CHI Health

# VOLUNTEERS
# APPLICATION

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

## VOLUNTEER HISTORY

Have you volunteered your time at another organization? ☐ Yes ☐ No If so, where?

| Name | Phone |
|---|---|
| | |

What were your responsibilities?

Have you volunteered at another CHI Health hospital? If so, where?

## PLEASE LIST A PERSONAL REFERENCE

| Name | Phone | | |
|---|---|---|---|
| | | | |
| **Address** | **City** | **State** | **ZIP** |
| | | | |

Relationship

| Name | Phone | | |
|---|---|---|---|
| | | | |
| **Address** | **City** | **State** | **ZIP** |
| | | | |

Relationship

Is there an agency, school, or anyone that will need documentation of your volunteer hours? ☐ Yes ☐ No

| If "Yes," Name | Address |
|---|---|
| | |

Why is this documentation needed?

Do you have a record of child abuse or dependent adult abuse? ☐ Yes ☐ No

If "Yes," please give a date, location, and disposition of your case

**HAVE YOU BEEN CONVICTED OF A CRIME (FELONY OR MISDEMEANOR) OR DO YOU HAVE A RECORD OF FOUNDED CHILD OR DEPENDENT ADULT ABUSE IN THIS STATE OR ANY OTHER STATE?** ☐ Yes ☐ No
(Conviction will not necessarily disqualify applicants. The recency, severity, and pertinence of the conviction to the placement will all be considered.)

If I am being requested to provide documentation of these volunteer hours, I have indicated it on this application. If accepted as a volunteer, I agree to serve according to CHI Health's Volunteer Guide. I will respect the patient's rights by not discussing confidential information that I might obtain through my volunteer assignments at CHI Health.

**Thank you for your interest in volunteering at CHI Health hospitals.**

| Signature | Date |
|---|---|
| | |

**********

## FOR OFFICE USE ONLY

| Forms Required For Teens | Received |
|---|---|
| Parent Consent form | |
| Teen Reference Letter | |
| Teen Reference Letter | |

| Background/Health Checks | Sent | Received |
|---|---|---|
| Adult/Child Abuse | | |
| Excluded Provider and Discipline | | |
| Criminal Background | | |
| Occupational Health | | |

| | | | |
|---|---|---|---|
| Request CHI Health Sign-on | | Badge Number | |
| Orientation Date | | Initial Assignment | |

Please visit the following website:

https://www.chihealth.com/en/nonemployees/frequently-used-links.html

- Volunteers **ONLY** need to complete **Step #1 - General Orientation**

This orientation is required for ALL volunteers, students, and contractors (or in other words, all "non-employees"), therefore, some of the information contained in the orientation may be more applicable for one group than another. Information that volunteers should pay close attention to is:

- Mission Statement and Core Values
- Patient Care and Safety
- HIPAA
- Professional Dress and Appearance
- Emergency Preparedness
- Abuse and Neglect
- Infection Control

At the end of the orientation you will be prompted to print a "certificate". This is proof of completing Orientation. PLEASE PRINT THE CERTIFICATE TO PROVIDE TO VOLUNTEER SERVICES.

# CHI Health Volunteer Occupational Health Requirements

**Standard Screening for All Volunteers:**

1. 2 Step PPD
2. Rapid 5 Drug Screen
3. Health History Review
4. Flu Vaccine
5. Stated immunization status of the following:
    a. MMR
    b. Varicella
    c. Tdap/TD
    d. Hep B – is not required but will have them complete the declination for their record

**Additional Testing for volunteers working in Hospice, Nursery, or NICU:**
Per CHI policy we will need Medical Documentation for the following (stated dates will not work)

1. MMR vaccines or titer
2. Varicella vaccines or titer
3. Tdap/TD

If no documentation then proceed with titers/immunizations

All screening/testing is provided at no cost to the volunteer and is paid for by CHI. You will need to call 402-572-3232 to set up an appointment.

The PPD test requires you to return in 48 hours to have the test read and an additional test will be administered the following week. It is best not to have initial test administered on Thursdays due to having results checked in 48 hours.

Teens, under the age of 19, will need to be accompanied by a parent or legal guardian to sign consent forms at initial visit.

What to bring:

1. Driver's license/Nebraska State Id card/Student School ID card
2. Vaccine records and list of current medications
3. A full bladder to give a urine specimen for the drug screen

CHI Immanuel Occupational Health is located directly west of the hospital in Medical Building Two (6715 N 72nd St) in Suite 205

Phone number: 402-572-3232
Fax number: 402-572-3218

Hours of operation are 7:00 am – 5:00 pm, Monday – Friday
Appointment are scheduled from 7:00 am – 3:30 pm

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# 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 Immanuel'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

# CHI Health
# Core Values

As part of Catholic Health Initiatives, we at Immanuel, want to make it clear that each and every employee/volunteer is expected to adhere and practice the four **Core Values** while present at this facility.

- **Reverence**- Profound respect and awe for all creation, the foundation that shapes spirituality, our relationships with others and our journey to God.
- **Integrity**- Moral wholeness, soundness, fidelity, trust, truthfulness in all we do.
- **Compassion**- Solidarity with one another, capacity to enter into another's joy.
- **Excellence**- Preeminent performance, becoming the benchmark, putting forth our personal and professional best.

I have read and understand the **Core Values** and I understand the behaviors expected of me. On Behalf of CHI Health Immanuel and our patients, families, employees, volunteers, and physicians, I pledge that I will uphold these behaviors in my daily work environment.

Signature_____ Date_____

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# 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 |

Alegent Health

# VOLUNTEER SERVICES AUTHORIZATION

## PLEASE CAREFULLY READ THE FOLLOWING BEFORE SIGNING THIS STATEMENT

I certify that the information contained in my application is complete and true to the best of my knowledge and that I have not knowingly withheld any facts or information that would affect my volunteer services. I understand that any falsification or omission of material and/or information requested may result in denial of my volunteer services or termination of these services if I have already begun.

I understand that my provision of volunteer services is contingent upon successful completion of a total screening process. This process includes, but is not limited to, references that are, in the sole opinion of Alegent Health, considered satisfactory, including successful completion of a health screening, satisfactory criminal and adult/child abuse and neglect checks and completion of orientation within 30 days of the start of my volunteer services.

I understand and agree that neither this form, nor any other written policy or procedure of Alegent Health and its facilities, shall constitute a contract between Alegent Health and myself for either a definite or an indefinite period of time. I further understand that my provision of volunteer services is at will and I may resign at any time and that Alegent Health may terminate or modify the terms and conditions of my volunteer services at any time.

## AUTHORIZATION AND RELEASE

In connection with my application for volunteer services, I authorize any employer, educational institution, law enforcement organization, state and federal government agency, information service bureau and other persons contacted, to release information regarding my character, performance, qualifications, background and reasons for termination of past employment to Alegent Health or its agent. I release all parties involved in providing said information from any and all responsibility or liability resulting from such investigation.

I also authorize the release of my criminal record to Alegent Health and its volunteer organization. Prior to taking any adverse action based upon my history, Alegent Health will provide me with a copy of the Report, upon my written request, and a summary of rights.

**BY SIGNING BELOW, I HEREBY CERTIFY THAT I HAVE READ AND AGREE TO THE ABOVE**

| | |
|---|---|
| Volunteer Applicant Signature* | Date* |
| Parent/Legal Guardian Signature (If Volunteer applicant is a minor, signature of parent or legal guardian is required.)* | Date |
| Volunteer Services Representative | Date |

CHI Health

CSD040

# 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<br>( ) |