CHI Health

CHI HEALTH MERCY COUNCIL BLUFFS
NEW VOLUNTEER PROCESS

Step 1

Required Forms for Volunteers: Please fill out the following forms and return to the Mercy Hospital Welcome Desk or Volunteer Services Office.

- CHI Health Volunteer Application Form
- CHI Health Confidentiality Agreement
- CHI Health Human Resources Volunteer Information Form
- State of Iowa Criminal History Record Check Request Form
- Teen Volunteer Parental Consent Form (if applicable)

Once we receive your completed forms, and your background check from the State of Iowa has been completed, you will be contacted by the Volunteer Services Manager. At this point we will schedule an interview and a tour of the Hospital. After your interview and tour, you will be asked to make an appointment with Occupational Health for a medical check. (see below)

Occupational Health: All volunteers must get cleared through Occupational Health before becoming a volunteer. Please call them at 712-328-5550 to schedule an appointment for your Volunteer medical check. The medical check includes a urine drug screen, 2-step tuberculosis test, and brief health assessment. Teens will require a parental signature.

Occupational Health is located at:

Mercy Hospital
715 Harmony Street
Suite 201
Council Bluffs, IA 51503
Phone: 712-328-5550
Hours: 7:00am – 4:00pm, Monday – Friday

Step 2

General Orientation: Once we receive your complete Occupational Health medical check results and you have been cleared, you will need to complete the General Orientation online. The General Orientation is a PowerPoint presentation. The website is:

https://www.chihealth.com/non-employee-volunteers

Click on the Non-Employee General Orientation under Step 2. Please print the **Certificate of Completion** and return it to the Volunteer Services Manager when you are finished. If you do not have your own personal computer, we can provide one for you in the Volunteer Services office.

Step 3

After completion of Steps 1 & 2, you will be contacted about becoming a volunteer based on open shifts and open positions. We thank you for considering a role as a volunteer and we look forward to your contributions at CHI Health Mercy Hospital. If you have questions, please contact the Volunteer Services Manager at 712-328-5394.

CHI Health

VOLUNTEERS
APPLICATION

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

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	

CHI 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 CHI 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 CHI Health and its facilities, shall constitute a contract between CHI 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 CHI 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 CHI 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 CHI Health and its volunteer organization. Prior to taking any adverse action based upon my history, CHI 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

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 ____ 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

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

STATE OF IOWA Criminal History Record Check Request Form

DCI Account Number: 1058
(if applicable)

To: **Iowa Division of Criminal Investigation**
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

CHI Health Human Resources
12809 West Dodge Road
Omaha, NE 68154
(402)717-6947
(402)717-1995

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	**First Name** (mandatory)	**Middle Name** (recommended)
Date of Birth (mandatory)	**Gender** (mandatory)	**Social Security Number** (recommended)
	☐ **Male** ☐ **Female**	

Waiver Information: **Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.**

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature:

Iowa Criminal History Record Check Results

(DCI use only)

As of _____, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI # _____

DCI initials

Alegent Creighton 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 Alegent Creighton 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 Alegent Creighton Health. I understand that this test is required for all Facility volunteers and employees to comply with Alegent Creighton 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 Alegent Creighton 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 ( )

Occupational Health FAQ's

You will need to call Occupational Health and make an appointment for a *New Volunteer Assessment*.

SITE LOCATION	PHONE	HOURS-OPEN MONDAY-FRIDAY
Immanuel Medical Center Immanuel Two Professional Center 6751 North 72nd Street Suite 205 Omaha, NE 68122	402-572-3232	7:00 A.M. – 4:00 P.M.
Mercy Hospital 715 Harmony St Suite 201 Council Bluffs, IA 51503	712-328-5550	7:00 A.M. – 4:00 P.M.
Occupational Medicine Clinic 11909 P Street Omaha, NE 68137	402-829-5660	7:00 A.M. – 4:00 P.M.

There will be consents and release forms to sign, which **will require a parental signature**, unless you are 19 years old. These forms can be obtained ahead of time, but must be signed within 24 hours of your scheduled appointment time; or, the parent can come with you.

The assessment includes the following:

1. A urine drug screen
    a. Please **bring a picture ID**, and **be prepared to provide a urine sample**.
2. A 2-Step TB testing process
    a. You will receive a TB test at your first appointment, which will need to be "read" in 48-72 hours by the Occupational Health nurse, or the ED dept., if after hours or on the weekend.
    b. A second TB will need to be placed a week after the first TB was placed, unless you have documentation of having had a negative TB within the past year. This will also need to be read in 48-72 hours.
3. A brief nursing assessment will be done, which includes taking a set of vital signs (temperature, blood pressure, pulse). They will review with you the answers you marked on your Health Update form. It is very helpful if you can bring your vaccination records with you. The schools (if minor) will usually provide you with a copy of your vaccination records if asked.

CHI Health

Imagine better health.℠