORIDA REGIONAL HOSPITAL – HCA – VOLUNTEERS #6838
VOLUNTEER DISCLOSURE & AUTHORIZATION

FULL NAME _____
 Any Other Names Used _____
 Social Security No. ____ / ____ / _____ Date of Birth¹ _____
 Current Address _____
 City _____ State _____ Zip _____
 Driver's License State _____ No. _____
 Address: _____

Have you ever been convicted of a crime? Yes No
 Offense _____ County _____ State _____ When _____

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.	_____ / _____	_____	_____	_____	_____
5.	_____ / _____	_____	_____	_____	_____
6.	_____ / _____	_____	_____	_____	_____
7.	_____ / _____	_____	_____	_____	_____
8.	_____ / _____	_____	_____	_____	_____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Central Florida Regional Hospital - HCA ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, volunteering, privileges or appointment to the extent permitted by law.

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 necessary for the proper processing of a consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout term of my employment, contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

STATE LAW NOTICES

Minnesota or Oklahoma applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

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

Signature _____ Date _____