Confluence Health
Volunteer Application Form

Identification:

Name: Last: _____First:_____MI _____

Address: _____Phone:_____

City: _____State:_____ Zip Code:_____

Email address_____ Today's Date:_____

Are you under 18 years of age? ☐ **Yes** ☐ **No** Date of Birth: _____/_____/_____

Person to contact in case of Emergency: _____

Phone #: _____Relationship: _____

Have you ever been employed at CWH? ☐ Yes ☐ No If Yes, when? _____

Work Preferences:

Please list areas of interest:_____

Date available to start: _____

Time Available:

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

☐Morning ☐Afternoon ☐ Evenings

Hours per shift: ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ Other

Number of shifts per week: _____

How did you learn about the volunteer program? _____

_____

Prior Experience:

Volunteer: _____

_____

Work: _____

_____

Education			
Name of School	Field of Study	Graduated yes/no	Diploma/Certificate

References: (Must be over 18 and not an immediate family member.)

1. Personal Reference:

Name: _____ Phone Number: _____

Organization: _____

Describe type and length of acquaintance:

_____

_____

2. Employment Reference:
***(If no employment history, please list additional references)**

Name:_____ Phone Number: _____

Organization: _____

Describe type and length of acquaintance:

_____

_____

Important Notice:

I understand that my services are donated to Confluence Health without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

I consent to and authorize Confluence Health and its Volunteer office to request any information concerning criminal conviction record information from the Washington State Patrol Identification and Criminal History Section Pursuant to the Child/Adult Abuse Information Act, RCW 43.43.830 through 43.43.840.

Signature:_____ Date: _____

DISCLOSURE AND AUTHORIZATION

PLEASE READ CAREFULLY

DISCLOSURE FORM

Confluence Health (CH), when considering individuals for Student Rotations or Observation, must review conviction and criminal history records as they relate to the safety and security of their patients, staff and visitors. Additionally, the Washington State Child and Adult Abuse Information Law (RCW 43.43.830 - 43.43.842) requires that the organization ask applicants to disclose specific information about any convictions for crimes against persons, crimes relating to financial exploitation and findings in related actions and proceedings. This conviction information must be disclosed before an applicant can be considered for a student rotation or observation which may involve unsupervised access to children, developmentally disabled persons or vulnerable adults as defined by the law. **A conviction/criminal history does not necessarily disqualify an individual for a student rotation. A conviction/criminal history does disqualify an individual for an Observation.** Criminal history records will be verified through the Washington State Patrol (WATCH), Department of Social and Health Services (DSHS) and a reporting agency contracted by the organization. The report will contain information regarding your criminal history for the past 7 years. The types of information that may be obtained include, but are not limited to, social security number verification, criminal records checks, public court records checks, licensing and certification actions. You are entitled to request more information & / or receive a copy of these reports by submitting a request to: Student Services Specialist, Education Services – Confluence Health.

Have you ever been:

1. Convicted of any crime against persons (definition: ***"Crimes against persons" means a conviction for offenses such as theft, murder, kidnapping, assault, rape, robbery, arson, burglary, manslaughter, extortion, incest, indecent liberties, vehicular homicide, prostitution, or criminal mistreatment.)***?
2. Found in any dependency action to have sexually assaulted or exploited any minor or to have abused any minor?
3. Found by a court in a domestic relation proceeding to have sexually abused or assaulted any minor or to have physically abused any minor? ☐ No ☐ Yes
4. Convicted of any crime? ☐ No ☐ Yes

In the State of Washington? ☐ No ☐ Yes

Outside the State of Washington? ☐ No ☐ Yes – which state:_____

AUTHORIZATION FORM

I have carefully read and understand this Disclosure and Authorization form. By my signature below, I consent to the release of investigative criminal history reports prepared by a reporting agency, such as **Washington State Patrol, Department of Social Health Services and other reporting agencies** , to Confluence Health.

By my signature below, I authorize the disclosure of information concerning my criminal history, and all other information deemed pertinent by the reporting agencies (law enforcement; federal, state and local courts) to the organization.

Signature:_____ Date:_____

The following information is required for identification purposes. Please print clearly in black ink.

Name: Last	**First**	**Middle**
List all other names used in the last 7 years		
Date of Birth	**Social Security Number (optional)**	**Gender**
Current Address		
City	**State**	**Zip**
Daytime Telephone Number	**Email Address**	

Protection and Security of Confidential Information – Workforce Agreement

PURPOSE:

The purpose of this agreement is to outline Workforce Member obligations with respect to the protection and handling of Confidential Information.

DEFINITIONS:

Confidential Information: Medical, financial, personal, as well as non-public information originating from Confluence Health and/or its affiliated entities. This information includes, but is not limited to:

A. Protected Health Information (PHI), which is any information created or received by Confluence Health that relates to the past or present health condition, treatment, or payment for treatment of a patient.
B. Any information originating from or belonging in a patient's medical record including scheduling information.
C. Demographic data such as address, age, telephone number, employer, e-number, or insurance information, etc.
D. Financial information related to pricing, budgets, financial analysis, and financial reports.
E. Contractual information about vendors, suppliers, business partners, and insurers.
F. Administrative information about Confluence Health's internal operational capabilities, logistics, and methods of doing business.
G. Business strategy, business plans, or marketing strategy information.
H. Salary, salary history, and employment records of all current or former employees.
I. Log-in credential information, passwords, or passcodes

Workforce Member: Employees, contracted staff, volunteers, trainees, students, and other persons whose conduct, in the performance of work for Confluence Health, is under the direct control of Confluence Health, whether or not they are paid by Confluence Health.

POLICY:

A. All Workforce Members of Confluence Health and its affiliates must protect Confidential Information related to Confluence Health's patients, employees and business practices. Workforce Members have a legal and ethical responsibility to prevent access to and disclosure of Confidential Information without proper authorization or for unauthorized purposes.
B. The obligation to protect Confidential Information applies regardless of the context or format in which it appears (written, verbal, computer or other electronic media, direct observation), the manner in which it is received, or whether it is received purposefully or inadvertently.
C. Workforce members shall only access information which is necessary to perform their job. Workforce members understand that they do not have the right, apart from performing their job duties, to access confidential information of any patient or employee including, but not limited to:
    1. spouse
    2. children
    3. family members
    4. co-workers
    5. friends
D. Protected Health Information (PHI) is a special type of confidential information that Confluence Health is obligated by law to protect. Workforce Members are forbidden from removing PHI from the work premises without express authorization and are forbidden from sharing or retaining PHI except as provided by law.

E. When a Workforce Member's relationship with Confluence Health ends, he or she will not retain, upload, download, copy, or otherwise transfer any Confidential Information. Workforce Members must return or delete any Confidential Information in their possession. Workforce members must also make a diligent search of any storage devices or cloud-based accounts to which they have access to, and return or destroy such information.

F. Workforce Members may only disclose Confidential Information to persons authorized to receive it and in a manner, that will prevent disclosure to anyone other than the person(s) for whom disclosure was intended. This means ensuring discussions about Confidential Information are done in a place and manner that avoids incidental disclosures. Workforce members shall not leave Confidential Information in areas where unauthorized persons could view it.

G. Workforce Members have an obligation to report to any situation they believe may constitute a breach of patient confidentiality to their supervisor, the privacy officer, or in Quantros.

H. Workforce Members must protect computer passwords and log-in credentials. Passwords and log-in credentials may not be shared with anyone, whether or not that other person has his/her own password and/or login.

I. Workforce Member name badges for identification and/or security access may not be shared with others. Badges may be used to charge meals, pharmaceuticals and purchase items at the Central Washington Hospital gift shop. Workforce members authorize payroll deduction of all charges that incurred through the name badge upon receipt of the badge. Badges are to be worn where they can easily be seen by other workforce members and patients. Workforce Members must have their badge on during their entire shift.

J. Computer workstations and information stored in applications on the workstations are to be used for business purposes only. Confluence Health reserves the right to monitor these systems at any time with or without permission or knowledge by the user.

K. Any violation of confidentiality, whether intentional or not, may result in disciplinary action, up to and including immediate termination of employment.

___Employee ___Student ___Volunteer ___Physician ___Observer

___Other:_____

I have read and agree to this policy.

Print Name: _____

Signature: _____ Date: _____

Submit

Reset