

Thank you for your interest in Volunteering!

At Monadnock Community Hospital, we are grateful for our dedicated team of volunteers who serve in departments throughout the organization. We are delighted that you are interested in joining!

We ask for an initial commitment of at least six months service for most tasks, to give you the chance to become familiar with the daily routine of the hospital and the departments you'll serve.

Please read the following information carefully. Typically, volunteers can expect to begin within 4-5 weeks to allow for required background checks and training.

Step 1. To begin, please complete our:

- **Volunteer Application:** This form provides the necessary contact and background information to help us find the most appropriate support role.

Step 2. Next, call Toni Gildone at 603.924.4699 ext. 4190 to schedule an appointment to meet and go over the:

- **Service/Confidentiality Agreement:** Applicants are required to read and sign this form covering general liabilities.
- **Criminal Background Check:** This form is required by the State of NH for all employees and volunteers. Results typically take 2-3 weeks from the State and are required before applicants can begin serving.
- **PPD Test:** This blood test for tuberculosis is administered in Occupational Health is mandated for all employees and volunteers. We will schedule together after reviewing your volunteer application.
- **Volunteer Badge and Parking Permit:** This photo ID is issued in our Security Office and requires an appointment. We'll help you schedule it.

Step 3. Meet with a Department Representative:

- Then be paired with an experienced volunteer who'll assist in your training and orientation.

Please Note: within 60 days of beginning, we'll ask you to attend MCH's Orientation. This 4 hour (½ day) orientation covers MCH's policies/procedures, mission, vision and values.

QUESTIONS? Call Toni Gildone, Volunteer Coordinator, at 603.924.4699 ext. 4190
or email Toni.Gildone@mchmail.org

Toni's office is located in the Window Shop. Please stop by anytime & I am always available by phone.

I look forward to working with you!

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO (PLEASE CIRCLE)

ADDITIONAL COMMENTS _____

Please choose your preferred contact method for mailings, newsletters, and updates:

☐ Email ☐ Mail

Do you give permission for the Volunteer Coordinator to include your birthday (no year) and/or photo in the monthly newsletter and other marketing collateral for the hospital?

☐ Yes ☐ No

SIGNATURE

DATE

*** You must provide emergency contact information to enroll as an MCH Volunteer.**

Updated 08/6/2018

Reference: CMS C-0309, C-0310
Distribution: Hospitalwide
Attachments: Confidentiality Agreement

Effective: 02/2011
Replaces: 04/2003

CONFIDENTIALITY POLICY

Policy:

In order to ensure the privacy of patients, Monadnock Community Hospital is committed to protecting the confidentiality and privacy of those who seek services. Employees, medical staff, contractors, vendors, volunteers, and Board members are charged with maintaining the confidentiality and privacy of all patients.

Purpose:

To outline the responsibility of members of the workforce, including employees, volunteers, members of the medical staff, contractors, vendors and trustees, in maintaining the privacy and confidentiality of sensitive information.

Definitions:

Members of the Workforce: Any employee, contractor, vendor, volunteer, and member of the medical staff or trustee who has access to information regarding MCH, its operations or its patients.

Confidential Information includes any written or spoken information shared in confidence between patient and healthcare provider.

Procedure:

- 1) All members of the workforce shall consider all hospital and patient information as private and confidential and will utilize it only for purposes of carrying out the duties of their respective roles within the organization.
 - 2) Each member of the workforce shall only utilize the minimum amount of information necessary to perform the duties/responsibilities of his/her role within the organization;
 - 3) Information shall be disclosed only as outlined in the HIPAA Disclosure policies and procedures, which are found in the Administrative Manual;
 - 4) Care must be taken to avoid accidental or inadvertent disclosure of information to those who have no reason to possess that information;
 - 5) The unauthorized use, possession, copying, reading, disclosing, transmitting or selling of any information of a confidential or personal nature about patients, members of the workforce or Hospital operations to unauthorized individuals is a serious breach of Hospital policies, and is a cause for disciplinary action, up to and including discharge.
 - 6) Failure to report suspected violations to a supervisor, administrator or Privacy Officer shall also subject a member of the workforce to disciplinary action.
 - 7) Each member of the workforce shall be provided with a copy of the Confidentiality Policy, and will sign a Confidentiality Agreement upon joining the organization (through hire, by contract, by admission to the medical staff, by accepting a position with the Board of Trustees, or when volunteering, as appropriate).
 - 8) Each member of the workforce, except for medical staff shall, on an annual basis, re-sign a Confidentiality Agreement. Medical staff shall re-sign a Confidentiality Agreement at time of reappointment. Department Managers shall be responsible for obtaining Confidentiality Agreements from vendors/contractors.
 - 9) Signed documents for employees will be sent to Human Resources to keep in the employee personnel file. Volunteer documents will be kept with the Volunteer Coordinator. Trustee documents will be filed in Administration. Medical staff documents will be filed with Credentialing files. Vendor documents will be filed with Infection Control/Safety.
 - 10) Any member of the workforce who refuses to sign the Confidentiality Agreement shall be discharged from his/her position.
 - 11) The requirements to maintain confidentiality, as defined in this policy, shall be maintained by members of the workforce throughout his/her time with the Organization, and after departure from the Organization, whether voluntary or involuntary.
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CONFIDENTIALITY AGREEMENT

I understand that as an employee, member of the medical staff, Board member or non-employed patient care provider or support personnel (volunteer, intern, vendor, student, contractor, EMS personnel, etc.) at Monadnock Community Hospital, I may have access to or become aware of confidential information such as patient healthcare or financial information (defined under HIPAA as “protected health information”), physician performance and personnel information, business information of Monadnock Community Hospital including know-how, trade secrets, plans, designs, processes, discoveries, interventions and ideas, photographs, marketing data and plans, financial information, supply information and any other technical or business information, employee personnel information, and other sensitive information (collectively MCH confidential Information). By signing below, I agree to the following:

1. I understand that my access to and use of MCH confidential Information in verbal, written, and/or electronically stored form is a privilege. Access to such information is granted to me only on a “need to know” basis to allow me to carry out my job responsibilities as an employee, medical staff member, non-MCH patient care provider or support personnel. I understand that patient information may only be used for research purposes when authorized by the appropriate institutional review board or for teaching purposes in compliance with MCH Policies and Procedures.
2. I agree to take appropriate action to maintain the confidentiality of MCH Confidential Information, including but not limited to:
 - Not leaving hardcopy patient records, computers, computer printers, fax machines, or copy machines containing MCH Confidential Information unattended unless properly secured;
 - Not providing MCH Confidential Information to unauthorized persons by any means whatsoever including but not limited to postings to social media such as e-mail, Facebook, Twitter, or personal blogs, and not capturing such information with personal cell phones, I-phones, cameras, or other recording devices;
 - Not disclosing to unauthorized persons verbally any information gathered from printed material, electronic data, observed incidents or overheard conversation; and
 - Following the MCH document destruction policy for any MCH Confidential Information that is not being retained on file.
3. I understand that I must not access, view, or copy any MCH Confidential Information that is not necessary for me to do my job, including but not limited to the protected health information of patients for whom I do not have responsibility or who are not directly related to my job responsibilities, my own protected health information, or the protected health information of my family members and friends. I understand that in accordance with MCH’s Information Security Plan, an audit trail of my access to electronically stored information may be viewed by MCH.
4. I understand I may only use or disclose the minimum MCH confidential Information necessary to perform the identified task.
5. I understand that I am granted a computer login, password and/or physical token devices such as a plastic key card or identification badge (collectively “Account”), that I will not allow another person to use my account, or use another person’s account. I will notify my department leader, the Privacy Officer, or the Information Security Officer should my account be compromised in any way, another person requests my account, or if my account is lost or stolen. I will reimburse MCH, if requested, if any lost token device is not recovered. If I am provided with traditional key(s) to any part of the MCH facility, I will only allow another person to use my traditional keys if I know for certain that the person has the same level of key access to the area in the MCH facility in question.

6. I understand that the obligations imposed by the Confidentiality Agreement remain even after I leave my employment or terminate my affiliation with MCH. I agree to return/no longer use (as appropriate) all MCH Confidential Information in my custody or control, my ID badge, any Passwords, voice message access codes and any traditional keys issued to me upon leaving the MCH workforce, or when my contract/assignment has been completed.
7. I agree to report any breach or suspected breach of this Confidentiality Agreement by myself or confidentiality breaches by others to my department leader, the Privacy Officer or the Compliance Officer.
8. I understand that **violation of this Confidentiality Agreement** will result in:
 - **For Physicians:** disciplinary action up to and including dismissal from the Medical Staff;
 - **For Employees:** disciplinary actions under the guidelines in the MCH Human Resources Policies and Procedures;
 - **For Non-physician, Non-Employees;** disciplinary actions up to and including immediate termination of your relationship with MCH.
9. **In addition, I understand that violation of the Confidentiality Agreement** may result in possible legal action, fines or criminal prosecution against me and any organization that I represent. I acknowledge that irreparable injury may result from any breach of this Agreement by me, and money damages and other legal remedies may be inadequate to fully compensate MCH or remedy the injury. Accordingly, in the event of a breach of this Agreement, MCH shall be entitled but not limited to equitable relief, including injunctions and specific performance. I understand that the failure of MCH at any time to enforce any provision of this Agreement against me or any other person shall not affect its right to later insist upon performance of that provision by me. I agree that any waiver by MCH of any breach of this Agreement shall not be construed as a waiver of any continuing or succeeding breach, or of any right under this Agreement. If MCH prevails in an action against me to enforce the terms of this Agreement, I understand that I will be liable to pay its costs associated with the action including its attorneys' fees.

Name (printed)

Signature

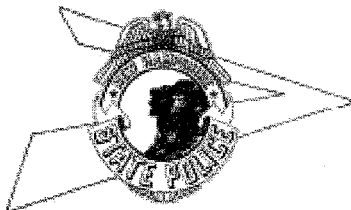
Department

Date

CRIMINAL RECORD RELEASE AUTHORIZATION FORM

Signed under penalty of unsworn falsification pursuant to NH RSA 641:3

NOTE: A \$25.00 fee is required for each request- make checks payable to: State of NH – Criminal Records.



New Hampshire Department of Safety
DIVISION OF STATE POLICE
Central Repository for Criminal Records
33 Hazen Drive, Concord, NH 03305

REDUCED FEE REQUEST FORM

SECTION 5703.07 **Fee Exemption** of the Rules and Regulations for the Operation of the Central Repository: (d) Volunteers for public or private not-for-profit agencies that provide services to the elderly, the disabled or children shall be charged \$10.00 for each criminal record check requested.

PLEASE PRINT OR TYPE CLEARLY

NAME Monadnock Community Hospital
ORGANIZATION OR AGENCY

ADDRESS 452 Old Street Rd Peterborough NH 03458
STREET CITY STATE ZIP CODE

TELEPHONE NUMBER (603) 924-7191 FAX NUMBER (603) 924-9727

IS AGENCY OR ORGANIZATION NON-PROFIT? YES X NO

IS THE REQUESTED PERSON(S) A VOLUNTEER? YES X NO

WILL THE SERVICES BE TO THE ELDERLY, THE
DISABLED, OR CHILDREN? YES X NO

The identity of the volunteer for whom this reduced fee is requested:

NAME OF VOLUNTEER (please print) _____ who will be working with:
☒ Elderly
☒ Disabled
☒ Children

THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Authorized Signature *[Signature]* Date _____
FOR THE AGENCY OR ORGANIZATION
Signed under penalty of unsworn falsification pursuant to RSA 641:3

NOTE: This form *must* be accompanied by a completed Criminal Record Release Authorization Form.

Effective 1/01/2009



Volunteer Badge/Parking Registration

Name		
Street Address		
City		
Zip Code		
Telephone #	Home: _____ Cell: _____	
Department:	Volunteers	
Job Title:	Volunteer	
Hire Date:		
License Plate #:		State:
License Plate #:		State:
License Plate #:		State:

Emergency Contact:	Name : _____ Phone # : Home/Work: _____ Cell: _____
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Badge #:		Photo #:
Payroll Notified By:		Date: