

Clinical Volunteer Application

(Must be completed in its entirety for credentialing)



In what area do you currently work?

CRNA Pre-Op PACU OR Circulator Ophthalmology Tech Other _____

Last Name: _____ First Name: _____

Home Address: _____

City _____ Zip Code _____

Cell #: _____ Email: _____

Professional License Type (please include copy): _____ License # _____

DOB: _____ SSN: _____

Certifications: _____

Employer/Practice: _____

Please list 3 references with phone numbers and email

1. _____
2. _____
3. _____

Please include:

Copy of Driver's License, Immunization Record, and Verification of TB Test

Release of Information Authorization

I, _____ hereby give Surgery on Sunday, Inc. permission to ascertain information and/or documents from credentialing hospitals and agencies in regards to my professional licensure and standing to be used for Surgery on Sunday, Inc. purposes only.

Applicant Signature

Date

NOTE: For new applicants, credentialing takes approximately 30-45 days. Once the process has been completed, you will be contacted for your availability.

For office use only:

Volunteer Agreement Confidentiality Agreement Media Release Statement Personal Electronics Driver's license
 Flu vac Hep vac TB verif TB risk assess Sub to NPDB Sub to FTCA FTCA app Added to email

VOLUNTEER AGREEMENT

I, _____ (Print Name) wish to provide volunteer services for Surgery on Sunday, Inc. As a volunteer, I understand that I am not entitled to and will not receive any compensation, salary, benefits or other payments in exchange for my providing volunteer services to the facility. I further understand that my volunteer service is donated without contemplation of future employment, and given for educational, humanitarian, religious or charitable reasons. I understand that as a volunteer, I am not covered by any state or federal wage and hour laws, nor am I eligible for workers' compensation, unemployment insurance benefits or any other type of employment benefit offered to employees.

I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on Surgery on Sunday premises, unless I receive the express authorization from the facility's administration to do so.

I understand that Surgery on Sunday facilities offer medical services to the public for the treatment of illness, including but not limited to tuberculosis, hepatitis, and HIV and I assume a risk that I might be inadvertently exposed to such diseases.

I shall submit to examinations and annual retesting as necessary, which may include skin tests, chest x-rays, and appropriate laboratory test and/or immunizations as a condition of my volunteer service.

I release, discharge and relieve Surgery on Sunday, Inc from any and all claims whatsoever of any nature arising as a result of my volunteer services and related activities.

I understand and agree that I will comply at all times with all rules, policies and standards of conduct that apply to clinic employees, independent contractors and volunteers including the system policy on confidentiality which I have signed and submitted.

I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others and endeavor to make my work professional in quality. I shall make my best effort to fulfill my commitment to the program by following the assignment descriptions and completing all assignments I accept. If I am unable to perform my volunteer duties, I will notify the appropriate leadership as soon as possible.

I understand that the facility reserves the right to terminate my volunteer status if I fail to follow all hospital policies, rules, regulations; if I am absent without prior notice; or if I have unsatisfactory attitude, appearance or attendance.

Name (Please Print): _____

Signature: _____ **Date:** _____

CONFIDENTIALITY AGREEMENT

Surgery On Sunday, Inc. (SOS) treats information about SOS's business and patients as confidential and takes precautions to protect the privacy, confidentiality, and security of this information.

SOS confidential information means any information regardless of the format that it is in (paper, electronic, or oral conversations) about a patient, resident, employee, student, physician, professional staff, or SOS business and financial information that is not available to the public. Confidential information includes, but is not limited to, protected health information, billing, payroll, employment records, employee benefits, trademark, copyright, intellectual property, technical ideas and inventions, written published works, contracts, supplier lists and prices, price schedules, business practices, marketing, or strategy, confidential information of third parties for business purposes, or information that is only intended for internal use.

During the course of your employment of your employment or association with SOS, you may have access to SOS confidential information. In order to access confidential information you must read the following statements and sign below.

1. I will look at and use only the minimum amount of confidential information needed to perform my job duties or to perform SOS business related job duties. Use or review of confidential information to third-parties or outside of my job duties is strictly prohibited.
2. I will take reasonable precautions and follow SOS policies and procedures for safeguarding confidential information to prevent the unauthorized use or disclosure of confidential information and return such information to SOS when no longer needed.
3. I understand that SOS may take disciplinary action if I do not abide by this Confidentiality Agreement and the SOS policies and procedures, including termination of my employment, contract or association with SOS.
4. I understand that my obligation to maintain the confidentiality of SOS's confidential information extends beyond termination of my employment or association with SOS, and I agree that I will not disclose or use SOS confidential information for any purpose after my employment or association ends.
5. I understand that SOS is entitled to take legal action against me if I do not follow this Confidentiality Agreement and SOS's confidential information is used or disclosed inappropriately, including obtaining money damages and attorneys' fees.
6. I understand that this Confidentiality Agreement is not an employment contract. I understand that these policies and procedures may be revised or amended at any time and I will be made aware of the updated policies and procedures.

Volunteer Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

MEDIA RELEASE STATEMENT

I, _____, a patient and/ or volunteer with Surgery On Sunday, Inc., hereby grant and give permission for Surgery On Sunday, Inc. staff and media outlets (such as but not limited to: radio/ television, newspapers, magazines and internet) permission to take and/ use photographs of me at any state of my procedure or involvement with Surgery On Sunday, Inc. for media purposes or website use concerning the Surgery On Sunday, Inc. program.

I also hereby grant and give permission for Surgery On Sunday, Inc. to use any information obtained from my friends, family or Surgery On Sunday, Inc staff volunteers for media purposes or website use concerning the Surgery On Sunday, Inc. program.

Volunteer

Date

PERSONAL ELECTRONICS, COMPUTERS and SOCIAL NETWORKING ACKNOWLEDGEMENT

Personal Electronic Devices

Electronic devices for personal use, including but not limited to cellular phones, Bluetooth, laptops, tablets, iPods, mp3 players, or any personal electronic device are prohibited while on duty. These devices are to be placed on silent or vibration mode and be put away. You may use your personal device if you are on lunch break.

Clinic Telephones

Clinic telephones are designed for patient care or clinic business use and should be used for personal calls only in an emergency.

Camera Use

Due to the sensitive and confidential nature of the work performed at our facilities, you are not permitted to take pictures or video without approval from the executive director. If you are given permission, any pictures or video taken must **NEVER** include anything that would identify a patient. Photos of patients, staff, proprietary information, or work areas should never be posted on social networking pages.

Social Networking

Although the organization understands and supports the value of sharing information electronically, it is the responsibility of all staff and volunteers to ensure appropriate content and behavior when engaging in social networking sites.

When using social networking, you should do so with the understanding that you are accountable for anything you send or post regarding the organization, its patients/families, staff and physicians. If any such postings are in violation of the organization's policies or in any way harm the reputation/image of the organization, the volunteer may be subject to disciplinary action, possibly including termination. Any volunteer who wishes to establish a website, social network, electronic bulletin board or other web based communication tool regarding the business of the organization must have the permission of the executive director. By signing this document, you are acknowledging you have received this information and agree to follow these guidelines:

Volunteer Signature: _____ **Date:** _____

Parental Signature: _____ **Date:** _____

1594 Harrodsburg Rd, Lexington, KY 40504 ~ 859.246.0046 ~ Fax 859.246.1752

Confidential Tuberculosis Risk Assessment Questionnaire

Name: _____ Date: _____

Allergies: _____

Do you have any of the following signs/symptoms? (Circle)

Night sweats	Yes	No
Anorexia	Yes	No
Unexplained fever	Yes	No
Bloody sputum	Yes	No
Cough > 3 weeks	Yes	No
Unexplained weight loss	Yes	No

Please complete below where appropriate:

Date IGRA or TB Gold serum test given: _____

Results: positive negative

Date PPD given: _____ Given by: _____

_____mm induration Date read: _____ Read by: _____

Two-step – indicated if last PPD was greater than 1 year ago. To be given 1-3 weeks after initial PPD.

Date PPD given: _____ Given by: _____

_____mm induration Date read: _____ Read by: _____

Complete this section only if you are a positive PPD reactor:

Year of (+) PPD conversion: _____ Date of last chest x-ray: _____

Treated w/medication? No ___ Yes ___ Year _____ How long? _____

If you are a new (+) converter today, you will be required to have a chest x-ray and a TB evaluation by your primary care physician or the health department. The CXR results and the treatment plan must be sent with this completed form for documentation.

CXR date: _____

CXR result: _____