

VOLUNTEER APPLICATION

PERSONAL INFORMATION

Name (Last, First, Middle Initial) _____

Street Address _____

City, State, Zip Code _____

Home Phone _____ Work or Cell Phone _____

Date of Birth _____ E-mail Address _____

Emergency Contact _____ Phone _____

Community, organization, or church affiliation (s) _____

EXPERIENCE RELATED INFORMATION

Highest level of education and/or training _____

List any education acquired you believe could be helpful to you at Access Carroll, Inc. For example: courses taken, on-the-job experience, office skills. _____

Type of volunteer work preferred **Area:** **Medical** **Dental** **Behavioral**

Clerical () Answer phones () Filing () Data entry () Other _____

Clinical () Licensed or Certified Professional () Retired Nurse () Other _____

Licensed or certified professional volunteers may require additional information for credentialing and privileging.

Physician _____ CRNP/PA-C _____ RN/LPN _____ CMA/CNA _____

Dentist _____ Hygienist _____ Dental Assistant _____ Other _____

Scope of practice of specialty _____

Why do you wish to volunteer at Access Carroll, Inc.? Give a few details about personal interests or hobbies.

Total number of hours per week you would be available to volunteer: _____ () Daytime () Evenings () Weekends
Days/times of your availability _____

WORK EXPERIENCE

Place of employment _____

Address _____

Phone _____ Supervisor _____

Describe position held _____

Dates of employment _____ Reason for leaving (if applicable) _____

REFERENCES (List names with complete addresses and telephone numbers – no relatives, please)

1. _____

2. _____

Have you ever been convicted of a crime? () No () Yes If yes, please provide details.

The following documentation is recommended for all volunteers serving in patient care areas:

- PPD Review or Screening
- Influenza Vaccination – documentation of receiving or a declination form may be submitted

A current copy of the following is preferred as applicable to those serving in specified clinical patient care areas:

- Measles and Varicella titer results or immunization records
- Hepatitis B titer or immunization records
- CPR certification

Signature _____

Date _____

Revised 2017-11

Employee/Volunteer Health

CLINICAL STAFF: Employees, in-kind staff and volunteers having direct patient contact are considered clinical staff.

NON CLINICAL STAFF: Employees, in-kind staff and volunteers not having direct patient contact are considered non-clinical staff.

The following documentation is required for clinical staff working in patient care areas:

- PPD Review or Screening
- Influenza Vaccination – documentation of receiving the influenza vaccination or a declination form may be submitted

A current copy of the following is preferred, but may be necessary per Job Description and as applicable for staff and volunteers serving in clinical patient care areas:

- Measles and Varicella titer results or immunization records
- Hepatitis B titer or immunization records
- CPR certification

Clinical Staff of Access Carroll, Inc. are required to have proof of a tuberculosis review or screening as deemed necessary through current guidelines of the Carroll County Health Department. A screening may be acquired through a private physician, other employer or at Access Carroll, as necessary.

Clinical Staff of Access Carroll, Inc. are required to provide documentation of an annual influenza vaccination or a declination form may be submitted. Influenza vaccinations are available through a private physician, community pharmacies, and at Access Carroll, as necessary.

For more information on the adult vaccinations, contact the Carroll County Health Department at 410-876-4936 or visit <http://www.carrollhealthdepartment.dhmh.md.gov/>.

BATHROOM – PLUMBING NOTICE

No one will be permitted to work, volunteer or function as a student at Access Carroll unless the following document is signed and a competency checklist is completed on bathroom usage and toilet paper replacement.

By signing this document, I acknowledge the following about usage of bathrooms at Access Carroll, Inc.:

1. At no time is anything other than body waste and toilet paper allowed to be flushed in the toilet.
2. Paper towels, tampons, feminine napkins, toileting cloths, and any other cleaning item is not permitted in the toilet, and must be disposed of in the trashcan.
3. Empty rolls of toilet paper must be replaced immediately. Additional rolls are located in the cabinet above the toilet and in the main supply closet.
4. If the cabinet is empty of toilet paper, restocking the toilet paper is required as noted in the orientation competency checklist.
5. The bathrooms are to be used with respect with everyone responsible for cleaning up after themselves.

I further understand that not following these simple but necessary rules will cause plumbing issues for Access Carroll that is both inconvenient and costly to repair.

I understand there are alternate bathroom options in the main foyer of the building.

Staff Member, Volunteer, or Student Signature

Date

PRINT NAME

Staff/Trainer Witness Signature

Date

CONFIDENTIALITY AGREEMENT

Access Carroll, Inc. is a non-profit organization providing integrated health services for residents of Carroll County, Maryland. Our patients are entitled to confidentiality in accordance with HIPAA's Protected Health Information or Electronic Protected Health Care Information. In order for our clinic to be effective, patients must feel they can seek treatment without jeopardizing their privacy.

I understand one of my responsibilities, as an employee/volunteer/student of Access Carroll, Inc., is to respect and maintain patient confidentiality. Staff, contractors and volunteers/students are expected to treat ALL data about a patient as confidential, understanding that approval to access and use such information (whether verbal, written, or electronic) is a privilege. Staff, contractors and volunteers/students are not to discuss or exchange information about patients, except for discussion or disclosures necessary or desirable to furnish or arrange health or social services for a patient – on a need to know basis. I understand that I may not seek patient information not required to perform my duties. I further understand that a violation of confidentiality is a serious disservice to the community and this organization.

I understand that I may be given the use of a computer workstation including the use of internet, electronic health record, or internal e-mail or internet access enabling me to seek patient information. I will exercise this privilege in accordance with the policies and procedures of Access Carroll, Inc. I understand there is no expectation of privacy with respect to e-mail and all access in any form is granted only to support the business purposes of Access Carroll, Inc.

I have read and understand the statements above. I have read, understand, and received a copy of Access Carroll's policies and procedures on confidentiality. I recognize that sharing any of the information I see, hear or read while performing my duties associated with Access Carroll, Inc. is prohibited. I also understand any breach of confidentiality is a serious offense and subject to disciplinary action, possibly resulting in termination as an employee/volunteer/student at Access Carroll, Inc.

Employee Signature _____ Date _____

Employee Printed Name _____

Volunteer/Student Signature _____ Date _____

Volunteer/Student Printed Name _____

Parent/Guardian Signature (for Volunteer/Student under age 18) _____

Parent/Guardian Printed Name _____ Date _____

Witness Signature _____ Date _____

CONFLICTS OF INTEREST ACKNOWLEDGMENT AND DISCLOSURE

All Access Carroll Associates (Board Members, Committee Members, Staff, Volunteers, Students, and Contractual Service Providers) shall scrupulously avoid any conflict between their own respective personal, professional, or business interests and the interests of Access Carroll, in any and all actions taken by them on behalf of Access Carroll in their respective capacities.

In the event any Access Carroll Associate shall have direct or indirect financial interest in, or relationship with, any individual or organization which proposes to enter into any transaction with Access Carroll, including, but not limited to transactions involving:

- The sale, purchase, lease or rental of any property or other asset.
- Employment or rendition of services, personal or otherwise.
- The award of any grant, contract, or subcontract.
- The investment or deposit of any Access Carroll funds.

An individual with an interest or relationship as described above shall give notice of the conflict of interest to the Executive Director for review and action by the Access Carroll Board of Directors, prior to final approval.

Gifts of entertainment from vendors should be limited to common business courtesies which may include an occasional lunch, dinner, or gift of limited value. Monetary gifts/favors in an attempt to gain an unfair financial and/or personal advantage are strictly prohibited. Business courtesies that would influence or appear to influence an Access Carroll Associate in the conduct of their duties must be declined.

GLOSSARY/DEFINITIONS:

- **Access Carroll Associate** - Board Member, Committee Member, Staff Member, Volunteer, Student, or Contractual Service Provider
- **Unusual Gain** – Business dealings with outside entities that result in an unfair advantage for those entities, Access Carroll, or an Access Carroll Associate. Unusual gain refers to bribes, product bonuses, special fringe benefits, unusual price breaks, and other windfalls designed to ultimately benefit Access Carroll and/or its Associates.
- **Conflict of Interest** – Any situation in which financial or other personal considerations may compromise or appear to compromise.
 - Access Carroll Associate's business judgement
 - Delivery of care, treatment, or services to the individual served
 - Ability for a Access Carroll Associate to do his or her job
 - Access Carroll Associates listed on the Office of the Inspector General Exclusions Database may be deemed a conflict of interest
 - Secondary Employment may be deemed a conflict of interest
 - An Associate starts a company that provides similar services to similar clients as those of Access Carroll

- A member of the board of directors accepts fees and provides advice to a company that is in direct competition with Access Carroll.
- ETC.

An actual or potential conflict of interest occurs when an Access Carroll Associate is in a position to influence a decision that may result in a personal gain or that Staff Member or a relative as a result of business dealings.

I have read this document and agree to comply fully with its terms and conditions at all times during my service at Access Carroll. If at any time following the submission of this form I become aware of any actual or potential conflicts of interest, or if the information provided below becomes inaccurate or incomplete, I will promptly notify Access Carroll.

Disclosure of Actual or Potential Conflicts of Interest:

Access Carroll Associate Signature

Date

Access Carroll Associate Printed Name



**Authorization to Procure a Consumer Report
And/Or Investigative Consumer Report
Under the Fair Credit Reporting Act**

In connection with my application for employment with Access Carroll, Inc., I understand that a consumer report, or an investigative consumer report, may be obtained by Carroll Hospital Center for Access Carroll, Inc. from a consumer reporting agency. A “consumer report” may contain information bearing on my character, general reputation, personal characteristics, mode of living, credit worthiness, credit standing or credit capacity. An “investigative consumer report” is a consumer report which includes information obtained through personal interviews with my neighbors, friends, or associates, or with others with whom I am acquainted or who may have knowledge concerning any such items of information.

I further understand that Carroll Hospital Center for Access Carroll, Inc. may not request a consumer report or an investigative consumer report from a consumer reporting agency, nor may the agency give out information about me, without my prior written consent. It is also understood that the agency may not report medical information about me to Carroll Hospital Center for Access Carroll, Inc. without my specific prior consent as to the release of such information, which is in addition to my general authorization herein.

I hereby authorize Carroll Hospital Center for Access Carroll, Inc. to order a consumer report or an investigative consumer report containing information about me from a consumer reporting agency as part of Carroll Hospital Center’s investigation into my application for employment at Access Carroll, Inc. or at any time while I am employed by Access Carroll, Inc. This authorization does not include the release of my medical information.

PLEASE PRINT:

Name: (Mr., Mrs., Miss) First	SS#:
Middle	Phone #:
Last	Drivers License # & State:
Maiden or Other	Birthdate:
Current Address: Box# and Street	Years at this address:
City, State, Zip	County of residence:
Previous Address: Box# and Street	Years at this address:
City, State, Zip	County of previous residence:
Previous Address: Box# and Street	Years at this address:
City, State, Zip	County of previous residence:

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE DISCLOSURE STATEMENT AND HAVE UNDERSTOOD IT.

SIGNATURE: _____

DATE: _____

*This report will only be requested after a contingent offer of employment has been made. Additional information will also be obtained from you at that time which is necessary for proper identification.

DECLINATION OF INFLUENZA VACCINATION

My employer or affiliated health facility, Access Carroll, has recommended that I receive influenza vaccination to protect myself and the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact including
 - All patients in this healthcare facility
 - My coworkers
 - My family
 - My community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

- Medical Exception _____
- Religious Accommodation _____
- Other _____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Emergency Call Tree Information Form



All staff shall receive instruction from their manager in planning for an emergency or disaster. An Emergency Call Tree is maintained for communication. Please provide your information to your Manager ASAP.

Your Name:

Today's Date:

Your Manager:

Your Office Telephone Number:

Your Home Telephone Number:

Your Mobile Telephone Number:

Your Home Email Address:

Your Emergency Contact Person's Name:

Your Emergency Contact Person's Phone Number:

Managers: Provide this document to the Compliance Specialist to update changes to the Call Tree as needed.

STAFF AGREEMENT TO OBTAIN IMMUNIZATION RECORDS

Staff Name: _____

Date of Birth: _____

I, _____ **Do** give Access Carroll, Inc. permission to obtain my personal vaccination record history from “ImmuNet” (Maryland Immunization Information System) Department of Health records.

I, _____ **DO NOT** give permission to Access Carroll, Inc. to obtain my personal vaccination record history from “ImmuNet” (Maryland Immunization System) Department of Health records. However; I do acknowledge I will provide vaccination records to Access Carroll, Inc. within 5 days of starting.

I understand these records **will not** be shared with anyone and will only be for my personnel file only.

Staff Signature

Date

Witness Signature

Date

Signature of Administrator
(after obtaining records for Staff File only)

Date

Records obtained _____ Yes _____ No



10 Distillery Drive, Suite 200
Westminster, MD 21157
410-871-1478
www.accesscarroll.org

PHOTO CONSENT AND RELEASE FORM

PHOTOGRAPHY CONSENT FORM / RELEASE

I, (print name) _____, hereby grant permission to Access Carroll, Inc. representatives, to take and use: photographs and/or digital images of me for use in news releases and/or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Access Carroll, Inc.

(Date)

(Signature of adult subject)

(Address)

(City, State, Zip)

RELEASE FOR MINOR CHILDREN (Under 18)

I, (print name) _____, parent or official guardian of (child's name) _____ hereby grant permission to Access Carroll, Inc. representatives, to take and use: photographs and/or digital images of **my child** for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child's name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Access Carroll, Inc.

(Date)

(Signature of Parent or Guardian)

(Address)

(City, State, Zip)

Tuberculosis Risk Assessment

Personnel/Patient Name: _____ Date: _____

Person completing Assessment (if different from above): _____

Persons with any of the following risk factors are candidates for tuberculin (PPD) testing, unless there is written documentation of a previous positive tuberculin skin testing (TST) or Quantiferon TB testing (QFT). If the answer to all questions is “NO,” testing is not recommended.

RISK FACTOR	YES	NO
TB Symptoms: <ul style="list-style-type: none"> • Unexplained fever for more than 1 week • Unexplained weight loss • Unexplained night sweats • Persistent cough for more than 3 weeks • Productive cough with bloody sputum 		
Recent close or prolonged contact with someone with infectious TB disease		
Foreign-born person from high-prevalence area who has lived in the US for < 5 years		
HIV infection/AIDS/Injection drug use		
Immunosuppression secondary to use of prednisone or other immunosuppressive medications (i.e. chemotherapy or anti-rejection drugs)		
Resident, employee, or volunteer of high-risk congregate setting (i.e. prison, hospital, nursing home, homeless shelter)		
Medical conditions associated with risk of progressing to TB disease if infected (i.e. Diabetes, Cancer of head/neck, Hodgkin’s disease, Intestinal bypass or gastrectomy, Chronic malabsorption syndrome)		
For children only: Travel to a high-incidence country for more than a year, or resides with an individual at high-risk for TB (i.e. from high-incidence country, HIV –infected, or employed at a high-risk setting)		
Personnel/Patient		
Signature: _____		Date: _____
TB Testing Recommended:		
Screening Nurse/Provider		
Signature: _____ Date: _____		

Sworn Statement Regarding Criminal Activity

The Maryland Department of Health and Mental Hygiene requires that employees working for behavioral health organizations provide a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside of the State of Maryland.

- This is my sworn statement that I have never been convicted of any criminal charge and I am NOT subject to any pending charges for any criminal offense within or outside of the State of Maryland.
- This is my sworn statement that I have been convicted or I have pending the following criminal charges:

Date of Offense	Description of Offense	Disposition	Disposition Date

Authorization:

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if I am employed any falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references and employers listed to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information. I also understand and agree that no representation of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative. I also understand that Access Carroll, Inc. may request a pre-employment, random, and for cause drug screening and that I must pass this screening to be eligible for employment. *Note: This form is also required as part of the Annual Review.*

Printed Name

Signature

Date

Witness Signature

Date