Revised 5.22.12

Cardinal Hill Rehabilitation Hospital

Volunteer Application

PERSONAL INFORMATION:

Name:_____Date:_____

Address:_____
Street city/state/zip

Phone: _____
Home Work Cell

Birth date:_____ Email: _____

Emergency contact: _____ Relation: _____

Phone: _____
Home Work Cell

EDUCATION (if applicable)**:**

Current grade in school: _____ Name of school/institution: _____

High School Graduate: Year: _____ College Graduate: Year: _____

College: _____ Degree:_____

EMPLOYER (if applicable): _____

AVAILABILITY-Circle day and provide preferred times.

Monday	Tuesday	Wednesday	Thursday	Friday
Time:	Time:	Time:	Time:	Time:

Saturday	Sunday
Time:	Time:

Do you have reliable transportation? Yes No

VOLUNTEER/ WORK EXPERIENCE/ SPECIAL SKILLS:

What special skills or experience can you offer as a volunteer?

_____

_____

Do you consider yourself a behind the scene person or more of a leader?_____

Why?_____

Why are you interested in volunteering? Why did you choose Cardinal Hill?

_____

_____

_____

How did you hear about the volunteer program at Cardinal Hill? (please circle)

Volunteer Fair Friend Another Volunteer Website Volunteer Center

I am a Former Patient (Date Discharged: _____) Other: _____

VOLUNEER ASSIGNMENTS

Please indicate your preference for volunteering. Descriptions and qualifications are listed online at www.cardinalhill.org.

_____ Adult Day Health Assistant
_____ Center of Learning Assistant
_____ Chaplain Assistant
_____ Childcare Assistant
_____ Clerical-General
_____ Equipment & Logistics Assistant
_____ Event Volunteer
_____ Gift Shop Volunteer
_____ Greeter
_____ Home Health Department Assistant
_____ Housekeeping Assistant
_____ Information Desk Worker
____ Nutrition Care Assistant
_____ Outpatient Therapy Services Assistant
_____ Patient Concierge
_____ Pediatric Center Assistant
_____ Pet Therapy Assistant
_____ Quality Management Assistant
_____ Technology Assistant
_____ Therapeutic Garden Assistant
_____ Therapeutic Recreation Assistant
_____ Unit Assistant-Brain Injury Unit
_____ Unit Asst-Spinal Cord Unit/General Rehabilitation Unit
_____ Unit Assistant-Stroke Unit

Other: If you have a special gift or talent you are willing to share with our patients and staff, please describe below.

_____

_____

_____

HEALTH SCREENING REQUIREMENTS

1. **TB Screening** - Proof of a negative PPD skin test within the 3 months is required in order to volunteer. If you have a history of positive PPD, you must have documentation that you are free of the disease from a health department or physician - chest x-ray results and/or proof of medications. Without this, you will not be allowed to volunteer in the hospital.
    - Volunteers may have a TB skin test done free of charge on Friday mornings. Please call 859-254-5701 ext 5369 for an appointment.
    - Volunteers under the age of 18 years must have a parent or guardian present during the TB test.

2. **Proof of Immunization** - If you were born after 1957 you must have documentation of **TWO** MMR vaccines (Measles, Mumps, Rubella) OR documentation of a MMR Titer that indicates immunity.

****Application is NOT considered complete without the above documentation.****

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CARDINAL HILL REHABILITATION HOSPITAL
HEALTH QUESTIONNAIRE
VOLUNTEER / STUDENT / CROTHALL

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name:_____ Date:_____

Address:_____ Supervisor/Manager:_____

_____

Home Phone #:_____ Birth Date: _____

Social Security #: _____

In case of emergency, please notify:

Name:_____ Phone:_____

Address:_____

Primary Physician Name:_____ Phone:_____

HISTORY OF VACCINATIONS / IMMUNITY

CHICKENPOX

Have you ever had Chickenpox (Varicella) or Shingles? ☐Yes ☐No

If no:

Have you received the Chicken pox Vaccine or had a blood test (titer) showing immunity? ☐Yes ☐No

If your answer to both questions is no, you may be susceptible to Chickenpox. If you are exposed to someone with Chickenpox, and you are not immune, you could be contagious to others; and you should refrain from your volunteer or work activities at Cardinal Hill until your doctor says you are no longer contagious to others.

MEASLES, MUMPS, RUBELLA

Were you born before 1957 ? ☐Yes ☐No

If no:

Have you received 2 MMRs (measles, mumps, rubella vaccinations)? ☐Yes ☐No

If no or unsure:

Have you ever had a blood test (titer) showing immunity ☐Yes ☐No

to measles, mumps, and rubella?

If your answer to all 3 questions is no, you may be susceptible to measles, mumps, or rubella. If you are exposed to someone with measles, mumps, or rubella, and you are not immune, you could spread these very contagious diseases to our patients or staff. Please contact your doctor and make sure your measles, mumps, and rubella vaccinations are up-to-date before participating in volunteer or work activities at Cardinal Hill.

Additional vaccinations recommended:

Have you received ALL THREE (3) vaccinations for Hepatitis B? ☐Yes ☐No

Have you received a tetanus booster in the last 10 years? ☐Yes ☐No

If your answer to either question is no, please discuss this with your doctor.

TB HISTORY and QUESTIONNAIRE

Have you ever had a POSITIVE TB SKIN TEST (PPD) reaction? ☐Yes ☐No

If NO, please provide copy of negative TB skin test done within the past 3 months or contact Employee Health nurse at ext 5521 to schedule.

If Yes, please provide documentation from your doctor or the Health Department indicating date and results of last chest x-ray, medical evaluation noting you are free of active TB disease, and any treatment received. Contact Employee Health nurse at 5369 for further information and complete the questionnaire below regarding current signs or symptoms of active TB disease.

In the past year, have you experienced any of the following **unresolved signs/symptoms that lasted more than three 3 weeks?**

	Yes	No	Present at this time
Prolonged cough	___	___	___
Fever or chills	___	___	___
Night sweats	___	___	___
Loss of appetite	___	___	___
Weight loss	___	___	___
Coughing up blood	___	___	___
Lymph node swelling	___	___	___

Employee's Signature : _____Date:_____

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The following is for Employee Health Only: Mantoux method TB Skin Test (PPD) record.

Copy of recent TB Skin Test (PPD) provided/date_____ OR

Date PPD placed_____ R. or L. forearm (initials)_____

Lot #_____ Exp date:_____

Date read_____ Results_____mm induration. Read by:_____

Date 2nd Step PPD placed _____ R. or L. forearm (initials)_____
Date read_____ Results_____mm induration. Read by:_____

TB Questionnaire Only (PPD exempt)_____

Chest x-ray or documentation provided?_____ Referred for Medical Evaluation of + PPD?_____

Nurse's Signature:_____

Cardinal Hill Healthcare System

CONFIDENTIALITY AGREEMENT

I understand that Cardinal Hill Healthcare System has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Cardinal Hill Healthcare System must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information (collectively "Confidential Information").

In the course of my employment/assignment at Cardinal Hill Healthcare System, I understand that I may come into the possession of Confidential Information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of Cardinal Hill Healthcare System's 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. In addition, I understand that my personal access code, user ID(s), and passwords used to access computer systems are also an integral aspect of this Confidential Information.
2. I will not access or view any Confidential Information, or utilize equipment, other than what is required to do my job.
3. I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, or at social events.) It is not acceptable to discuss Confidential Information in public areas even if a patient's name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.
4. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such confidential information.
5. I will not willingly inform another person of my computer password or knowingly use another person's computer password of my own for any reason.
6. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information in Cardinal Hill Healthcare System's computer system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring Confidential Information from Cardinal Hill Healthcare System's computer system to unauthorized locations (for instance, home).
7. I understand if I am permitted or requested to work from home where I will access the patient/hospital data electronically, I agree to protect all information in a manner which is compliant with hospital standards. I further agree to deny access/view by other family members, visitors, etc. and to shred any printed information obtained through the electronic patient/hospital system. Any information downloaded to the home-based storage devices will be password protected, and I guarantee that the password will not be shared with others within the home.
   If I become a home-based employee, I will ensure that the home-based computer includes approved anti-virus protection, encryption and other software that is compatible and meets the minimal hospital standard.
8. I will log off any computer or terminal prior to leaving it unattended.
9. I will comply with any security or privacy policy promulgated by Cardinal Hill Healthcare Systems to protect the security and privacy of Confidential Information.
10. I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of the Agreement or of any Cardinal Hill Healthcare System security or privacy policy.
11. Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information to Cardinal Hill Healthcare System.
12. I agree that my obligations under this agreement will continue after the termination of my employment.
13. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment and/or suspension and loss of privileges, in accordance with Cardinal Hill Healthcare System's Sanction Policy, as well as legal liability.
14. I further understand that all computer access activity is subject to audit.

By signing this document I understand and agree to the following:

I have read the above agreement and agree to comply with all its terms.

Signature of employee/physician/student/volunteer _____

Print Name _____ Date _____

TO BE FILED IN EMPLOYEE'S PERSONNEL RECORD

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CARDINAL HILL® HEALTHCARE SYSTEM

CRIMINAL BACKGROUND CHECK AUTHORIZATION FORM -- DISCLOSURE & RELEASE

This form MUST remain in the Human Resources office.

A consumer report including information concerning your police record, education, qualifications, motor vehicle record, and/or credit may be obtained in connection with your application for and/or continued employment with the Cardinal Hill Healthcare System. A consumer report may be obtained at any time during the application process or during your employment. The information on this form is necessary for proper verification of consumer report information only.

Before any adverse action is taken, based in whole or in part on the information contained in the consumer report, you will be provided a copy of the report and the name of the reporting agency. Your rights are protected under the Fair Credit Reporting Act (FCRA). For more information regarding the FCRA, you may visit the Federal Trade Commission's web site at http://www.ftc.gov or you may ask a Human Resource representative for this information. If this report contains any information that is inaccurate or incomplete, you should contact our office immediately.

I hereby authorize any law enforcement and/or background check agency to search their criminal records or other information they have regarding me, and to make this information available to HireCheck, Inc. and to the Cardinal Hill Healthcare System prior to my employment or at any time during my employment so that my employment qualifications can be evaluated.

PLEASE PRINT—This form must be completed in its entirety.

Name:_____
First Middle Last Maiden

Previous Name(s) Used: _____

Address:_____
Street City State Zip

Phone Number: (_____)_____ Other Phone #: (_____)_____

Previous Address:_____
Street City State Zip

How long have you lived in Kentucky? _____
Have you lived in any state other than Kentucky? Yes No
If yes, which state(s)?_____ What year(s) and for how long? _____

Social Security Number: _____ Date of birth: _____

Were you previously employed by the Cardinal Hill Healthcare System? No Yes If yes, indicate the names you used and the dates employed:
_____

Sex: Male Female Race (check one): ____White ____Black/African American ____Hispanic/Latino ____Asian ____Native Hawaiian/Other Pacific Islander ____American Indian/Alaskan Native ____Two or More Races

Veteran: yes no
Vietnam Era Veteran: yes no
Disabled under the Americans with Disabilities Act: yes no

Position(s) applying for: _____

_____ _____
SIGNATURE OF APPLICANT **DATE**

HUMAN RESOURCES OFFICE USE ONLY

SIGNATURE: _____DATE: _____ RESULTS RECEIVED: _____

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