

Dear Prospective Junior Volunteer:

First of all, thanks for expressing interest in the Junior Volunteer Program here at CJW Medical Center, Chippenham Campus. We have a very strong volunteer program for teens aged 15 -18 years old. Many students in our community have volunteered with us and have found it helpful with their college admissions process. Some have even made career decisions based on their experiences here.

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

- Be 15 years old
- **Complete application**, consumer authorization form, confidentiality & security agreement, health history form, tobacco free policy form (**must submit all completed documentation at one time**).
- Have an interview (in-person or by phone) with the Volunteer Coordinator or Manager – 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 orientation – topics include safety, infection control, policies, Confidentiality
- Make a commitment to be here every week.

Return all paperwork to Volunteer Services, 7101 Jahnke Road, Richmond, VA 23225 or fax to 804.483.3258

General Areas for Volunteering at Chippenham Hospital. Maybe one of these interests you?

Labor and Delivery	CVICU	Surgical Waiting Area
Deliver Newspapers	Coffee Cart	Nursing Floors
Gift Shop	Information Desks	Human Resources
Employee Health	Errand Runners	and so much more.....

When you come in for orientation, please bring a picture ID.

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

Sincerely,

Maria Gilmore
Manager, Volunteer Services

Coordinators: 804.483-3256

Walter Sackett Walter.Sackett@hcahealthcare.com

Victoria Noakes Victoria.Noakes@hcahealthcare.com

Referred by: _____

Date: _____

JUNIOR VOLUNTEER APPLICATION

Name: _____
(Last) (First)

Home Address: _____
Street City State Zip

Telephone: _____ Birthday: _____

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: _____ email address: _____

Telephone: _____ Relationship _____

School Attending _____ Grade _____

List extra-curricular activities: (either school-sponsored, organized youth group or part-time job)

Hobbies, Skills, Special Interest _____

Have you done volunteer service before? Yes _____ No _____

If Yes, please state the nature of same _____

Have you ever had a serious illness or accident? Yes _____ No _____

If yes, please state the nature of same _____

Please indicate schedule desired by circling:

During Summer

Day: Mon. Tues. Wed. Thurs. Fri.
 Shift: 9:00 am – 1:00 pm or 1 pm – 5:00 pm

During School Year (age 15 work up to 3 hours only)

Day: Mon. Tues. Wed. Thurs. Fri.
 Shift: 2:30 pm – 5:00 or 3:00 – 5:00 or 3:30 – 5:00 pm or other 2 hour shift

Day: Sat. Sun.
 Shift: 11:00am – 2:00 pm 12:00 – 3:00 pm

Please list two references (not relatives):

 Name Address Occupation

 Name Address Occupation

(over)

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?

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? Yes _____ No _____

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

I hereby apply for volunteer work with Chippenham 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 Director of Volunteer Services.

When I resign from my volunteer position, I will state in writing my last day, and **return my volunteer jacket and name tag.**

Please enclose with this application:

1. A copy of your birth certificate;
2. A copy of your immunization record;
3. A small wallet size picture
4. A signed PPD and Background Check consent form;
5. A letter from your school stating that you are a student in good standing; and
6. A written reference from a teacher, minister, neighbor, etc.

Volunteer service cannot be started until all forms and tests are in our file and the interview and orientation have been completed.

Signature

Date

PARENTAL CONSENT

My daughter/son has my consent to serve as a volunteer at CJW Medical Center.

I also give my permission to CJW Medical Center to use my daughter/son's picture or likeness, which may be taken at the hospital, activity, event, for use in advertising, promotional materials, website display, posters, or publications, etc.

4-29-16

Parent or Guardian's Signature

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.

Employee/Consultant/Vendor/Office Staff / Volunteer Signature	Facility Name and COID Chippenham Hospital 34632	Date
Employee/Consultant/Vendor/Office Staff / Volunteer Printed Name	Business Entity Name Chippenham-Johnston-Willis Hospitals, Inc. DBA CJW Medical Center	



Chippenham Hospital

A Campus of CJW Medical Center

HCA Virginia Health System
An HCA affiliate

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



AGREEMENT COMMITMENT OF 40 HOURS

I understand in exchange for the valuable learning experience provided to me by Chippenham Hospital, I will commit 40 hours of volunteer work in an agreed upon service area. I further understand that if I fail to finish the 40 hours that I have committed myself to, I will not receive a reference letter or statement of hours from the Volunteer Services Department.

Student Volunteer Signature

*Please note:

The regular Junior Volunteer Schedule is one (1) day a week for 2- 4 hours during the school year and a 4 hour shift (9-1) or (1-5) during the summer and/ or every other Saturday (11am – 2pm) and/or Sunday (12:00 – 3:00 pm). Adjusted hours (more or less) are available for juniors once the program starts.

**** PLEASE SIGN AND RETURN WITH APPLICATION****

ATTENDANCE POLICY FOR JUNIOR PROGRAM

Juniors are encouraged to make careful assessment of the time available before making commitment to volunteering.

1. **A total of three absences with no call-in** is the maximum allowed each session and the Junior will be dropped from the program.

Sessions Include: Summer Program (June – August)
Fall Program (September – December)
Winter Program (January – May)

2. If a Junior is called and requested not to come in, this will not count as an absence.
3. In case of an extended illness, a Junior will be placed on the inactive list and may be reactivated when space is available.

If you will need to be out for an extended period of time you need to contact the Volunteer Services Director to discuss arrangements for staying in the program.

Signed _____
Parent or Guardian

Signed _____
Junior Volunteer

PROSPECTIVE JUNIOR VOLUNTEERS

PLEASE READ.....

We are glad that you are thinking about volunteering at CJW Medical Center – Chippenham Campus. You will be very much appreciated.

You will spend about 15 hours (or until we feel you are ready) of “on-the-job-training” or shadowing before you will be ready to perform your duties independently.

For this reason, we require a 40 hour minimum commitment from all of our junior volunteers.

Are you planning to volunteer for the summer only?

If so, please be aware that our program requires that you do one 4-hour shift each week during the summer. You will be assigned your time slots **after** you complete orientation.

Since we require a 40 hour minimum commitment for all junior volunteers, if you have paperwork that needs to be filled out for school, we will fill it out for you **only after you have completed your 40 hours.**

Please keep in mind; if you are planning to be away for 3 or more weeks this summer then this is probably not the program for you.

Are you planning to volunteer to complete a community service requirement for your school?

If yes, GREAT... we still require a 40 hour minimum commitment (even if your school requires less) we will fill out the paperwork for you **only after you have completed your 40 hours.**

We want you to know this up front, so that there are no misunderstandings. If you decide that 40 hours is too much time for you to give, we suggest that you call the United Way Voluntary Action Center at 771-5855. They may recommend one of their smaller agencies that does not require as many hours.

Thanks and we hope to have you as a part of our team!

JUNIOR VOLUNTEER BEHAVIOR CONTRACT

- You must arrive on time but, if for any reason you will be late you must call in advance to let the coordinator know. Please do not call 15 minutes prior to your arrival to tell them you will be late. During the week, call: 483-3256 or email, maria.gilmore@hcahealthcare.com ; Walter.Sackett@hcahealthcare.com or Victoria.Noakes@hcahealthcare.com.
- . On the weekends please call the Information Desk at 483-0769 or email Dana.clayborn@hcahealthcare.com; maria.gilmore@hcahealthcare.com
- If you are unable to work, we expect to hear from your parent/guardian **at least 1 hour** before the time you are to begin volunteering. Call 483-3256 during the weekdays. Call your coordinator for the weekends at 483-0769.
- Please wear your uniform each time you volunteer. The uniform consists of the khaki colored FULL length pants ONLY (**NO JEANS, capris, shorts, skorts, skirts, leggings, etc**), the Junior Volunteer Apron or Vest, **Solid white shirt** for females (**covering belly and tucked in**) and **solid white collared shirt for males (tucked in)**, and comfortable **closed toe walking shoes** with socks. (NO SANDALS, BOOTS, HIGH HEELS) You must wear your ID Badge at all times and must be visible at your chest area not at your waist.
- No chewing gum.
- Be sure to sign in and out each day using the computer and place a check mark next to your name on the clipboard. Do not sign out until you are ready to leave the building.
- ALWAYS check in with a Volunteer Staff when you arrive to let them know you are here, especially for evenings and weekend shifts.
- ALWAYS be polite and respectful to everyone.
- Do not eat or drink in the corridors or on the floors, except in the volunteer office, and not during your assignment.
- Report any problems to your supervisor or Volunteer Staff.
- Friends visiting you during your assignment are prohibited.

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- You are expected to remain in your assigned area unless you are on an errand.
- Patient Confidentiality must be respected at all times. Do not discuss patients in elevators or hallways or outside the hospital environment.
- You are asked not to run in the hallways or act in a noisy manner within the Hospital. A hospital is a professional place and we expect the Junior volunteers to approach their assignments with a professional attitude.
- Do not engage in any intimate behavior while on the Hospital's property. You will be terminated immediately!
- Never enter a section of the Hospital in which you are not authorized to enter such as the OR, Nursery, NICU, or PICU (unless instructed by your coordinator to pick up specimens). DO NOT enter patient rooms with isolation signs.
- Telephones are to be used for necessary or emergency calls ONLY such as calling home concerning transportation, illness, etc.
- No use of hospital computers unless assigned to the Information Desk and then only for hospital related work. No googling, surfing, playing games, looking up personal information, etc on any hospital computer. Immediate termination!
- **CELL PHONES are allowed in the Volunteer Office ONLY, iPods, MP3 players, iPads, computers, electronic devices, Nooks, laptops, etc. are NOT ALLOWED.**

If any of the above rules are not followed, we will discuss the problem with you and a warning will be issued. The second offense will result in your parent/guardian being notified and the third offense will result in your immediate dismissal from the program and your parent/guardian called to come take you home.

Let's all have fun and work together to make this a great experience!!

Junior Volunteer Signature

DATE

Parent's/Guardian's Signature

DATE

TST CONFIRMATION OF CONSENT FORM

Name of Junior Volunteer: _____

I hereby confirm and give my consent for my son/daughter to have the TST (Tuberculin Skin Test) done at CJW Medical Center, Chippenham Hospital Campus. I understand that this test is a necessary part of health screening for hospital volunteers, and that there is no charge to the volunteer for this test. In the event that a positive result is obtained, I will be notified by the hospital and given further directions.

Parent/Guardian

Date

LEGAL BACKGROUND CONSENT FORM

I, _____ (parent/guardian) give CJW Medical Center permission to do a legal background check on my son/daughter,

Junior Volunteer Name

Parent/Guardian

Dated: _____



Mandatory TST and Flu Shots

New Volunteer –

All new Chippenham 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 **Monday, Tues, Wed, or Friday**, 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, Tues, Wed, Fri) _____
date
- (4) Get second TST Test read **48 -72 hours** after shot by Employee Health Nurse _____
date
- (5) **Mandatory** - Volunteer Director must receive the **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 (483-0774) located 1st floor of Tucker Pavilion (park in the back of the hospital and enter thru the Tucker Pavilion Entrance - Employee Health Office is First door on your right as you start walking down the long corridor). Enter the office and sign in on the sign-in sheet.

Employee Health Office Hours for TST Skin Test

Monday, Tuesday, Wednesday or Friday **7:30 am – 3:45 pm**

Employee Health Office Hours for reading the test (48 -72 hours after shot)

Monday thru Friday **7:30 am – 3:45 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 Chippenham Hospital.
2. Volunteers are NOT allowed to use tobacco products in their personal vehicles while on Chippenham 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: _____

Chippenham and Johnston-Willis Hospitals

Hand Hygiene Attestation

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: _____