ST. JOSEPH'S HOSPITAL AUXILIARY
12866 Troxler Avenue
Highland, Illinois 62249
APPLICATION FORM

Name:_____ Spouse's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone:_____ Email: _____

Social Security Number:_____ Birth date: _____
(Required for background check)

Membership: ☐ $10 yearly membership – **Payment must be included with the application!**

Work/Volunteer Experience: _____

_____

Hobbies, Skills, Special Interests: _____

_____

Work Days Preferred:_____ Morning ☐ Afternoon ☐ Evening ☐

Volunteer Duties Preferred: _____
Gift Shop 9:00-12:00 ☐ 12:00-3:00 ☐

Messenger Mornings ☐ Greeter: MOB/Main Lobby ☐ Clerical ☐

Monday-Friday – Any day, time is flexible ☐

Comments: _____

In Case of Emergency, Please Notify: _____

Relationship:_____ Phone Number: _____

Date: _____ Signature: _____

Date: _____ Coordinator Signature: _____

Please return application with a check payable to HSHS St. Joseph's Hospital Highland Auxiliary. 12866 Troxler Ave., Highland, IL 62249 Attn. Auxiliary Coordinator - Questions? Call 651-2980

AUXILIARY VOLUNTEER SERVICES

_____**Blood Drives**: Greet donors, pass out snacks and other duties as they become necessary.

_____**Bulk Mailings**: Fold, stuff, label and sort bulk materials for mailings, on an as-needed basis.

_____**Cardiovascular Services**: Greet patients, help maintain equipment and help Therapists as needed.

_____**Food & Nutrition**:

_____**Gift Shop** : Serve as a cashier in the gift shop providing friendly customer service to all visitors and patients. Duties may include light dusting, straightening up and stocking of merchandise. The Gift Shop is an important source of funds for Auxiliary donations to the hospital for various projects and equipment.

_____**Healing Garden & Landscaping**: Assist in light maintenance and gardening chores to upkeep the Healing Garden and Landscaping.

_____**Front Desk and Registration**: Cordially greet visitors to the hospital, and assist the Receptionist on duty. They will provide directions and answer questions to make the visitor's first impression a good one.
M T W Th F ☐ 7 a.m. – 10 a.m. ☐ 10 a.m. – 12 p.m. ☐ 12 p.m . – 2 p.m

_____**Special Events**: The Auxiliary and Hospital conduct many special events throughout the year. Auxiliary events help raise funds for various projects and equipment. The Hospital hosts special events for the community, employees and their families.

Various departments sometimes appreciate volunteers performing regular office work for them in order to allow them to perform their other duties. This service is scheduled on an as-needed basis.

AUXILIARY VOLUNTEER IMMUNIZATION SURVEY

Name: _____

Areas of Volunteering: _____

Does your volunteering require patient contact? Yes No

Documentation of the following is required:

- ☐ 2 MMR Vaccines OR documentation of positive/immune blood titers for Rubella, Rubeola, and Mumps
- ☐ 2 Varicella Vaccines OR documentation of positive/immune blood titer for Varicella
- ☐ 3 Hepatitis B Vaccines OR documentation of positive/immune blood titer for Hepatitis B
- ☐ Tdap Vaccine (Adult dose-after 18 years of age)
- ☐ Flu Vaccine (only required between October 1-March

Have you had any allergic reactions or vaccine contraindications? Yes No

If yes, list and describe reactions.

_____

All current and new Auxiliary members will have titers drawn for Hepatitis B, a QuantiFERON TB Gold Test (Tuberculosis screening), and any additional titers needed from missing immunizations listed above.

_____ _____

Auxilian Signature Date:

Office Use Only

MMR Immunity:
Vaccine Dates: _____ _____

Titer Results: _____

Varicella Immunity:
Vaccine Dates: _____ _____

Titer Results: _____

Hepatitis B Immunity:
Vaccine Dates: _____ _____ _____ _____

Titer Results: _____

Tdap Vaccine Date:_____ **Flu Vaccine Date**: _____

_____ _____

Auxilian Signature Date

_____ _____

Colleague Health Nurse Signature Date

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBD to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRL I certify that the ISP, FBI any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 IL.CS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name : _____ Full Middle Name: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Other Names Used: _____ Telephone: _____
States Where You Have Lived?
☐ Male ☐ Female Race :_____Height: _____ Weight: _____ Date of Birth:_____Social Security #: _____
(Enter a letter from below)
Hair Color: _____ Eye Color : _____ Place of Birth : _____

Race

A Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
B Black or African American (Not Hispanic or Latino)
H Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
I American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
U Of undetenninable race. Of Untold mixture.
W Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If Yes, give full details and state on back.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ? ☐ Yes ☐ No If Yes, give full details of each offense and the state in which convicted on back.

I certify that the above is true and correct and give my consent for my name to appear on Department's HealthCare Worker Registry with the results of my criminal history records check.

_____ _____
Signature Date

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
Signature of Parent or Guardian when applicable Date

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133
***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****

DISCLOSURE REGARDING BACKGROUND INVESTIGATION
IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION

Hospital Sisters Health System ("the Company") may obtain information about you for employment/volunteer or contractor purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education (including transcripts), or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you. These searches will be conducted by Aurico Reports LLC, 3800 Golf Road, Suite 120, Rolling Meadows, IL 60008, (866) 255-1852, www.aurico.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your assignment or employment to the extent permitted by law.

_____ _____
Signature Date

ACKNOWLEDGMENT AND AUTHORIZATION
I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGAT ION and A SUMMARY OF YOUR RIGHT S UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" by the Company at any time after receipt of this authorization and throughout my assignment or employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, branch of the military, 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 **Aurico Reports LLC, 3800 Golf Road, Suite 120, Rolling Meadows, IL 60008, (866) 255-1852, www.aurico.com** and/or the Company. I agree that a facsimile (fax), electronic or photographic copy of this Authorization shall be as valid as the original.

_____ _____
Signature Date

PLEASE PRINT NEATLY AND MAKE SURE THE PRINTING IS LEGIBLE

First Name: _____ Middle Name: _____ Last Name: _____

Maiden Name: _____ Date Changed: _____

Other last names used: _____ Date Changed: _____

Other last names used: _____ Date Changed: _____

Other last names used: _____ Date Changed: _____

List all cities and states where you have lived for the past 7 years - Attach additional sheet if necessary

	Street	City	County	State	ZIP	How Long?
Current:						
2						
3						
4						

Present Phone Number(with area code):

Social Security Number:

Date of Birth* (MM/DD/YYYY):

Gender*

○ Male ○ Female

Driver's License Number:

Driver's License State:

*This information will be used for background screening purposes only and will not be used as hiring criteria.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, and additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - *a person has taken adverse action against you because of information in your credit report;*
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. For additional information see www.consumerfinance.gov/learnmore

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give consent for reports to be provided to employers.** A consumer reporting agency may not give information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to: www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:
1) Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates,
CONTACT: Consumer Financial Protection Bureau, 1700 G Street, N.W., Washington, DC 20552

Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau,
CONTACT: Federal Trade Commission: Consumer Response Center-FCRA, Washington, DC 20580, (877) 382-4357

2) To the extent not included in item 1 above:
National banks, federal savings associations, and federal branches and federal agencies of foreign banks
CONTACT: Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050

State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act
CONTACT: Federal Reserve Consumer Help Center, P.O. Box. 1200, Minneapolis, MN 55480

Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations
CONTACT: FDIC Consumer Response Center, 1100 Walnut Street, Box #11, Kansas City, MO 64106

Federal Credit Unions
CONTACT: National Credit Union Administration Office of Consumer Protection (OCP), Division of Consumer Compliance and Outreach (DCCO), 1775 Duke Street, Alexandria, VA 22314

3) Air carriers
CONTACT: Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division, Department of Transportation, 1200 New Jersey Avenue, S.E., Washington, DC 20590

4) Creditors Subject to Surface Transportation Board
CONTACT: Office of Proceedings, Surface Transportation Board Department of Transportation, 395 E Street, S.W., Washington, DC 20423

5) Creditors Subject to the Packers and Stockyards Act, 1921
CONTACT: Nearest Packers and Stockyards Administration area supervisor

6) Small Business Investment Companies
CONTACT: Associate Deputy Administrator for Capital Access United States Small Business Administration, 409 Third Street, S.W., 8th Floor, Washington, DC 20416

7) Brokers and Dealers
CONTACT: Securities and Exchange Commission, 100 F St, N.E., Washington, DC 20549

8) Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations
CONTACT: Farm Credit Administration, 1501 Farm Credit Drive, McLean, VA 22102-5090

9) Retailers, Finance Companies, and All Other Creditors Not Listed Above
CONTACT: FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center -FCRA Washington, DC 20580, (877) 382-4357.

Confidentiality Agreement

I understand that Hospital Sisters Health System ("HSHS"), including its Local Systems and Affiliates, has a legal and ethical responsibility to safeguard the privacy and security of all patients and the confidentiality of their protected health information. This responsibility includes but is not limited to all data related to HSHS People Services, payroll, fiscal, research, computer systems, and any protected health information ("Confidential Information".) Therefore, I understand my employment/assignment of services with HSHS is contingent upon my agreement that:

- During the course of my employment/assignment with HSHS, I recognize that I may become aware of Confidential Information in verbal, written, or electronic form and that I may have additional responsibilities for protecting Confidential Information.
- I will not disclose Confidential Information to unauthorized parties or access any Confidential Information not required to do my job. This means not accessing my own, my friends, my family, or co-workers Confidential Information without proper consent and authorization.
- I will not share my personal access code(s), user ID(s), or password(s) or knowingly use or try to learn another person's personal access code, user ID, or password for any reason.
- If I have electronic signature capabilities, I certify that my user ID and password represent my signature and carry all the ethical and legal implications of a written signature. I will not disclose this password to anyone for any reason.
- I understand that all of my actions on HSHS information systems, including HSHS provided email accounts, are the property of HSHS and are subject to audit without regard to my privacy.
- I will lock or log off any workstation prior to leaving it unattended for more than 10 minutes.
- I will not make any unauthorized transmissions, e-mails, inquiries, or modifications of Confidential Information. I will not remove any Confidential Information from any HSHS facility without proper authorization.
- I will safeguard Confidential Information from intentional or unintentional unauthorized access, modification, loss, destruction or disclosure.
- I will comply with all HSHS HIPAA Privacy and Security policies.
- I will comply with the HSHS Colleague Social Networking policy.
- I will immediately report to my supervisor, the HIPAA Privacy Officer, or the HIPAA Security Officer any activity violating this agreement or any HSHS HIPAA Privacy or Security policies.
- I will immediately take steps to change my password if I have reason to believe the confidentiality of it has been compromised.
- Upon termination of my employment or assignment with HSHS, I will immediately return any documents, equipment, or other media containing Confidential Information to HSHS. I also agree to tum over any keys, access cards, and any devices providing access to any HSHS facility or its information.
- I understand that my obligations under this Agreement will continue after the termination of my employment or assignment.
- I understand that violation of this Agreement will result in disciplinary action, up to and including suspension, loss of privileges, and/or termination of employment or assignment and I may be subject to criminal and/or civil prosecution in the event I circumvent any of the above.
- My signature below acknowledges that I agree to and will abide by these provisions and that I will only access HSHS information systems for authorized patient care or business functions according to HSHS policies.

_____ _____

Signature Date

_____ _____

ID# Date Signed

This signed document is to be kept on file in Human Resources