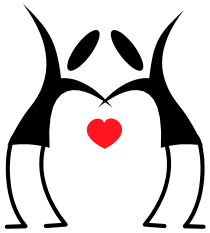
About Volunteering
at Ogden Regional Medical Center



Thank you for your interest in volunteering at Ogden Regional Medical Center. We have approximately 150 volunteers ages 17 and older. We look forward to the opportunity to work with you. Following are answers to frequently asked questions that are intended to simplify the application process. Court ordered community service, attendance credit hours, internships and shadowing cannot be signed off at Ogden Regional. After reviewing this process, if you feel Ogden Regional Medical Center is a good match for your service, please complete and submit the attached application.

Application - Complete an application, answering all questions fully. It is imperative that we are able to contact you by e-mail, so include an e-mail address. Incomplete applications are not considered. Please thoughtfully respond to each question. Phrases such as "I want to give back to the community," need to be followed with deeper reflection. Return application to the volunteer office:

Ogden Regional Medical Center
Attn: Trudy Peterson, Volunteer Manager
5475 South 500 East, Ogden, UT. 84405
Phone - 801-479-2075 FAX - 801-479-2164
Trudy.Peterson@mountainstarhealth.com

Immunize - Disease History Most people can use the following guidelines to approximate their immunization/ and communicable disease history. For Utah students who started school after 1960, before entering kindergarten, most had the polio, MMR, and Tdap (Tetanus/diphtheria) vaccine. At age 12, before entering Junior High school, most Utah students had an MMR and Tetanus booster. If you do not have a written immunization record, use this information to jog your memory and record the year according to your best memory. **Do not leave this section blank.** Write "No" in the year if you did not have the vaccination/disease. If you are selected for a position, without memory or record of the vaccination/disease will be required to have a Tdap booster and Varicella (chicken pox) vaccine. Our Infection Control Nurse will counsel you if needed. *(Applicants do not need to get vaccinations. We will address vaccinations if you are selected for a position.)*

Background- A background check is required. You must be willing include driver's license, social security number and former addresses. Any offense revealed on a background check that has not been fully taken care may disqualify applicant.

Drug Test- A drug test is required. Please bring proper ID to your interview.

Commitment- Due to the resources and time invested in volunteer training, **we require a minimum commitment of 100 hours.** This can be accomplished by volunteering in one department weekly for 6-months, or through a more intense schedule. Please do not apply if you are unable to make the commitment. There is a system in place that allows for reasonable absence, vacation and family time-off.

As a general rule, volunteers are asked to serve a minimum 4- to 5-hour shift, one day per week. Students are encouraged to increase the pace. We offer limited openings in clinical areas; however, these positions are peripheral support in nature as volunteers are not permitted to offer patient medical care.

Interview - After an application review, you may be contacted for an interview appointment. Interviews are scheduled based on current openings. **It may take up to 4-8 weeks before you are contacted.** The interview objective is to determine if this is a good match for you and us. For those offered a position, you can expect the following:

TB Test - Two Tuberculosis tests are mandatory before beginning service. The first test is administered on the interview day. The second will be administered at orientation. You will need to return to the hospital 48-72 hours following the second test for our lab to view the results.

Badge - Human Resources will take a photo and prepare a volunteer badge for new volunteers.

Flu Vaccine- As a volunteer, we want to protect you and our patients. Therefore, volunteers are required to have the annual flu vaccine. If you have not had the vaccine, it will be offered to you at no cost by the hospital. If you have had the vaccine, please attach documentation.

Uniform - Select a teal uniform top, our complements. The remainder of the uniform consists of tan/khaki ankle length slacks, closed-toed shoes and socks (volunteer responsibility). Facial jewelry is limited to one pair of earrings. Those who accept an assignment in a clinical area may not wear artificial nails.

Orientation - Orientation sessions are scheduled each month on a Monday, 8:00 am-1:30 pm. New volunteers must attend the entire orientation. Further training and supervision is offered in the assigned department.

Volunteer Defined: A volunteer is an individual who donates services without contemplation of payment for a public spirited or charitable purpose. Volunteer must have: the ability to traverse long distances; acceptable visual and audio acuity; possess excellent interpersonal and communication skills; be alert and able to problem-solve; have the ability read/write English legibly; be of sound mental and emotional health; and be flexible.

Time spent in these preparatory steps is necessary and informative. You will feel more at home in the hospital atmosphere, and you will be well prepared to serve. We expect you will enjoy your volunteer service and benefit personally from this fulfilling experience. We are anxious to get acquainted with you and put your talents to use.

OGDEN REGIONAL MEDICAL CENTER

VOLUNTEER APPLICATION

Attn: Trudy Peterson, Volunteer Manager
5475 South 500 East, Ogden, Ut. 84405
PH: (801) 479-2075 FAX: (801) 479-2164
Trudy.peterson@mountainstarhealth.com

Name _____Date_____

Address_____City_____St_____Zip_____

Birth Month/day _____Home Phone #_____Work/Cell#_____

E-mail address_____

1. Volunteer positions generally require a minimum commitment of one day per week, for 4-6 hours. **The minimum commitment is 100 service hours**. Are you able to fulfill this commitment? _____

2. Volunteer positions require the ability to traverse long distances; acceptable visual and audio acuity; excellent interpersonal and communication skills; alertness, ability to problem-solve; ability read/write English legibly; sound mental and emotional health; and flexibility. Are you able to perform the essential functions of volunteer service for which you are applying without accommodations? _____If no, explain accommodation: _____

3. Describe employment, school or community experience and skills applicable to the volunteering_____
   _____
   _____

4. What specifically brought you to volunteer at this time in your life?
   _____
   _____

5. What desire can volunteering fulfill in your life? _____
   _____

6. How did you hear of us? _____

ORMC VOLUNTEER ASSIGNMENT PREFERENCE

Please indicate service area(s) of interest to you. Check day(s) and time(s) you are available to volunteer on a regular weekly basis.

- ☐ **Information/Reception** *(day & evening)*
- ☐ **Nursing Station**
- ☐ **Mail Delivery/Materials Management** *(daytime only)*
- ☐ **Radiology** *(students in this career field)*
- ☐ **Total Joint Center** *(knee/hip replacement experience preferred)*
- ☐ **Emergency Room** *(21 yrs. & older)*
- ☐ **Pet Therapy** *(Certified pet teams)*
- ☐ **Anything available** *(special events, clerical, gift shop etc)*

Day Available	Morn-ing	Mid-Day	Eve 4 –8 pm
☐ **Sunday**	☐	☐	N/A
☐ **Monday**	☐	☐	☐
☐ **Tuesday**	☐	☐	☐
☐ **Wednesday**	☐	☐	☐
☐ **Thursday**	☐	☐	☐
☐ **Friday**	☐	☐	☐
☐ **Saturday**	☐	☐	☐

Positions are filled based on qualifications, current openings and the applicant's availability.

In case of illness or personal emergency during my volunteer assignment, please contact:

1)_____
Name Relationship Phone(s)

2)_____
Name Relationship Phone(s)

3) Under age 18, parental permission required. Parent's signature:_____

I AM ORMC

As a volunteer at Ogden Regional Medical Center I commit to:

OWN
Offer solutions to problems. Offer help to others, even if it is not my job. Accept ownership of my concerns.
Work area – Keep clean and organized. Care for all equipment and return to proper storage.
Negativity is unacceptable – Be positive with all patients, visitors, customers, all hospital staff, employees, volunteers and physicians.

RESPECT
Recognize and acknowledge the good in my fellow co-workers.
Each of us is responsible: I am accountable for my attitude and actions.
Stay informed.
Proper tone of voice. Use appropriate verbal and nonverbal language. Be non-judgemental.
Employees manage up – "Manage up" everyone!
Core Values–Maintain honesty, integrity, compassion, trustworthiness, kindness, hospital loyalty, professional image (includes dress code).
Teamwork.

MESSAGE
Make sure patients, families, and physicians are kept informed.
Escort patients and visitors to their destination.
Scripts! I will use them!
Save personal conversations for a time away from patients – Never complain to a patient
Always say what I CAN do, not what I can't do.
Greet each patient with a smile and maintain eye contact.
Everyone - Use the ICARE model.

CARE
Communication - Complete and maintain the whiteboard at all times.
Actively LISTEN to the patient without interrupting.
Relationships are very important – Build them with customers and patients.
Environment – Keep the noise level down and check the comfort level of patients & guests.

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_____ _____

Volunteer Signature Date

For HIPAA purposes, if I am hospitalized at Ogden Regional Medical Center, I grant permission to my volunteer colleagues, hospital staff and leadership to acknowledge my visit with a remembrance or visit during my stay. This authorization applies to all future admits including those while I am volunteering and those following my volunteer service.

_____ _____

Volunteer Signature Date

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 a11 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 purging 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 1 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.

Volunteer Signature	Facility Name and COID Ogden Regional Medical Center 34415	**Date**
Volunteer Printed Name	Business Entity Name Ogden Regional Medical Center	

Rev. 10/2010

OGDEN REGIONAL MEDICAL CENTER

Immunization Record

THIS FORM MUST BE COMPLETED AND GIVEN TO **VOLUNTEER ON ORIENTATION DAY or 1st DAY OF WORK,** WHICH EVER COMES FIRST. IF FORM IS NOT TURNED IN, YOU WILL NOT RECEIVE YOUR NAME BADGE AND WILL NOT BE ALLOWED TO WORK.

NAME _____ **DATE OF HIRE** _____

ADDRESS _____ **HOME PHONE** _____

CITY, STATE, ZIP _____ **CELL PHONE** _____

SOCIAL SEC. NUMBER _____ **DATE OF BIRTH** _____

DEPARTMENT _____ **SERVICE AREA** _____

DATE	PPD (mm)	FOLLOW-UPON ABNORMALITIES	NOTES

COMMUNICABLE DISEASE HISTORY

(Give approximate date)

Chicken Pox _____Date

Red Measles (Rubeola) _____Date

Mumps _____Date

German Measles _____Date

TITER HISTORY

(Give approximate date)

Rubella Titer _____Date

Rubeolla Titer _____Date

Hep BsAB Titer _____Date

Varicella Titer _____Date

Allergies ☐ Yes ☐ **No**

_____

Latex Allergy: ☐ Yes ☐ No

IMMUNIZATION HISTORY

(Give approximate date)

Tetanus Toxoid _____Date

Tdap _____Date

Polio _____Date

Measles _____Date

Mumps _____ Date

Rubella _____ Date

MMR Vaccine ____ Date
(Measles, Mumps, Rubella)

Hepatitis B _____ Date
(3 injections completed)

Hepatitis A
(2 injections completed) _____Date

Varicella Vaccine _____Date

Influenza (flu)

Previous TB skin test _____Date

Sage harbor language: "The Genetic Information Nondiscrimination Act 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you do 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 or his/her family member's genetic tests, the fact that an individual or his/her family sought or received genetic services, and genetic information of a fetus carried by an individual or his/her family member or an embryo held by an individual or his/her family member receiving assistive reproductive services."

I have read and certify that all of the above information is true to the best of my knowledge.

Signature_____ Date _____

OGDEN REGIONAL MEDICAL CENTER # 11259

APPLICANT INFORMATION

FULL NAME _____

Any Other Names Used _____

Email address: _____ (Provide if you prefer to receive information via email)

Social Security No. _____ /_____ / _____ Date of Birth[1] _____ /_____ / _____

Current Address _____ City _____State _____ Zip _____

Driver's License State _____ No. _____

Name of High School, College, University or Institution of Professional Training where you completed the highest level

(or for GED – provide state and name when GED received)_____

Campus Name _____Campus City _____Campus State _____

Dates of Attendance and/or Graduation _____

Year(s) Attended Year Graduated/GED Completed

Have you ever been convicted of a crime?* Yes No

Offense _____County _____ State _____ Date_____

Offense _____County _____ State _____ Date_____

*To disclose additional criminal history, please provide those details on a separate sheet of paper and attach it to this form.

Please provide all locations where you have resided for the past seven (7) years, starting with your current residence.

City State Dates From: To:

1. _____/ _____ _____

2. _____ / _____ _____

3. _____/ _____ _____

STATE LAW NOTICES

Minnesota applicants or employees only: You have the right to request in writing from PreCheck, Inc., a complete and accurate written disclosure of the nature and scope of the report(s) requested by the Company. Place an X here _____ for a disclosure to be sent to you.

Oklahoma applicants or employees only: Mark an X here ____ for a free copy of a consumer report if one is obtained by the Company.

California applicants or employees only: Please mark this field ____ to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: If an investigative consumer report has been requested by the Company, the name and address of the consumer reporting agency furnishing the report can be found on the following disclosure and authorization document. You have the right to inspect and receive a copy of the investigative consumer report by directly contacting the consumer reporting agency, PreCheck, Inc. In connection with the Company's request for the preparation of a consumer report or investigative consumer report about you, the Company has provided you with a copy of Article 23-A of the New York Correction Law. Please mark this field to acknowledge receipt of a copy of Article 23-A: ____.

Maine applicants or employees only: If you are applying for a position in the State of Maine, you may request and promptly receive from the consumer reporting agency copies of all investigative consumer reports about you requested by the Company. The name and address of the consumer reporting agency furnishing the report can be found on the following disclosure and authorization document.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature _____ **Date** _____

1 The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

OGDEN REGIONAL MEDICAL CENTER # 11259

DISCLOSURE & AUTHORIZATION

FULL NAME _____

Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth _____ / _____ / _____

Driver's License State: _____ DL Number: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my employment or contract, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

ACKNOWLEDGMENT AND AUTHORIZATION

TRIAGE STAFFING ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application for employment or contract for services. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment or contract to the extent permitted by law.

My present employer may be contacted for a job reference. Yes ☐ No ☐

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature _____ **Date** _____

www.PreCheck.com info@precheck.com ph: 800-999-9861 fax: (800) 207-2778

Ver. 0913 Nevada Private Investigator License # 1618