Guardian Angel FOUNDATION

Wings of support.

Volunteer Application

412 W Sycamore St., Kokomo, IN
Ph:765-452-3034 Fx: 765-452-0932

Date: _____

Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Ph: _____ Cell Ph: _____

Email: _____

Availability:

_____ weekday mornings
_____ weekday afternoons
_____ weekday evenings
_____ weekend mornings
_____ weekend afternoons
_____ weekend evenings

Which areas are you interested in volunteering:

_____ Office
_____ Gift Shop
_____ Fundraising
_____ Yard Work
_____ Special Events (health fairs, golf outing, gala, etc)
_____ Representative in your Church
_____ Donation pick-up or delivery

Summarize any special skills and qualifications you feel you have acquired from employment, previous volunteer work, or thought other activities, including hobbies or sports.

Please list the name and phone numbers of two places you have volunteered before. If you have not previously volunteered, please list two references not related to you.

Name: _____ Phone: _____

Name: _____ Phone: _____

Case of emergency contact:
Name:
Address: _____
Phone: _____ Cell: _____

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions or other misrepresentations made by me on this application may result in my immediate dismissal.

Signature: _____ Date: _____

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CONFIDENTIALITY AGREEMENT

(Employee/Volunteer/Student/Board Member)

As an employee/volunteer/student/board member with access to patient medical records, you will have access to what this agreement refers to as "confidential information." The purpose of this agreement is to help you understand your duty regarding confidential information. Confidential information includes patient information, medical records and reports. You may learn of or have access to some or all of this confidential information through a computer system, the patient chart or through your employment/volunteer activities. Confidential information is valuable and sensitive and is protected by law and by strict Guardian Angel Hospice, Inc. policies. The intent of these laws and policies is to assure that confidential information will remain confidential—that is, that it will be used only as necessary to provide authorized patient care. As an employee/volunteer/student/board member, you are required to conduct yourself in strict conformance to applicable laws and Guardian Angel Hospice, Inc. policies governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties will subject you to discipline, which might include, but is not limited to, termination of employment and to legal liabilities.

Accordingly, as a condition of and in consideration of your access to confidential information, you promise that

1. You will use confidential information only as needed to perform your legitimate duties as an employee/volunteer/student/board member. This means, among other things, that:
    A. You will only access confidential information for which you have a need to know, and
    B. You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized by Guardian Angel Hospice, Inc.
    C. You will not misuse confidential information or carelessly care for confidential information.
2. You will safeguard and will not disclose your access code or any other authorization you have that allows to access confidential information.
3. You accept responsibility for all activities undertaken using your access code and other authorization.
4. You will report activities by any individual or entity that you suspect may compromise the confidentiality of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
5. You understand that your obligations under this Agreement will continue after termination of your employment/ending of volunteering. You understand that your privileges hereunder are subject to periodic review, revision and if appropriate, renewal.
6. You understand that you have no right or ownership interest in any confidential information referred to in this Agreement. Guardian Angel Hospice, Inc. may at any time revoke your access code, other authorization or access to confidential information. At all times during your association with Guardian Angel Hospice, Inc., you will safeguard and retain the confidentiality of all confidential information.
7. You will be responsible for your misuse or wrongful disclosure of confidential information and for your failure to safeguard your access code or other authorization access to confidential information. You understand that your failure to comply with this Agreement may also result in your loss of employment and other legal liability.

_____ _____

Employee/Volunteer/Student/Board Member Signature Date

_____

Printed Name

NAME OF REFERENCE

Name: _____

Address: _____

_____ Phone #: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED ON THIS FORM

Applicant: _____ Date: _____

The above applicant has applied for employment with Guardian Angel Hospice and has authorized the release of information requested on this form. Please complete the bottom section and return it to us. All information is confidential. Thank you for your assistance.

Name: _____ Date: _____

Office Address/Phone: _____

_____

APPLICANT'S NAME: _____

Name used while employed: _____ SS#: _____

Position held: _____ Date started: _____

Date employment ended: _____ Reason for leaving: _____

Did worker give proper notice? Yes☐ No ☐ Would you rehire? Yes ☐ No ☐ If no, please explain:

_____

Please rate applicant on the following:

	Above Average	Average	Below Average	Knowledge
Appearance				
Attendance				
Cooperation				
Dependability				
Initiative				
Job Knowledge				
Relation with Others				
Quantity of Work				
Quality of Work				

Comments: _____

_____

Guardian Angel Hospice

As a prospective employee/volunteer of Guardian Angel Hospice, I understand that it is this Agency's policy to secure Conviction Only Criminal History Information as a part of their pre-employment screening process using the information provided below.
Information pertaining to race, color, creed, sex, or age will not be used as a determining factor in the employment process, but is used to secure criminal conviction information only.

NAME:_____
(LAST) (FIRST) (MIDDLE)

MAIDEN NAME/NAMES PREVIOUSLY USED: _____

BIRTHDATE: _____RACE: _____SEX: _____

SOCIAL SECURITY NUMBER: _____/_____/_____

DRIVER'S LICENSE NUMBER: _____

I UNDERSTAND THAT THE ABOVE INFORMATION IS REQUIRED BY THE CENTRAL RECORDS DIVISION OF THE STATE POLICE. I AUTHORIZE GUARDIAN ANGEL HOSPICE TO UTILIZE THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF OBTAINING A CONVICTION ONLY CRIMINAL HISTORY FILE SEARCH.

EMPLOYEE SIGNATURE: _____ DATE: _____

This form may be substituted by the State's approved consent form.

In the event that Guardian Angel Hospice is made aware of the fact that an employee has had a criminal conviction brought against them since their date of hire, the Administrator will determine if the offense may put the patient's safety, health, or well being at risk, Guardian Angel Hospice reserves the right to immediately suspend that employee until such time this information is verified. Upon positive criminal conviction verification, employment will be terminated.