HSHS
St. Elizabeth's
Hospital

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

Dear Perspective Student/Youth Volunteer,

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, as well as providing a quality health care experience to patients and visitors.

Youth Volunteer Qualifications:

1. Be 16-18 years of age;
2. Complete an application;
3. Obtain parental/guardian signature on all necessary volunteer permission forms;
4. Have the personal reference form completed by a teacher, counselor, or clergy member. It is not appropriate for friends or relatives to complete the personal reference forms;
5. Attend the appropriate initial orientation and training sessions, as well as any additional training that may be required as a volunteer;
6. Be responsible for maintaining a volunteer vest in adherence to the volunteer department's dress code. The vest must be worn while volunteering;
7. Carefully read through the Volunteer Orientation Manual provided to you and sign the Acknowledgement Form;
8. Accept your assignment in good faith and volunteer on a set schedule for a minimum of four hours each month.

Volunteering is rewarding but it is work; therefore, your assigned department relies on you. Be on time, come with a cheerful disposition and a helpful attitude.

Please complete the attached application, obtain the letter of recommendation and the required signatures. Once you have the application completed in its entirety, email, mail or hand deliver to the hospital.

Thank you again and we look forward to your participation in our volunteer program.

Sincerely,

Donna Meyers
Director, Mission Integration/Volunteers
HSHS St. Elizabeth's Hospital

Dianne Heck
Coordinator Support Services
HSHS St. Elizabeth's Hospital

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Youth Volunteer

PLEASE PRINT

DATE_____ SCHOOL_____
GRADE JUST COMPLETED _____
GRADE AVERAGE_____
SOCIAL SECURITY # _____ BIRTHDATE_____

NAME_____
LAST FIRST MIDDLE
HOME ADDRESS _____
STREET CITY ZIPCODE
HOME PHONE _____ CELL PHONE_____

EMAIL ADDRESS _____

EMERGENCY CONTACTS:

FATHER'S NAME_____ BUSINESS PHONE_____
MOTHER'S NAME_____ BUSINESS PHONE_____

DO YOU HAVE PREVIOUS EXPERIENCE AS A VOLUNTEER? YES____
NO____
WHERE? _____
HOBBIES, INTERESTS,TRAINING,PREVIOUS HOSPITAL WORK?
_____
_____
COMMUNITY AFFILIATION (CHURCH, CLUBS, ETC.)
_____
_____
NAME & NUMBER OF FAMILY PHYSICIAN_____

I understand that in the course of my volunteer work I may be exposed to information of a confidential nature pertaining to patients and/or their families.

I will consider as confidential all information which I may hear directly and will not seek information in regard to a patient except as it pertains to my volunteer assignment.

I will uphold the traditions and the standards of this hospital and will safeguard its reputation by maintaining the highest standards of confidentiality.

SIGNATURE_____ DATE _____

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618-234-2120, ext. 11280

Please give serious consideration to your schedule before completing this form. Volunteer assignments are primarily on a weekday basis.
Please list your three choices in order of preference.
DAY / TIME
MONDAY _____
TUESDAY _____
WEDNESDAY _____
THURSDAY _____
FRIDAY _____

HOSPITAL VOLUNTEER PLEDGE

Believing that the hospital has real need of my service as a Volunteer, I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously. I will conduct myself with dignity, courtesy and consideration. I will consider confidential all information which I may hear directly or indirectly concerning a patient, doctor, or any members of the staff and will not seek information in regard to a patient. I will take any problems, criticisms or suggestions to the Coordinator of Volunteer Services. I will endeavor to make my work of the highest quality. I will uphold the traditions and standards of St. Elizabeth's Hospital and will interpret them to the community at large. I pledge to serve in the capacity of a Volunteer for at least a three month commitment. I promise to observe hospital ethics and the hospital's regulations.
DATE _____

SIGNATURE _____

PARENTAL PERMISSION
Permission is granted for _____ to participate in the Volunteer program at St. Elizabeth's Hospital. I understand that neither St. Elizabeth's Hospital nor the Department of Volunteer Services will assume any responsibility for my child prior to their signing in for duty or following their signing off of volunteer duty. I also understand that I will be responsible for their transportation to and from the hospital.

DATE _____ SIGNATURE _____
Parent or Guardian

TO BE COMPLETED BY TEACHER, COUNSELOR, OR MINISTER
PERSONAL REFERENCE FOR

_____

Applicant's name

The above student has applied to our volunteer program. This program requires discipline, dependability, responsibility, a pleasing personality, the ability to get along with others, personal neatness, and the ability to accept and follow instructions.
In the hospital environment, the student must consider all information concerning the hospital and patients as confidential.
Our program is designed to teach, expose the student to the hospital and encourage interest in the health care field.
Would you kindly complete the form below and return it to the Volunteer Services office at your earliest convenience? This student will not be considered for the program until all forms are completed. The information requested will be kept in strict confidence.

ATTITUDE_____

_____

ABILITY TO GET ALONG WITH OTHERS_____

_____

_____

APPEARANCE_____

_____

DEPENDABILITY_____

_____

ABILITY TO FOLLOW INSTRUCTIONS_____

_____

_____

DO YOU HAVE ANY INFORMATION CONCERNING THE APPLICANT'S HONESTY OR INTEGRITY? _____

_____

HOW LONG HAVE YOU KNOWN THE APPLICANT?

_____

ADDITIONAL COMMENTS_____

_____

_____

SIGNATURE_____ DATE _____
RELATIONSHIP TO APPLICANT_____
PHONE NUMBER_____

HSHS St. Elizabeth's Hospital

St. Elizabeth's Hospital Confidentiality Acknowledgement

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-employe, 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_____

HSHS Division
SOUTHERN ILLINOIS

COLLEAGUE CONSENT TO FILM, PHOTOGRAPH, RECORD AND QUOTE
HOSPITAL SISTERS HEALTH SYSTEM, SOUTHERN ILLINOIS DIVISION

Colleague Name: _____

Employer (Hospital): _____

Department: _____ **Employee #:**_____

[redacted]

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