Dear Prospective Volunteer:

First of all, thanks for expressing interest in the Volunteer Program here at CJW Medical Center's Johnston-Willis Campus. We have a very strong and outstanding volunteer program and we are always looking for good volunteers who fit our needs.

We look forward to having you with us. There are several steps that must be taken before you can join the program. You must:

- **Complete application**, consumer authorization form, confidentially & security agreement, health history form, tobacco free policy form (must submit all completed documentation at one time).
- Need TWO references (unrelated to you) – forms attached
  Ask your references to complete the form and return to you, mail to Volunteer Office or fax 804.483.5235 the forms back to Volunteer Services at Johnston-Willis Hospital.
- Have an interview with the Volunteer Manager/Coordinator – to get a better understanding of your interests and talk about our program and discuss specific volunteer positions
- Consent to Background Check – form attached (please complete)
- Get two TST Skin Test (FREE no cost to you – done here at the hospital)
- Attend a 2-hour orientation – safety, infection control, policies
- Make a commitment to be here every week.

Return all paperwork to 1401 Johnston-Willis Drive, Richmond, VA 23235 or fax to 804.483.5235

General Areas for Volunteering at Johnston-Willis Hospital. Maybe one of these interests you?

Maternal/Infant	Cancer Center	Surgical Waiting Area
Deliver Newspapers	Coffee Cart	Nursing Floors
Gift Shop	Information Desks	Escorting Patients
Visiting Program	Hostesses	and so much more……

When you come in for orientation, please bring a picture ID and your Social Security card.

Thanks for considering us as a volunteer site – we look forward to meeting you!

Sincerely,

Maria Gilmore

Maria Gilmore
Manager, Volunteer Services
Maria.gilmore@hcahealthcare.com

Coordinators: 804-483-5081

Sheila Hill Sheila.hill@hcahealthcare.com
Josephine Gozzi Josephine.gozzi@hcahealthcare.com

Referred by:____________________ **Date: ______________**

ADULT VOLUNTEER APPLICATION

_________________________ _________________________ _________________________
(Last) (First) (Spouse's Name If Married)

Home Address: _________________________ ____________________ ___________ __________
(Street) (City) (State) (Zip)

Telephone #: ______________________________ Cell #:________________________________

Email Address: ____

***Social Security #**: ________________________ Birthday (Month/Day/Year): ________________

**** SS# Mandatory… without your social security number your application will not be processed***

In case of Emergency Notify: __________________________________Relationship:__________________

Telephone/cell #: _________________________ Email: _______________________________________

Your Occupation: ___________________________ Your Employer: ______________________________

College Graduate: YES or NO or STUDENT If yes, Degree_______________________________

If Student, School Attending: _____________________ Grade:_______ Degree Pursing: ________________

Make of Automobile: ____________________________ Color: __________ Plate #: _________________

Have you volunteered before? ___________ Yes ______________ No

If yes, when and where:____

Have you had any experience working with the sick? Yes _________ No _________________________

If Yes, explain: ____

Would you enjoy: Direct Patient Contact or Public Contact or Clerical Assignments or doesn't matter?
(circle as many as you would like)

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HCA Virginia Health System

Give the name, address and telephone number of TWO references: (not related)

Name:	Address:	Telephone:
___________________________	___________________________________	_________________________
___________________________	___________________________________	_________________________

Please √ preferred days and hours:
9:00 AM-1:00 PM_____ 1:00 PM - 5:00 PM____ 2 or more hrs anytime between 2:00 PM - 5:00PM_____

Monday_______ Tuesday_______ Wednesday______ Thursday______ Friday_____

Saturday
11:00 AM - 2:00 PM_____

Sunday
CLOSED

Are you seeking a volunteer position to fulfill community service requirements? Yes______ No________

If Yes, Explain: ____

We CANNOT ACCEPT COURT APPOINTED community service requirements.

Have you ever been convicted of any criminal offense other than traffic violations within the past seven years?

Yes ___________ No ________ (Arrests or charges that have been expunged need not be disclosed.)

If "Yes," give the date, place and nature of each such conviction.______________________________________

Have you been released from confinement following conviction for any criminal offenses within the past seven years? Yes _________ No ______________

Are you presently charged with any violation of the law other than traffic violations? Yes _____ No _____

Please √ after reading each statement, then sign and date:

____I hereby apply for volunteer work with Johnston-Willis Hospital. I voluntarily give this institution the right to check my references and verify past employment or volunteer work.

____I hereby state that all information given by me in this application is true.

___I understand and agree to comply with the requirements and regulations of the hospital, and to consider all privileged information concerning the hospital, its patients or staff strictly confidential. I will take all criticisms or problems to the Manager of Volunteer Services.

___When I resign from my volunteer position, I will have an exit interview and return my volunteer jacket, nametag and parking card (if have one).

___I give my permission to CJW Medical Center to use my picture (likeness) which may be taken at the hospital, activity, event, for use in advertising, promotional materials, website display, posters, publications, etc.

____ ____________________________________

Signature Date

VOLUNTEER REFERENCE

___________________________ (Volunteer's Name) has listed you as a personal reference. In order for them to become a volunteer at Johnston-Willis Hospital, please complete this form and mail to: **Attention:** Volunteer Office at Johnston-Willis Hospital or **FAX it to 804.483.5235**. Your speedy response would be very much appreciated.

Thank you for your time.

Reference Name: ____

Phone #: _________________________

Questions:

1. How long have you known him/her? _________________________________.
2. In what capacity? ____.
3. Is this person:
   Friendly? ____.
   Punctual? ____.
   Dependable? ____.
4. Does this person have good communication skills? _______________________
   ____.
5. Does this person work well with people? _______________________________
   ____.
6. Would you recommend this person as a hospital volunteer? ________________
   ____.

Signature: ________________________________ Date: ______________________

Additional Information you would like to share:

Volunteer Office ● 1401 Johnston-Willis Drive ● Richmond, VA 23235 ● Phone: 804.483.5081● Fax: 804.483.5235

Johnston-Willis Hospital
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HCA Virginia Health System
An HCA affiliate

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Thank you for your time.

Reference Name: ____

Phone #: _________________________

Questions:

1. How long have you known him/her? _________________________________.
2. In what capacity? ____.
3. Is this person:
   Friendly? ____.
   Punctual? ____.
   Dependable? ____.
4. Does this person have good communication skills? _______________________ ____.
5. Does this person work well with people? ______________________________ ____.
6. Would you recommend this person as a hospital volunteer? ________________ ____.

Signature: ________________________________ Date: ______________________

Additional Information you would like to share:

Volunteer Office ● 1401 Johnston-Willis Drive ● Richmond, VA 23235 ● Phone: 804.483.5081● Fax: 804.483.5235

CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc. (GIS), on behalf of HCA or one of its affiliates may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with HCA or one of its affiliates' consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with HCA or one of its affiliates, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.

III. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

IV. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

V. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box □.

VI. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by GIS to furnish the information described in Section I.

VII. Upon proper identification, you have the right to make a request to GIS, within a reasonable period of time, as to the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that GIS has previously furnished. Communications with GIS should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETE THE FOLLOWING:

____ Signature

_______________________ Today's Date

____ Please print full name

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

____ Month, Day and Year of Birth

____ Social Security Number

____ Home Address

____ City State Zip

____ Driver's License Number and State

____ Name as it appears on License

Have you ever been convicted of a crime? __ No __ Yes If yes, please provide city, state, and date of conviction along with conviction details.

____

____

FAIR CREDIT REPORTING ACT NOTICE:

In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state . Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by HCA or one of its affiliates by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

□ I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that 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 or Company systems.

❑ General Rules

1. 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.
2. 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 email, in order to manage systems and enforce security.
3. 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.

❑ Protecting 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. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
5. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

❑ Following Appropriate Access

1. 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.
2. 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.

❑ Using Portable Devices and Removable Media

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (*e.g.*, Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
   a. Require the use of only encryption capable devices.
   b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
   c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
   d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
   e. Restrict access to any mobile application that poses a security risk to the Company network.

❑ Doing My Part – Personal Security

1. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. 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.
3. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Use tools or techniques to break/exploit security measures.
   c. Connect unauthorized systems or devices to the Company network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

❑ Upon Termination

1. 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.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

<table>
<tr><td>Employee/Consultant/Vendor/Office Staff /Volunteer Signature</td><td>Facility Name and COID
Johnston-Willis Hospital
34632</td><td>Date</td></tr>
<tr><td>Employee/Consultant/Vendor/Office Staff /Volunteer Printed Name</td><td colspan="2">Business Entity Name
Chippenham-Johnston-Willis Hospitals, Inc.
DBA CJW Medical Center</td></tr>
</table>

Johnston-Willis Hospital
A Campus of CJW Medical Center
HCA Virginia Health System

Mandatory TST and Flu Shots

New Volunteer –

All new Johnston-Willis Hospital volunteers are required to have **TWO Tuberculin Skin Tests (TST)** before you begin volunteering and then complete a mandatory questionnaire yearly.

Before you can begin to volunteer, all new Volunteers are required to have two Tuberculin Skin Tests.

(1) Go to Employee Health **Mon, Tues, Wed or Fri (no Thurs)** , receive First TST test ____________
date

(2) Get TST Test read **48 -72 hours** after shot by Employee Health Nurse ___________________
date

(3) At least 7 days after the first TST Test - Get 2nd TST Test (Mon-Fri no Thurs) _________________
date

(4) Get second TST Test read **48 -72 hours** after shot by Employee Health Nurse ____________
date

(5) Mandatory - Volunteer Director must receive two **signed yellow** Employee Health – Tuberculin Skin Test forms before you can start volunteering**.**

***If you forget to return to have the shot read you will need to repeat the shot.**

**** You will not be able to volunteer if these two yellow forms are not received in the volunteer office by the first day you volunteer. The forms must be read, signed and approved by the Employee Health Nurse ONLY ****

Employee Health Office/Occupational Health (483-5080) located in the Medical Office Building outside the hospital at 1457 Johnston-Willis Drive. Employee Health Office/Occupational Health first left as you start walking down sidewalk from the parking lot (left of Thomas Johns Entrance). Enter the office and sign in on the sign-in sheet.

Johnston-Willis Employee Health Office Hours

* No appointment is necessary *

Monday thru Friday (No TST shots given on Thursdays)

7:30 am – 7:00 pm

MANDATORY FLU SHOTS: From October thru April FLU SHOTS are MANDATORY!! Flu shots are available to all Volunteers FREE of charge in Employee Health. Must show ID Badge to Health nurse. *If you decline a FLU SHOT you will not be able to volunteer October thru March!*

Tobacco Free Campus Policy

My signature below acknowledges:

I understand that:

1. Volunteers are prohibited from using tobacco products at Johnston-Willis Hospital.

2. Volunteers are NOT allowed to use tobacco products in their personal vehicles while on Johnston-Willis Hospital property.

3. Sidewalks, street and neighboring property should not be used as tobacco use areas.

4. Using tobacco products in any of the above mentioned places are grounds for termination.

Signature______________________________ Date:___________

Printed Name:__________________________

\

Volunteer Health History

Name: ____ Phone Number: _____________________

Date of Birth: __________________

Are you currently under a physician's care for any health problem? Yes____ No____

Have you had or do you currently have any of the following?

Chicken Pox:	Yes____	No____
Tuberculosis:	Yes____	No____
Walking Problems:	Yes____	No____
Lifting/Pushing Limitations:	Yes____	No____
Short Term Memory Problems:	Yes____	No____
Speech Problems:	Yes____	No____
Hearing Problems:	Yes____	No____
Vision Problems:	Yes____	No____

Complete the following regarding immunizations:

Chicken Pox:	Yes____	No____
Tetanus:	Yes____	No____
Measles:	Yes____	No____
Mumps:	Yes____	No____
Rubella:	Yes____	No____
Hepatitis B:	Yes____	No____
PPD (Mantoux):	Yes____	No____

Have you had a PPD in the last 12 months? Yes____ No____

____ ________________________

Signature of Volunteer Date

Chippenham & Johnston-Willis Hospitals

Hand Hygiene Attestation

Take5!

A **"Red Rule"** has been developed for **hand hygiene**. Red Rules are rules that cannot be broken. These rules are few in number, are easy to remember, and are associated with processes that can cause serious harm to employees or customers when not followed. Every worker, regardless of rank or experience, is expected to stop work if a red rule is violated. The most important aspect of a red rule is to empower all workers to speak up when the rule is not being followed and to "stop the work" until completed.

- **Hand hygiene** is the *single most important factor* in preventing the spread of infection and decreases the incidence of healthcare associated infections (HAIs).
- **Hand hygiene** may be performed through the use of a 20 second soap and water scrub or alcohol-based hand rubs
- **Hand hygiene** must be performed:
    - When hands are visibly soiled or dirty (use soap and water only)
    - Upon entering a patient room
    - Before patient contact
    - Before donning sterile gloves
    - Before inserting invasive devices
    - After contact with intact skin
    - After exposure to blood, body fluids, secretions, wounds, mucous membranes, or non-intact skin
    - After removal of gloves
    - When moving between dirty and clean activities
    - Upon exiting a patient room
    - After personal hygiene and bodily functions
    - Between patients
    - Use soap and water hand hygiene for patients with or suspected to have C. Diff

I, ____, pledge that I will follow the **"Red Rule."** I realize that violation of the **"Red Rule"** puts myself, my coworkers, and patients at risk for illness. I understand that failure to follow the **"Red Rule"** could result in a corrective action plan up to and including termination. When I see someone miss an opportunity for hand hygiene, I will ask them to "Take 5," to remind them of the importance of hand hygiene. I pledge to be a champion for **hand hygiene** efforts.

Signature: ____ Date: ______________________