Jackson Purchase Medical Center
Auxiliary Volunteer Application

PLEASE PRINT

Date of Application: _____
Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____ (Home/Work): _____
Social Security Number: _____ Birthdate: _____

In Case of Emergency, Notify
Name: _____
Phone: _____ (Home/Work): _____
Relationship: _____

Educational Background: _____
Current Occupation: _____
Have you ever worked for Jackson Purchase Medical Center? _____
If yes, when? _____
Have you been convicted of a felony within the past ten years? _____
If so, explain offense, date and sentence: _____

Hobbies and Accomplishments: _____
_____
_____
_____

Previous Volunteer Experience: _____
What days and times are you available to volunteer? _____
In which of the following service areas would you like to work? _____

Information Desks: Front _____ *Medical Office Building* _____ *Birthing Center* _____

Gift Shop _____ *Senior Friends* _____ *Other* _____

Would you like to work a regular scheduled day? _____
Alternatively, would you like to be a substitute? _____

References

Name: _____ Phone: _____
Name: _____ Phone: _____

LifePoint IT&S Security Access Form (Facility)

FIELDS MARKED WITH AN * ASTERIK ARE REQUIRED. FORMS WILL BE RETURNED IF ANY REQUIRED FIELDS ARE LEFT BLANK.

(1) Applicant Last Name*	(2) Applicant First Name*	(3) MI or "NA"*

(4) Work Address	(5) City, State, Zip code
1099 MEDICAL CENTER CIRCLE	MAYFIELD, KY 42066

(6) Phone Number*	(7) Date of birth*	(8) SS# Requester*
EXT. 4200		— —

(9) User Type* ☑LifePoint ☐Contractor Company name & phone # required for Contractor/Vendor ☐Vendor	(10B) Exp. Date for Contract or Vendor*

Expiration and Approval Requirements — Expiration date must be supplied in field 10 for "Contractors" and "Vendors." The expiration date should be the end of the contract or engagement period.

(14) Department #*	(15) Department Name*	(16) Job Title*
900	HOSPITAL AUXILIARY	VOLUNTEER

(17) Universal ID	(17a.) Network login if different from UID	(17b) Domain
		LPNT

(18) Applicant Signature*	(19) E-mail Address	(20) Date*

Authorizing Security Coordinator Statement — By signing this request I am stating that I have reviewed the above information for completeness and it is accurate to the best of my knowledge. Also I have reviewed the Information Security Agreement and verified that it has been completely filled out and signed. Also that I verify this request and authorize its processing. 2 signatures required.

(21) Manager's Signature*	(22) Security Coordinator's Signature	(23) Date

(24) Manager's Printed Name*	(25) Security Coordinator's Printed Name	(26) Phone Number of HDIS/LSC
	INFORMATION SYSTEMS DEPT	270-251-4263

□ **Applicant has Information Confidentiality & Security Agreement on file** □ **Yes** □ **No**

Action*: ☑ New ☐ Change ☐ Delete ☐ Terminate Effective Date*: _____

Access Granted by HDIS/LSC	Level	Other Comments
☐ Imaging – Fortis		
☐ Collections		
☑ Meditech	ADM.zcus.n.volunteer.main.menu	MOX, OE
☐ Internet Access		
☐ HOST/Mainframe		
☐ SMART		
☐ Kronos		
☐ Additional Access		

X NT/AD account

Background Check Authorization Form

I authorize [Jackson Purchase Medical Center] and its designated investigative agency Certiphi to make whatever inquiries it may deem necessary in connection with my application for volunteerism. As part of such inquiries, [Jackson Purchase Medical Center] and the agency have my permission to contact persons who may have information relating to my suitability for volunteerism.

_____

Name (Printed)

_____

Other Names Used (maiden, Previous Married Names)

Please list your last three addresses and # of years there:

_____

Address **City** **State** **Zip**

_____

Address **City** **State** **Zip**

_____

Address **City** **State** **Zip**

_____

Last School Attended **Date-Month-Years Attended** **Type of Degree Received**

_____ _____

Home Telephone Number **Business Telephone Number**

_____ _____

Date of Birth **Social Security Number**

_____

Driver's License and State of Issue/Expiration Date

_____

Signature **Date**

BACKGROUND SCREENING AUTHORIZATION FORM

[FOR VOLUNTEER PURPOSES]

The volunteer acknowledges that this company many now, or at any time while volunteering, verify information within the application, resume or contract for volunteering. In the event that information from the report is utilized in whole or in part in making an *adverse decision,* before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq.*

Please be advised that we may also obtain an ***investigative consumer report*** including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting and/or conducting personal interviews with your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq.,* is available at the Federal Trade Commission's website (http://www.ftc.gov). For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

By signing below, I hereby authorize the company to obtain a consumer report and/or an investigative consumer report on me, and further authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Background Screening Authorization Form shall remain valid and in effect during the term of my contract and/or employment, subject to applicable laws, and authorize the company to obtain a consumer report and/or an investigative consumer report on me during the hiring process as well as at any time during the term of my employment, where permitted by law.

Date: _____ Signature of Volunteer: _____

Print Full Name: _____

BACKGROUND SCREENING DISCLOSURE FORM

[FOR VOLUNTEER PURPOSES]

Please be advised that a consumer report may be obtained on you for volunteering purposes.

Consumer reports may be obtained at any time after the company receives your written authorization, including during the initial screening and onboarding process; and, during any subsequent period you may serve as a volunteer with the company, where permitted by law.

Under the Fair Credit Reporting Act (FCRA), consumer reports include any written, oral or other communication of information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Consumer reports may include credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources.

By signing below, I acknowledge that I have read the above.

Date: _____ Signature of Volunteer: _____

Print Full Name: _____

Confidentiality and Security Agreement

I understand that the facility or business entity named below (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 individually identifiable health information and protected 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 not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies are available through the Company , copies of which will be provided upon request. 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, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.

4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions 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 Company's Privacy and Security Policies 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 Company 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 electronic media devices 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., Multi-Factor Authentication "MFA").
b. Use only approved licensed software.
c. Use a device with virus protection software.

15. I will never:

d. Share/disclose user-IDs, passwords or MFA.
e. Use tools or techniques to break/exploit security measures.
f. Connect to unauthorized networks through the systems or devices.

16. I will notify my manager, Facility Information Security Officer, 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.

18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.

19. I understand that the Company may, at its sole reasonable discretion, rescind any person's access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility's rules and regulations, may subject me to disciplinary action pursuant to the facility's medical staff bylaws

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

JACKSON PURCHASE MEDICAL CENTER
LABS FOR NEW EMPLOYEES
{Charge to Employee Health}

NAME _____ **D.O.B.** _____ **SS#**_____

PHYSICIAN _____ **ORDERED BY** Susan Deaton, Interim HR Director

DATE ORDERED _____

	TEST ORDERED	**MNEUMONIC**
_____	**Measles Titer**	**RUBEGAB**
_____	**Mumps Titer**	**MUMIGG**
_____	**Rubella Titer**	**RUBSC**
_____	**Varicella IgG**	**VARG**
X	**Urine Drug Screen**	**DRUGNDOT** (Chain of Custody)
_____	**"STAT" Rapid Anti-HIV Assay (SUDS)**	**HIVR**
_____	**HIV Antibody**	**HIV1AB**
_____	**Hepatitis Panel**	**HEPATEH**
_____	**Hepatitis B Surface Antibody** (Post Vaccination Titer)	**HBSAB**
_____	**Hepatitis B Surface Antigen**	**HBS**
_____	**Hepatitis C Antibody Assay**	**HCVAB**
_____	**Plasma HCV RNA by PCR Assay**	**HEPCRNA**
_____	**CBC**	**CBC**
_____	**Comprehensive Metabolic Panel**	**CMP**
_____	**Hepatic Function Panel**	**HFP**
_____	_____	

COMMENTS: _____

JACKSON PURCHASE MEDICAL CENTER

DRUG/ALCOHOL TEST RELEASE AND CONSENT

I. EMPLOYEE IMFORMATION

Employee Name	Date of Birth	Social Security No.	Date
Street Address	City	State	Zip

II. CONSENT

I, _____, understand that as a condition of my employment
(Print Name)

with Company/Facility that I will be required to undergo a drug and alcohol test for post-accident or reasonable suspicion in accordance with policy. Further, I understand that refusal to give consent to be drug and alcohol tested in order to comply with Company/Facility policy will subject me to termination of employment.

Signature of Employee	Date
Witness Signature	Date

III. RELEASE OF RESULTS

I, _____, do hereby give consent to release the results of my
(Print Name)

drug and alcohol test(s) conducted throughout the course of my employment with LifePoint Health and its affiliates to my Employer.

Signature of Employee	Date
Witness Signature	Date

Jackson Purchase Medical Center

Auxiliary's Creed

As a member of the Jackson Purchase Medical Center Auxiliary, I agree that:

- □ I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.
- □ My services are donated to the hospital without contemplation of compensation or future employment and given with humanitarian, religious or charitable reasons.
- □ I will be aware of the information provided at the hospital orientation and understand the Fire and Safety Rules and Infection Control Policies of Jackson Purchase Medical Center for all volunteers.
- □ I will annually have a TB skin test or have a signed waiver of my inability of taking that test filed in the Infection Control Department.
- □ I shall not sell or attempt to sell goods or services, request contributions or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the expressed written authorization from the hospital's administration.
- □ I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional quality.
- □ I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and if unsuccessful, attempt to resolve any such problems with the supervisor of the Auxiliary.
- □ I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
- □ I shall at all times uphold the philosophy and standards of the hospital.
- □ I shall make every effort to report to my volunteer hob the day I have agreed to work. If I find that I will not be able to report, I will notify the "Caller of the Month" at least 24 hours in advance, when possible. I understand that I do not ask someone to fill in for me.
- □ I will accept those who are placed to work with me, never to hurt anyone's feelings by refusing to work with fellow Auxiliary members.
- □ I understand that the hospital reserves the right to terminate my volunteer status as a result of (a) failure to comply with the hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgement of the supervisor of the Auxiliary, would make my continued services as a volunteer contrary to the best interests of the hospital.

I, as a member of the Jackson Purchase Medical Center Auxiliary, agree to the above.

_____ _____

Signature Date