General Volunteer Application

(*Must be completed in its entirety)*

Changing Lives One Surgery at a Time — Surgery on Sunday℠

Last Name: _____

First Name: _____Middle Name_____

Home Address: _____

_____

Email: _____SS #_____

Cell phone: _____ Other phone: _____

DOB: _____ Foreign language (if any) _____

Employer:_____ _

Area of volunteer interest?

Registration **Cleaning** **Data Entry** **Clerical/Administrative**

Please include a copy: ▪Driver's License ▪TB Test ▪ImmunizationRecord

Please list three references with email addresses and briefly explain why you want to volunteer with Surgery on Sunday

1)_____

2)_____

3)_____

_____

_____

_____

Applicant Signature **Date**

NOTE: FOR NEW APPLICANTS, PROCESSING OF VOLUNTEER FORMS TAKES 30-60 DAYS. AFTER PROCESSING IS COMPLETE, YOU WILL BE CONTACTED FOR YOUR AVAILABILITY.

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

~volunteers@surgeryonsunday.org ~ www.surgeryonsunday.org

Changing Lives One Surgery at a Time

Surgery on Sunday

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:** _____

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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. 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: _____

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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

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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: _____

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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 <u>new (+) converter today</u>, 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: _____