Monadnock
COMMUNITY HOSPITAL
Your life. Your health. Your Hospital.

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!

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MCH Volunteer Application

Name: _____ Date of Birth_____

Home/ Cell Phone:_____ E-mail Address:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact* _____
Name *Relationship* *Phone*

Business/Life Experience: _____

_____

Prior Volunteer Experience: _____

_____

Personal Reference: _____ Phone Number:_____

How Did You Become Interested In Our Volunteer Program? _____

_____

Interest/Skills: _____

_____

Areas Of Volunteer Service Interest: _____

_____

Please complete back side

Availability – Please Circle All Available Days And Times

Sun	Mon	Tue	Wed	Thu	Fri	Sat
a.m.	a.m.	a.m.	a.m.	a.m.	a.m.	a.m.
p.m.	p.m.	p.m.	p.m.	p.m.	p.m.	p.m.
eve	eve	eve	eve	eve	eve	eve

When Can You Start? _____

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 08/06/2018

Authorized Use Only			
Check list	**Date**	**Check list**	**Date**
Criminal background check		Hospital Orientation	
Confidentiality statement		Handbook/meals	
Flu shot		PPD (TB Test)	
ID badge Number:			

Status **Active** PolicyStat ID **12776655**

Origination	02/2011
Last Approved	12/2022
Effective	12/2022
Last Revised	12/2022
Next Review	12/2025
Owner	Molly Rajaniemi: Patient Experience Coordinator
Area	HIPAA
Keywords	Administrative

Confidentiality

Policy:

In order to ensure the privacy of patients, Monadnock Community Hospital (MCH) 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, review the 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.

Reference:

CMS C-0309. C-0310

45 CFR 160 & 164

All Revision Dates

12/2022, 02/2011

Attachments

Confidentiality Agreement

Approval Signatures

Step Description	Approver	Date
CEO Review and Approval	Cynthia McGuire: Chief Executive Officer	12/2022
Compliance Review and Approval	Denise Lord: Dir. Organizational Perf	12/2022
By approving this step, I certify that the policy has had Legal Review and has been Approved by MCH's Legal Representative	Denise Lord: Dir. Organizational Perf	12/2022
Policy Owner Approval	Molly Rajaniemi: Patient Experience Coordinator	12/2022

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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, smart 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 if 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 relationships 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 financial 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

State of New Hampshire

□epartment of Safety
DIVISION OF STATE POLICE

Criminal Records Unit
33 Hazen Drive, Concord, NH 03305

CRIMINAL HISTORY RECORD INFORMATION RELEASE AUTHORIZATION FORM

INSTRUCTIONS

NH RSA 1064:14 and Administrative Rule Saf-C 5700 authorizes the dissemination of NH Criminal History Record Information (CHRI) for non-criminal justice purposes. In NH, all CHRI is confidential and released only upon the knowledge and permission of the individual of whom the request is made. Individuals requesting their own record In person need only complete Section I. If the CHRI Is to be released to a third party, both Section I and Section II must be completed. All requests by mail must have both sections completed and Section II notarized, (not required).

SECTION I (PLEASE PRINT CLEARLY)

Last Name_____ **First Name**_____ **Maiden**_____ **MI**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Hair Color**_____ **Eye Color**_____ **Male** ☐ **Female** ☐

Driver's License Number_____ **State**_____

My signature below signifies I am the individual listed above and the information provided is true.

Signature_____ **Date**_____
Signed under penalty of unsworn falsification pursuant to RSA 641:13

PURPOSE OF RECORD

☐ **Housing** ☐ **Employment** ☐ **Annulment/Expungement** ☐ **Other**_____

SECTION II

I hereby authorize the release of my criminal record conviction(s), if any, to the following:

Person or Entity to Receive Record Toni Gildone @ Monadnock Community Hospital

Address 452 Old Street Road **City** Peterborough **State** NH **Zip** 03458

Your Signature_____ **Date**_____

Notary's Signature(not required)_____ **Date**_____
(Affix seal)

Signature of person/entity to receive record _____ **Date**_____

RECORD CHALLENGE

Saf-C 5703.12 Procedure for Correcting a CHRI (a) Persons or their attorneys desiring access to their CHRI for the purpose of challenge or correction shall appear at the central repository. (b) A copy shall be provided to a person if after review he/she indicates he/she needs the copy to pursue the challenge. (c) Any person making a challenge shall identify that portion of his/her CHRI which he/she believes to be inaccurate or incorrect, and shall also give a correct version of his/her record with an explanation of the reason that he/she believes his/her version to be correct. (d) The Director shall take the following actions within 30 days of receipt of challenge: (1) Review the records and contact the law enforcement agency or court which submitted the record to compare the information to determine whether the challenge is valid; (2) If the challenge is valid, which means there is a discrepancy between the information submitted and the information maintained by the law enforcement agency or court, the record shall be corrected and the person and appropriate CJAs shall be notified; and (3) If the challenge is invalid, the person shall be informed and advised of the right to appeal pursuant to RSA 541. (e) When a record has been corrected, the division shall notify all non-criminal justice agencies, to whom the data has been disseminated in the last year, of the correction. (f) The person shall be entitled to review the information that records the facts, dates, and results of each formal stage of the criminal justice process through which he passes, to ensure that all such steps are completely and accurately recorded.

WARNING: The Division of State Police is the Criminal Record Repository for the State of New Hampshire. The record you have received is based only on what has been reported to the Repository and may not be a complete Criminal History Record of the named individual.

☐ **To prevent a delay in processing, I have enclosed a self-addressed envelope.**

☐ **Prepaid Acc't Number**_____ 810018132 _____

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 Road (STREET) Peterborough (CITY) NH (STATE) 03458 (ZIP CODE)

TELEPHONE NUMBER 603-924-7191 **FAX NUMBER** 603-924-9727

IIS AGENCY OR ORGANIZATION NONPROFIT?	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:

- [X] Elderly
- [X] Disabled
- [X] Children

THE ABOVE INFORMATION IS ACCURATE AND TRUE:

Authorized Signature _____ **Date** _____
FOR THE AGENCY OR ORGANIZATION
Signed under penalty of unsworn falsification pursuant to RSA 61

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

Effective 1/01/2009

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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:	

Badge#:		Photo #:	
Payroll Notified By:		Date:	