

F A X

To: CHI Health Human Resources
Fax number: 402-717-1995

From:
Phone Number:

Regarding: Midlands Hospital Volunteer Packet
**SUBMIT TO CHI HEALTH HUMAN RESOURCES -
ATTENTION NON EMPLOYEE DEPARTMENT
FAX: 402-717-1995**

Checklist: *Before submitting your packet for review, please make sure you have included the following items:*

- Non-Employee/Volunteer Information Form
- CHI Health Confidentiality Agreement
- Non Employee Orientation Certificate

Please Note:

All documents must be assembled into one fax and sent to the CHI Health Human Resources department. Incomplete applications will not be accepted

*CHI Health Human Resources Address:
12809 West Dodge Road
Omaha, NE 68154*

*CHI Health Human Resources Phone
Number:
402-717-6947*



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:

- | | | |
|----------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Bergan Mercy -Omaha | <input type="checkbox"/> Community Memorial Hospital - Missouri Valley | <input type="checkbox"/> Creighton Univ. Medical Center-Omaha |
| <input type="checkbox"/> Immanuel Medical Center-Omaha | <input type="checkbox"/> Lakeside Hospital- Omaha | <input checked="" type="checkbox"/> Midlands Hospital- Omaha |
| <input type="checkbox"/> Memorial Hospital –Schuyler, NE | <input type="checkbox"/> Mercy Hospital-Council Bluffs | <input type="checkbox"/> Mercy/Corning Hospital |
| <input type="checkbox"/> Plainview Hospital | <input type="checkbox"/> Clinics | <input type="checkbox"/> Good Samaritan Hospital – Kearney |
| <input type="checkbox"/> St Mary’s Hospital – NE City | <input type="checkbox"/> St Elizabeth Medical Center – Lincoln | <input type="checkbox"/> St Francis Medical Center – Grand Island |
| | | <input type="checkbox"/> Other _____ |

Manager in Midland’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



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	