



Volunteer Services Application

Contact Information (Please Print)

Date: _____

Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Employer: _____

Availability: During which hours are you available for volunteer assignments?

___ Weekday mornings

___ Weekday afternoons

___ Weekend mornings

___ Weekend afternoons

Interests

___ Clerical/Data Entry

___ Health Fairs

___ Phone Calling Out

___ Internet/Research

___ Special Events

How did you hear about The Rose?

Is there a history of breast cancer in your family? Yes No

If so, who? _____

Are you a breast cancer survivor? Yes No

If so, when were you diagnosed? _____

Special Skills or Qualifications

Clerical skills: _____

Language(s): _____

Are you PC proficient? Yes No

Computer Program(s): _____

Other Skills/Qualifications: _____

Education

High School/GED

College

Graduate School

Name/Location: _____ Major: _____ Degree: _____

Previous Volunteer Experience

Summarize your previous volunteer experience.

Person to Notify in Case of Emergency

1 Name: _____ Relationship: _____ Phone: _____

2 Name: _____ Relationship: _____ Phone: _____

Confidentiality Agreement

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

I understand that The Rose has legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information.

In addition, I understand that during the course of my assignment/affiliation at The Rose, I may see or hear confidential information such as financial data and operational information pertaining to the facility that The Rose is obligated to maintain as confidential.

As a condition of my assignment/affiliation with The Rose, I understand that I must sign and comply with this agreement.

By signing this document I understand and agree that: I will disclose patient information and/or confidential information only if such disclosure complies with The Rose policies, and is required for the performance of my assignment(s).

My personal access code(s), user ID(s) access key(s) and passwords(s) used to access computer systems or other equipment are to be kept confidential at all times.

I will not access or view any information other than what is required to do my job. If I have any question about whether access to certain information is required for me to perform my assignment, I will immediately ask my supervisor for clarification.

I will not discuss any information pertaining to The Rose in any area where unauthorized individuals may hear such information (for example, in hallways, on elevators, in the break rooms, on public transportation, at restaurants, and at social events). I understand that it is not acceptable to discuss any information in public areas even if specifics such as patient's name(s) are not used.

I will not make inquiries about any of The Rose information for any individual or party who does not have proper authorization to access such information.

I will not make any unauthorized transmissions, copies, disclosures, inquiries, modifications, or purging of patient information or confidential information. Such unauthorized transmissions include, but are not limited to; removing and/or transferring patient information or confidential information from The Rose's computer system to unauthorized locations (for instance, home). I will not take any patient information home to complete the work.

Upon termination of my assignment/affiliation with The Rose, I will immediately return all property (e.g. Keys, documents, ID badges, etc.) to The Rose.

I agree that my obligations under this agreement regarding Patient Information will continue after the termination of my assignment/affiliation with The Rose.

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of my assignment/affiliation with The Rose and/or suspension, restriction or loss of privileges, in accordance with The Rose's policies, as well as potential civil and criminal legal penalties.

I understand that any confidential information or patient information that I access or view at The Rose does not belong to me.

I have read the above agreement and agree to comply with all its terms as a condition of continuing my affiliation with The Rose.

Signature: _____

Date: _____

Print your name: _____ The Rose Representative: _____

Acknowledgement of Reading HIPAA Privacy Rule

I am acknowledging that I have read the Overview of HIPAA Privacy Rule. I understand that I am to read and become familiar with the contents. If I have questions, I understand that I should talk to my supervisor or The Rose HIPAA Privacy Officer.

Further, I understand that this document will become a part of my personnel file.

Signature: _____ Date: _____

Print your name: _____

Conflict of Interest

All volunteers of The Rose are expected to avoid any conflict, or appearance of conflict between personal, professional, and/or business interests and the interests of The Rose. I understand that as a volunteer, I will not benefit personally or professionally, either financially or through business interests.

I understand that as a volunteer, if I am part of a volunteer committee that is making decisions about the possible transaction of business, I shall explain the nature and extent of the conflict and will:

- 1) Resign from the volunteer committee OR
- 2) Recuse myself from the business deal, in order to not affect the outcome of the decision making process with respect to that transaction.

Signature: _____ Date: _____

Print your name: _____