CHI Health

VOLUNTEERS
APPLICATION

☐ Bergan Mercy	☐ Creighton University Medical Center	☐ Immanuel	☐ Lakeside	☐ Mercy Council Bluffs	☐ Midlands
7500 Mercy Rd Omaha, NE 68124 (402) 398-6199	601 N 30th Street Omaha, NE 68131 (402) 449-4000	6901 N 72nd Street Omaha, NE 68122 (402) 572-2722	16901 Lakeside Hills Court Omaha, NE 68130 (402) 717-8657	800 Mercy Drive Council Bluffs, IA 51503 (712) 328-5141	11111 S 84th Street Papillion, NE 68046 (402) 593-3747

Application Date	☐ Adult (18 +) ☐ Teen (14-18)

*Please advise us if any accommodation is needed to participate in the application process.

PERSONAL INFORMATION

Last Name	First Name		Middle Initial
Social Security Number	Home Phone	Cell Phone	Work Phone
Address		Apartment Number	
City	State	ZIP	E-mail

EDUCATION AND WORK EXPERIENCE

Current Employment Status ☐ Full Time ☐ Part Time ☐ Other	If you are retired, what was your occupation
Business Address	
May we contact you at work?	Are you a student? ☐ Junior High (8th Grade) ☐ High School ☐ College Full or Part Time

SKILLS AND TALENT – PLEASE CHECK YOUR AREA OF EXPERTISE

- ☐ Retail/Cashier
- ☐ Good Customer Service Skills
- ☐ Accomplished Musician
- ☐ Computer Competency
- ☐ Phone Work
- ☐ Interacting with Patients
- ☐ Good with Children
- ☐ Organizational/Detail Work/Multi-tasker
- ☐ Fundraising
- ☐ Pastoral Care/Extraordinary Minister of the Eucharist (EME)
- ☐ Certified Pet Therapist

Please check the boxes for the days and times you are most often available to volunteer.

	SUN	MON	TUE	WED	TH	FRI	SAT
Morning							
Afternoon							
Evening							

PERSON TO NOTIFY IN CASE OF EMERGENCY

Last Name			First Name	
Address			Relationship	
City			State	ZIP
Home Phone	Cell Phone	Work Phone	E-mail	

CHI Health

CONFIDENTIALITY AGREEMENT

As an employee, volunteer, student, or other person affiliated with CHI Health, you may have access to what this agreement refers to as "Confidential Information." The purpose of this agreement is to help you understand your responsibility regarding confidential information.

Confidential information includes patient, employee, volunteer, student, financial information, and other information proprietary to CHI Health facilities or persons. You may learn or have access to some or all of this confidential information through a computer system or through your activities at CHI Health.

You are required to conduct yourself in a manner which is consistent with CHI Health Policies and Procedures. By reading and signing this agreement, you agree to the following:

- I will use confidential information only as needed to perform my legitimate duties.
- I will only access confidential information for which I have a need to know.
- I will not in any way divulge, copy, release, sell, lend, review, alter, or destroy confidential information except as properly authorized within the scope of my assigned duties affiliated with CHI Health, and will be held accountable for the misuse or wrongful disclosure thereof.
- I will not misuse confidential information or carelessly care for confidential information.
- I will report any activity by individuals whose actions compromise the confidentiality of information to either my department management or the CHI Health Information Security Administrator.
- My obligation under this agreement will continue after termination of my employment, voluntary association, or student experience.
- At all times during my affiliation with CHI Health, I will safeguard and retain the confidentiality of confidential information. I understand that I do not have right or ownership interest in any access, password, or other authorization to confidential information.
- I will safeguard and not disclose my password or any other authorization which allows access to confidential information.
- I will be accountable for the misuse or wrongful disclosure of confidential information obtained through the use of my sign-on and password.

I acknowledge that I understand and agree that if I should not abide by this agreement, disciplinary actions up to and including termination of my affiliation with CHI Health, will result.

Signature (Employee/Volunteer/Student/Person Affiliated with CHI Health)	Department/Associated Business Entity
Printed Name	Date
Title	Employee ID

CHI Health

Human Resources Volunteer Information Form

Please return this form with your packet to CHI Health Human Resources. If you have any questions, please contact your CHI Health Sponsor or Human Resources. Human Resources can be reached at 402-717-6947.

Personal Information

Name (First, Middle, and Last)

Preferred Name

Social Security Number

Date of Birth

Address- City, State, Zip

Email Address

Credentials

Please check all the CHI Health Facilities you will be working at:

- ☒ Bergan Mercy -Omaha
- ☐ Immanuel Medical Center-Omaha
- ☐ Memorial Hospital –Schuyler, NE
- ☐ Plainview Hospital
- ☐ St Mary's Hospital – NE City
- ☐ Community Memorial Hospital - Missouri Valley
- ☐ Lakeside Hospital- Omaha
- ☐ Mercy Hospital-Council Bluffs
- ☐ Clinics
- ☐ St Elizabeth Medical Center – Lincoln
- ☐ Creighton Univ. Medical Center-Omaha
- ☐ Midlands Hospital- Omaha
- ☐ Mercy/Corning Hospital
- ☐ Good Samaritan Hospital – Kearney
- ☐ St Francis Medical Center – Grand Island
- ☐ Other _____

Manager in Bergan's Volunteer Office

Are there any required Licenses or Certifications (please include Life Support Cards) required for the job you will be performing with CHI Health? ☐ Yes ☐ No

If yes, please attach a copy of your credentials. **Please Note: You are required to submit new credentials prior to their expiration date to CHI Health Human Resources department.**

Signature

Date

hirease

DISCLOSURE/AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT

DISCLOSURE: CHI Health – Bergan Mercy may now, or at any time while employed, verify information within the application, resume or contract for employment by obtaining a consumer report and/or investigative consumer report from a consumer reporting agency. The verifications and/or checks may include but are not limited to: driving records, workers compensation records (in compliance with the ADA or other applicable law), credit bureau files, employment references, personal references, any educational and licensing institution records, and any criminal records information pertaining to you which may be in the files of any Federal, State or Local criminal justice agency in any State. These reports may include information as to your general reputation, character, personal characteristics, or mode of living. You have the right to request, in writing, the nature and scope of any investigative consumer report conducted by Hirease, Inc. on behalf of CHI Health – Bergan Mercy, at Hirease, Inc., PO Box 2559, Southern Pines, NC 28388 • 1-866-693-1764 • www.hirease.com.

A photocopy or telephonic facsimile (Fax) of this Disclosure/Authorization and Release shall be valid as the original. The results of this verification process will be used to determine employment eligibility. All results will be kept CONFIDENTIAL. The information obtained will not be provided to any parties other than to the designated CHI Health – Bergan Mercy personnel.

According to the Fair Credit Reporting Act, if any adverse decision is made with regard to your application for employment, based entirely or in part on the information contained in a consumer report or investigative consumer report prepared by a consumer reporting agency, you are entitled to receive a copy of this report upon written request, and a disclosure of the nature and scope of the investigative report.

AUTHORIZATION. I have carefully read and understand this disclosure and consent form and by my signature consent to the release of consumer or investigative consumer reports, as defined above, in conjunction with my application for employment. I further understand this consent will apply during the course of my employment, should I obtain such employment, and that such consent will remain effect until revoked in a written document signed by me. In the event that I wish to refuse or revoke my consent at any time, I understand that I may do so. I further understand that any and all information contained in my job application, or otherwise disclosed to this company by me may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by CHI Health – Bergan Mercy and confirm that all such information is true and correct. I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed, any false statements will be considered as a cause for possible dismissal.

I authorize any agency, reference, employer, state or federal agency, school, university institution, or other agency that maintains information pertinent to my employment to furnish any and all information requested by Employer or its agent Hirease, Inc. or Hirease's agents. I further authorize Hirease, Inc. and any of its Agents, to disclose orally and in writing the results of this verification process and/or interview to authorized CHI Health – Bergan Mercy representatives.

Signature: _____ Date: _____

IDENTIFYING INFORMATION FOR CONSUMER REPORTING AGENCY
(PLEASE PRINT OR TYPE)

Applicant Name: (First Middle Last)	Current Address: (street address)
Other Name(s) Used: (like Maiden)	City: State: Zip:
Social Security Number:	Former Address: (1)
Sex: Race:	City: State: Zip:
Driver's License No.: State of Issue:	Former Address: (2)
Month, Day and Year of Birth*:	City: State: Zip:
Educational Institution Location (City, State)	Professional License State Issued
Name Attended Under Degree Awarded Dates of Attendance/Graduation	License Number Issue Date Expiration Date

FOR CA, MN, OK: PLEASE PROVIDE ME WITH A COPY OF MY BACKGROUND INVESTIGATION REPORT. ☐ YES ☐ NO

IF YOU RESIDE IN CT, PLEASE LIST YOUR CONTACT INFORMATION FOR REPORT NOTIFICATION: EMAIL: _____

Notice to New York Applicants. Under Article 25 § 380-c(B)(2) of the NY General Business Law, you have the right, upon written request, to be informed whether or not an investigative consumer report was requested, and if such report was requested the name and address of the company to whom the request was made. Under § 380-g of the NY General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide you a printed or electronic copy of Article 23-A of the NY Correction Law, which governs employment of persons previously convicted of one or more criminal offense. I certify I have received a copy of Article 23-A. ☐

Have you ever been sanctioned, disciplined, debarred, and/or excluded by a duly authorized regulatory agency or are there any current restrictions or limits on your license(s) or certification(s)? ☐ Yes ☐ No If yes, please attach a complete explanation.

Have you ever been convicted of any criminal violation of the law other than a minor traffic violation or are you now under pending investigation or charges? ☐ Yes ☐ No If yes, please attach a complete explanation. **If you live in Massachusetts or Philadelphia you do not have to answer this question.**

**Without this information, we will be unable to properly identify you in the event we find adverse information during the course of our background investigation.*

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services (CFS)
Nebraska Child Abuse and Neglect Central Registry (CAN Registry)/
Nebraska Adult Protective Services Central Registry (APS Registry)
Authorization for Release of Information for Registered Organizations

All designated fields must be completed or the request will be returned and not processed. Please type or print legibly. **This form is for use only by organizations who have registered with CFS to obtain CAN Registry and/or APS Registry information**. For information on how to register your organization go to: http://dhhs.ne.gov/children_family_services/Pages/nea_cr.aspx .

ORGANIZATION INFORMATION

Registered Organization ID Number	Registered Organization Name
1236	CHI Health Creighton Bergan Mercy - Volunteer Services

APPLICANT INFORMATION

First	Middle	Last Name

Date of Birth	Age	Social Security Number

Current Address

City	State	Zip Code

Applicant's E-Mail Address (Please leave the E-Mail field blank if you prefer to receive correspondence by U.S. Mail).

Other names, such as a maiden name, former married name, or nickname, used in the past 20 years:

Names and birthdates of your children and children who lived with you:

All previous addresses at which you have resided in the past 20 years (minimum City & State):

Please release the following information to the Organization listed above: (Check all that apply): .

☑ Nebraska Child Abuse and Neglect Central Registry (CAN Registry)
1. Whether or not I am listed on the CAN Registry, and the following information regarding any listing(s) which relate or pertain to me:
   a. Date of the alleged child abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-720. (i.e., Agency Substantiated or Court Substantiated).

☑ Nebraska Adult Protective Services Registry (APS Registry)
1. Whether or not I am listed on the APS Registry, and the following information regarding any listing(s) which relate or pertain to me:
   a. Date of the alleged adult abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-376. (i.e., Agency Substantiated or Court Substantiated).

This authorization is valid for a period of 6 months from the date of signature.

Signature of Applicant _____ Date _____

(NOTE: If Applicant is less than 19 years of age the signature of Applicant's Legal Guardian is also required below)

Section A - Verification of Identity of Applicant: Section A or B must be completed.

STATE OF _____)
COUNTY OF _____) ss.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____ by:

_____
(Printed Name of Applicant) .

Affix Official Notary seal here _____
Notary Public

Section B - Verification of Identity of Applicant: Section A or B must be completed.

The undersigned Organization employee hereby certifies that he or she has verified the identify of the Applicant by examining the Applicant's identification documents.

Signature of Organization Employee _____ Date _____

Printed Name of Organization Employee _____

Signature of Applicant's Legal Guardian _____ Date _____

(NOTE: This signature is necessary only if Applicant is less than 19 years of age).

Verification of Identity of Applicant's Legal Guardian (If applicable)

STATE OF _____)
COUNTY OF _____) ss.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____ by:

_____
(Printed name of Applicant's Legal Guardian) .

Affix Official Notary seal here _____
Notary Public

CHI Health

CS0040

TEEN VOLUNTEER PARENTAL CONSENT

Teen Volunteer Name (First, Middle, Last)		
Social Security Number	Date of Birth	Date of Measles Immunization

- I understand that teen volunteers are assigned to many different areas of the CHI Health Facility, and that they may be rotated as needs for their services arise. I understand that they may work on the patient floors, at the Information Desk, or in other supportive service areas.
- All employees and volunteers who were born in/after the year 1957 will provide verification of receiving the measles vaccine.
- My son/daughter has my permission to receive a Mantoux TB skin test at CHI Health. I understand that this test is required for all Facility volunteers and employees to comply with CHI Health policy, and that in the event of a skin reaction to the test, a chest x-ray will be performed at no charge.
- I understand that the Facility may take photographs of my son/daughter for publications or other uses.
- In signing this consent form, I release and forever discharge CHI Health and any and all employees thereof, from all liability which my son/daughter may incur during his or her volunteer service, i.e., contracting any contagious disease or diseases and/or personal injuries or property loss.

Signature of Parent or Guardian		Date
Address/City/State	ZIP	Phone ( )