Volunteer Application

Prior to filling out this application, please refer to the Volunteer Requirements & Benefits document, and the Villa Volunteer Requirements & Protocol (if applicable).

Name:			Date of Birth:
Address:	City:	State:	Zip:
Email Address:			Phone:

Personal Hobbies/Interests:

Emergency Contact:	Emergency Contact Phone:

Volunteer Positions Interested In:	☐ Villa ☐ Dialysis ☐ Hospitality Cart	☐ Welcome Desk ☐ Gift Shop ☐ *Hospice	* *(NOTE: Hospice volunteers must be willing to go into the homes of our hospice patients and assist the patient and their caregiver with nonmedical needs. Interested parties should be reliable, caring, honest, and able to deal with death and dying.)*

Shifts Interested In:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening

References:

Please list two references that are not related to you.

Name:	Phone:
Name:	Phone:

DRUG FREE WORKPLACE POLICY: Uintah Basin Healthcare hereby notifies the undersigned volunteer that the unlawful manufacture, distribution, dispensing, possession, or use of controlled substance is prohibited in the workplace. Furthermore, volunteers that violate the above policy may be disciplined or terminated. Volunteers may be required to take drug/alcohol tests, subject to Uintah Basin Healthcare's Drug and Alcohol Testing Policy. Drug/alcohol counseling, rehabilitation, and assistance may be available to assist volunteers who violate this policy.

By signing below, I acknowledge that information provided is true and accurate to the best of my ability, and that I have read and agree to abide by the Drug Free Workplace Policy.

____ __________________

Volunteer Applicant Signature Date

Volunteer Requirements and Benefits

Volunteers serve at our welcome desk, gift shop, in the homes of hospice patients, at The Dialysis Center, and at The Villa. To inquire of what volunteer opportunities are currently available, meet with the UBH Volunteer Services Team.

Requirements:

- Fingerprints/background check (as required)
  - A background check including fingerprints is required for all volunteers.
  - You must bring your drivers license with you. Your information will be entered electronically (including your SSN) to run a background check in Human Resources.
  - If your background check is clear, Human Resources will present you with an identification badge that you are expected to wear while on-duty volunteering.
- All volunteers must take the annual HIPAA test.
- All volunteers are required to meet immunization requirements. See attachment.
- Hospice Volunteers require 12 hours of initial training (electronic presentation or printed booklet), and ongoing training.
- Villa Volunteers must read and agree to abide by the *Villa Volunteer Requirements & **Villa Volunteer Protocol.
  - Refer to "Villa Volunteer Requirements & Villa Volunteer Protocol" document for further information.

Benefits:

To be considered an active volunteer with benefits, we ask that you commit to volunteer a minimum of 4 hours per week on a consistent basis. Active volunteers receive the following benefits:

- 20% discount in the gift shop
- Free lunch at the UBH Skyview Café during your shift
- 15% off healthcare costs, excluding co-pays (Clinic and Hospital)
- 10% off pharmacy (over-the-counter) items, excluding co-pays
- Free Annual mammogram for women or PSA for men
  - You must obtain paperwork from Human Resources prior to your test
- Individual use of the Physical Therapy gym
  - You must take your badge with you
  - Currently, gym hours are 5 AM – 10 PM, Monday through Friday
- You are invited to attend tri-annual volunteer meetings which include lunch or dinner

Volunteer Immunization Requirements

The Employee Health Department at Uintah Basin Healthcare takes the safety of our Patients, Employees, Volunteers, Students and their Families very seriously. Following the CDC and the Utah State Health Departments Immunization Recommendations, all Health Care Workers must meet the immunization requirements listed below. Health Care Workers include students, interns, volunteers and contract workers that are within our facilities.

Volunteer Immunization Records Must Include:

A. Proof of two MMR (Measles, Mumps, Rubella) vaccinations, positive MMR titer for, or history of disease

B. Varicella (Chickenpox): History of disease, positive titer or proof of two vaccinations

C. Current TB (Tuberculosis) skin test. (within the current year)

D. Proof of T-dap (Tetanus, Diphtheria, Pertussis) vaccination

E. Annual Influenza Vaccination (flu shot) between the months of October 1st - March 31st

You will be required to meet with the Employee Health Coordinator to review your immunization records and obtain additional required immunizations. Please locate any immunization records that you have at home and bring them with you. We also have access to our Electronic Medical Record and USCIS to help verify immunization records. This must be completed before you begin your Volunteer Service UBH. The best time to meet with me is Wednesdays between the hours of 8 am until 2 pm.

UBH welcomes you and appreciates your service.

If you have any questions, please call:

Julianne W Merkley, RN Employee Health Coordinator

Office: 435-247-4296

Email: julianne_merkley@ubmc.org

*Villa Volunteer Requirements:

Adults (Age 18+) who want to visit Residents at The Villa on a consistent basis must follow the volunteer application process. This requires the potential volunteer to meet with the DVS (Maigen Zobell) or Volunteer Coordinator to complete an application, get a background check including fingerprints, obtain a badge from Human Resources, and agree to visit an assigned Resident on a consistent basis. We ask that all active volunteers commit to volunteer a minimum of 4 hours per week on a consistent basis.

Active volunteers do have both requirements and benefits. Please refer to the "Volunteer Requirements & Benefits" document for further information.

**Villa volunteers must review & sign the Villa Volunteer Protocol below.

Villa Youth Volunteer Requirements:

Youth (Up to 17) who want to visit Residents at The Villa must be accompanied by a responsible adult (age 18+). Youth volunteers are welcome in group settings, but are not allowed to do one-on-one patient interaction without the supervision of an adult who has completed the volunteer application process and background check.

We encourage youth volunteers! We just ask that all youth volunteers coordinate a time with the Activities Director at The Villa to be assigned to a group activity.

Note that these guidelines do not apply to family and friends who are visiting their loved ones. These guidelines are for those who have a desire to volunteer or who need to fulfill volunteer hours.

**Villa Volunteer Protocol:

Residents of The Villa consider this facility their home! As such they should be treated as if in their home.

Please Knock.

Always knock before entering a Resident room. Get permission before entering. You may need to call out "This is Maigen, your volunteer… May I come in?". Residents have the right to receive or deny any visitor.

Invite Residents to Participate

You may invite a Resident to participate in group activities, sometimes coaxing, but the Resident has the right to choose to participate or not. Sometimes they would rather stay in their room and visit.

DO NOT enter a Resident's room without them.

If a Resident asks you to go into their room to get something, you should offer to push their wheelchair and go along with them. Never go into a Resident room alone.

DO NOT transfer a Resident.

No matter what, NEVER transfer a Resident. For example, if a Resident asks you to help them out of bed to get into their wheelchair, please call for a nurse/aide to transfer the Resident. If you were to find a Resident on the floor, do not attempt to move them; immediately call for a nurse/aide.

PHOTO/VIDEO RELEASE

I hereby grant **UINTAH BASIN HEALTHCARE** and/or all associated service lines permission to use my likeness in a photograph/video or other digital reproduction in any and all of its advertising methods.

I understand and agree that these materials will become the property of **UINTAH BASIN HEALTHCARE** and may be used in marketing efforts which may include (but are not limited to) internal flyers, newspaper, social media, theatre advertisements, billboards, company newsletters, videos, print and website use.

In addition, I waive the right to inspect or approve the finished product, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph/video or other digital items. I hereby hold harmless and release and forever discharge **UINTAH BASIN HEALTHCARE** from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age or older and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

____________________________________ ____________________
(Signature) (Date)

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(Printed Name)

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of ________________________, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

____________________________________ ____________________
(Parent/Guardian's Signature) (Date)

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(Parent/Guardian's Printed Name)

PRIVACY & CONFIDENTIALITY AGREEMENT
For Employee, Volunteers, Board Members and Others

This Privacy and Confidentiality Agreement ("Agreement") explains your duties as a member of the Uintah Basin Healthcare (UBH) Workforce, Volunteer, or Board Member regarding confidential information. Federal and State laws, as well as UBH policies and procedures, protect confidential Information. These laws and policies assure that confidential Information, which is sensitive and valuable, remains confidential. They also permit you to use confidential Information only as necessary to accomplish legitimate and approved purposes.

"Confidential Information" means data proprietary to the UBH, plus any other information that is private and sensitive and which the UBH has a duty to protect. You may learn of or have access to some or all of this confidential information through oral communications, paper documents, computer systems, or through your activities at or relating to the following:

1. Patients serviced by you. (Medical records, conversations, admittance information, patient financial information, etc.)
2. UBH that employs you, or acting as a volunteer or board member (financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology)
3. Third party Information. (computer programs, client and vendor proprietary information, source code, proprietary technology)

RECITALS

To qualify to access or use Confidential Information, I agree to comply with the laws and UBH policies governing confidential Information. My principal duties regarding confidential Information include, but are not limited to, the following. By signing this agreement, I promise to:

1. Safeguard confidential information
2. Use confidential Information only as needed to perform my legitimate responsibilities as a member of the UBH Workforce, Volunteer, or Board Member. This means, among other things, that I will NOT:
   a. Access Confidential Information for which I have no legitimate need to know
   b. Divulge copy, release, sell, loan, revise, alter, or destroy any confidential Information except as properly authorized within the scope of my responsibilities as a member of the UBH Workforce, Volunteer, or Board member.
   c. Misuse confidential Information.

3. Safeguard, and will not disclose, my password or any other authorization that allows me to access confidential information. This means, among other things, that I WILL:
   a. Report activities by any individual or entity that I suspect may compromise the confidentiality of Confidential Information. Reports made in good faith about suspected activities, as well as the names of the individuals reporting the activities, will be held in confidence to the extent permitted by law.
   b. Promise not to use or share confidential information after termination of my Workforce, Volunteer, or Board Member status.
   c. Claim no right or ownership interest in any confidential information referred to in this Agreement.

I AGREE THAT I am responsible for my noncompliance with this Agreement.

I AGREE THAT If I violate any provision of this Agreement, I will be subject to discipline, including termination of employment, volunteerism, or board membership with UBH and subject to legal liability.

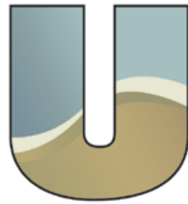
I AGREE THAT any violation by me of any provision of this Agreement, either while or after I am employed, volunteering, or participating as a board member will cause irreparable injury to UBH not adequately compensable in monetary damages alone or through other legal remedies, and will entitle UBH to preliminary and permanent injunctive relief, a temporary restraining order, and other equitable relief in addition to damages and other legal remedies.

I AGREE THAT the UBH may terminate my access to confidential Information if my status changes, then UBH determines that to be in the best interests of UBH mission, or I violate any provision of this Agreement.

I UNDERSTAND THAT my obligations under this Agreement will continue after termination of my status.

Name________________________________ Position___________________________

Signature_______________________________________ Date___________________



Uintah Basin Healthcare

DIRECT PATIENT ACCESS CLEARANCE QUESTIONNAIRE "DACS"

This clearance is required by the Utah Department of Health. Please answer the following questions.

Name: ______________________ SSN: ______________

Eye Color: __________ Hair Color: __________ Gender: __________

Race: __________ Birth Date: __________ Place of Birth: ______(state only)

Height: __________ Weight: ________lbs US Citizen (mark one): □ Yes □ No

Primary Phone: ______________________ Primary Phone Type: __________

Email Address: ____

Address: ____

Aliases/Prior Names (includes all names by which an applicant is currently known or has been identified as)

Please print legibly:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Prior Addresses you have lived at during the past seven years. Include the city and state (house number and street are not necessary), the year moved in, and the year you left that city.

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A live scan fingerprint must accompany the application with your authorization; we will be taking your prints and submitting them electronically along with the application, using DACS.

BACKGROUND CHECK AUTHORIZATION AND RELEASE FORM

Last Name________________ First Name________________ Middle Name____________

Soc. Sec. #________________ Driver Lic # (**MVR Only**)________________State Issued________

Date of Birth________________ Maiden and all other names used________________________

Present Address________________ City____________ State____ Zip______ County________

Length at present address__________ (If less than 7 years please provide previous addresses)

Prior Address________________ City____________ State____ Zip______ County________

Prior Address________________ City____________ State____ Zip______ County________

I hereby authorize the release to Blueline Services, an independent background screening agency, any information regarding my prior employment, criminal, credit, driving, workers compensation and educational history as well as information regarding my general character and reputation. I understand the information may be reviewed initially and periodically by Blueline Services and reported to my prospective/actual employer during the course of my employment.

I understand that my background may be used to determine my eligibility for employment, and I agree that falsification may make me ineligible for employment or subject to dismissal, if hired. I further acknowledge that Blueline Services is relying on third party information.

I hereby authorize that a photocopy or electronic facsimile of this document shall serve as an original.

Applicant Signature____________________________ **Date**________________

COMPLETED BY EMPLOYER

DATE________________________

COMPANY______________________

CONTACT PERSON________________

PHONE #______________________

FAX #________________________

ADDRESS______________________

____

____

EMAIL ________________________

SERVICES TO BE PERFORMED:

- ☐ Blueline National Plus (National + SSN)
- ☐ Federal Criminal Check
- ☐ State Criminal Check
- ☐ County Criminal Check
- ☐ Credit History
- ☐ Driving History (MVR)
- ☐ Employment Verification
- ☐ Education Verification

DISCLAIMER **- The consistency and accuracy of database searches rely wholly upon the frequency and thoroughness of individual state updates. Blueline suggests that all national criminal searches that produce criminal records be confirmed with a County Criminal Check. Blueline Services is not responsible for inaccurate or untimely information.**