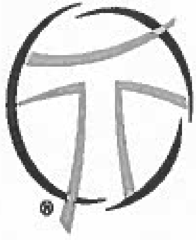


HSHS St. Elizabeth's Hospital

Volunteer Services Department
1 St. Elizabeth's Blvd.
O'Fallon, Illinois 62269
618-234-2120 ext. 11280

DEAR PERSPECTIVE VOLUNTEER/INTERN:

Thank you for your interest in our volunteer program. Volunteering in a hospital is a very rewarding experience. In addition to the satisfaction you receive from helping others, you also provide valuable assistance to the patients and staff. Remember, not all volunteer assignments involve direct contact with the patients; yet, each and every assignment is important to the overall functioning of the hospital.

To be a volunteer you must:

1. Be physically capable of doing volunteer work. If you have any physical limitations, please inform Volunteer Services so, your volunteer assignment will be kept within your abilities;
2. Be responsible for maintaining a volunteer uniform vest in adherence to the Volunteer Department's dress code. The uniform vest, as well as a volunteer badge, must be worn while volunteering;
3. Be responsible for providing your own transportation;
4. Attend the appropriate initial orientation and training sessions, as well as any additional training that may be required as a volunteer;
5. Complete the application containing your signature.

Volunteer orientations are held on a regular basis, and are informational and educational in nature. It is mandatory that you attend an orientation and receive the proper training before you are eligible for placement. Please complete the attached application and mail it back to the hospital.
Thank you once again. I look forward to meeting you.

Sincerely,

Donna Meyers	Dianne Heck
Director Mission Integration/Volunteers	Coordinator Support Services
HSHS St. Elizabeth's Hospital	HSHS St. Elizabeth's Hospital

HSHS St. Elizabeth's Hospital

Volunteer Services Department
1 St. Elizabeth's Blvd.
O'Fallon, Illinois 62269
618-234-2120 ext. 11280

VOLUNTEER/INTERN APPLICATION

Please Print

Date______________________

Name____
Last First Middle

Home Address____
Street City State/Zip Code

Home Phone__________________________ Cell Phone ______________________

E-mail Address____

Social Security Number__________________ Birth Date________________________

Marital Status____________________ Male____ Female____

Employment Status:

Employed____ Unemployed____ Retired____ Homemaker____

In an emergency, contact:____
Name Phone Number

Educational Background:

	Name of School	Specialty/Major	Degree/License
High School	______________	______________	______________
College	______________	______________	______________
Bus./Voc.	______________	______________	______________

Do you have previous experience as a volunteer? Yes____ No____

Where? ____

Sept. 19

Please list the names and addresses of two people we can contact to submit a personal/confidential reference for you:

Name ____________________

Address ____________________

City, State, Zip Code ____________________

Name ____________________

Address ____________________

City, State, Zip Code ____________________

Please give careful consideration to your schedule before completing this section. Volunteer assignments are primarily on a weekday basis.

Please list your three choices in order of preference.

DAY		**TIME**
Monday	________	________
Tuesday	________	________
Wednesday	________	________
Thursday	________	________
Friday	________	________

Comments:

____

____

Hobbies, Interests, Training, Previous Hospital Work:________________________________
____
____

Community affiliations (Church, Clubs, etc.):____
____
____

How did you hear of our Volunteer Program?____
____

Why do you want to be a volunteer at St. Elizabeth's Hospital?______________________
____
____

Name and phone number of family physician:____
____

Have you ever been convicted of a crime? Yes____ No____

This above question must be answered 'YES' if you have ever been convicted of, found guilty of, or pleaded guilty to any crime of any kind. This includes convictions as a juvenile, traffic offense, court supervision or probation, or convictions that are dismissed after completing court supervision or probation. Failure to list any criminal conviction may result in termination if volunteering or ineligibility to volunteer.

I have reviewed and understand the information for completing this section of the volunteer application.

Applicant Signature____

St. Elizabeth's Hospital Confidentiality Acknowledgment

Any information gained through association with St. Elizabeth's Hospital or its affiliates as an employee is confidential and, for the protection of all parties involved, must not be shared by or with anyone who is not properly authorized. Anyone employed by or associated with St. Elizabeth's Hospital shares in the responsibility to strictly protect the confidentiality of all hospital information. This level of confidentiality applies to information gained in any manner or from any source including verbal, written and electronic source.

Information concerning the treatment of patients is confidential and is not to be disclosed to any person or entity without appropriate patient authorization, subpoena, or court order. Confidential information or data is defined as any information where the individual, hospital(s), or physician(s) is named or otherwise identifiable. Any breach of confidentiality by an employee or volunteer may be cause for discipline up to and including termination of employment and/or prosecution under the law.

As a condition of my employment or association with St. Elizabeth's Hospital and its affiliates, I agree not too directly or indirectly disclose this information without proper authority including but not limited to the specific scenarios given below:

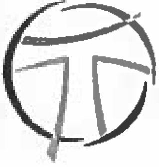
1. I will avoid any action that will provide confidential information to any unauthorized individual or agency.
2. I will not engage in any action or discussion involving privileged or confidential information in any form in common areas of the hospital or its affiliate entities (i.e. cafeteria, elevators, hallways, stairwells). If I observe any action or discussion involving confidential information, I will report it immediately to my supervisor.
3. I will not review patient information or files for which I am not authorized.
4. I will not make copies of any patient or other confidential data without specific authorization.
5. I will not remove confidential information from the facility except as authorized in the performance of my job.
6. I will not discuss in any manner, with any unauthorized person, employee, or non-employee, confidential information of any kind.
7. I will not provide my computer password or file access codes to any other employee or other unauthorized person. I will use only my assigned logon ID(s) and password (s) when using hospital hardware. I will use St. Elizabeth's Hospital computer capabilities only to the extent I am authorized to complete my job function.
8. If I observe unauthorized access or release of confidential records or data to other persons, I will report it immediately to my supervisor. I understand that failure to report violations of confidentiality by others is just as serious as my own violation.

I have read and understand this Acknowledgement and Agreement and will demonstrate my willingness to abide by these policies and procedures by signing below. I further understand and acknowledge that this Acknowledgement and Agreement does not constitute an employment contract and does not alter the at-will nature of my employment relationship with St. Elizabeth's Hospital or its
affiliates.

Signature______________________________ Date______________________________

Print Name______________________________ Employee Number__________________

Department______________________________



COLLEAGUE CONSENT TO FILM, PHOTOGRAPH, RECORD AND QUOTE

HOSPITAL SISTERS HEALTH SYSTEM, SOUTHERN ILLINOIS DIVISION

Colleague Name: ____

Employer (Hospital): ________________________________

Department: ____________________________ **Employee #:**______________

I hereby authorize ____________________________________ (**"Employer"**) an affiliate of
(PRINT HOSPITAL NAME)
Hospital Sisters Health System in the Southern Illinois Division, its officers, employees, agents and/or individuals assigned by my Employer, including Hospital Sisters Health System, to photograph or otherwise record and use, reproduce, publish, distribute, broadcast, and exhibit my image, likeness, and/or voice, by still or moving pictures, digital photographs or recordings, videotape, audiotape, and printed or other media (including, without limitation, the internet), for advertising, news, promotion, and/or educational purposes, such as presentations, and publications.

Additionally, I authorize my Employer, Hospital Sisters Health System, news/media organizations and/or other organizations as determined by my Employer to publish statements, quotations, or summarized excerpts from any interview(s) conducted with me in whole or in part for advertising, news, promotion, and/or educational purposes, such as presentations, and publications.

I understand and agree that such photographs and/or other recordings, and all copyrights and other rights and interests therein, shall be owned exclusively by my Employer, Hospital Sisters Health System, news/media organizations and/or other organizations as determined by my Employer. I further understand and agree that such photographs and other recordings may be scanned into computers and adjusted electronically and may be edited, cropped, or otherwise modified at the sole discretion of my Employer, Hospital Sisters Health System, news/media organizations and/or other organizations as determined by my Employer.

I understand that I will receive no monetary compensation for the use of my image, likeness, voice, statements, quotations, and/or summarized excerpts from interviews conducted with me. I hereby expressly release my Employer, its employees and agents, and Hospital Sisters Health System from any and all claims or demands that I might have against them to any remuneration or damages in connection with the use of the photographs and other recordings referred to herein.

In the event that I am no longer an employee of an affiliate of Hospital Sisters Health System, my former Employer will take reasonable steps to remove my image or likeness used in accordance with this authorization. I understand that certain releases pursuant to this authorization may not be rescinded, revoked or removed.

By signing this form, I certify that I understand the information and agree to the use(s) set forth above.

____

Colleague Signature Date

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, ____, understand that when I am employed as a
(Employee Name)

____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

____
Signature of Applicant/Employee

____
Date

CANTS 22
Rev. 8/2013

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov