WCA HOSPITAL
207 Foote Avenue - P.O. Box 840
Jamestown, New York 14702-0840
(716) 487-0141

Volunteer Application Form

For Office Use Only Volunteer Assignment

- ☐ Red Cross
- ☐ RSVP
- ☐ Community Service
- ☐ Short-Term
- ☐ Student
- ☐ Other

PERSONAL DATA *a little bit about yourself . . .* ADULT ☐ STUDENT ☐

Name: _____ Date: _____
Last First Middle Initial

Address: _____

Telephone # ( ) _____ E-mail Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate _____ Social Security # _____

Do you have any friends, relatives, acquaintances employed by or volunteering at WCA Hospital? :
☐ Yes ☐ No If **yes**, please list:

1. _____ 2. _____ 3. _____

IF YOU ARE AGE 14 THROUGH 17, YOU WILL NEED CURRENT WORKING PAPERS.
(WORKING PAPERS MAY BE OBTAINED FROM YOUR SCHOOL GUIDANCE COUNSELOR)

EDUCATION

	Name & Location	Major	Dates Attended	Degree Obtained
High School				
College				
Other				

SPECIAL SKILLS OR PROFESSIONAL MEMBERSHIP/ORGANIZATIONS

Have you ever volunteered at WCA? ☐ Yes ☐ No When? _____ Area? _____

Give a brief statement as to why you want to join our Volunteer Program:

_____

_____

_____

EMERGENCY NOTIFICATION

Name: _____ Relationship: _____

Address: _____

Telephone: Home: ( ) _____Cell: ( )_____

Do you have any physical limitations that would affect your area of volunteer service? ☐ Yes ☐ No
If yes, explain:

_____

Have you ever been convicted of a crime: ☐ Yes ☐ No If yes, please describe in full:

_____

In submitting this application, I understand that I will fulfill the requirements and policies for volunteers and I will respect all information as confidential. I understand that The New York State Hospital Code requires that hospital volunteers complete a medical examination if there is patient interaction. I further understand that WCA Hospital is a “tobacco free” facility and such, tobacco use is prohibited by patients, visitors, employees, volunteers, and physicians throughout the premises of the hospital. I hereby authorize WCA Hospital to investigate my reference records and make any further investigations deemed necessary in connection with my application to volunteer. I hereby release WCA Hospital and all informants from all liability resulting from any investigation. I waive all rights to see or review the information so furnished. WCA Volunteer Services is committed to work force diversity and does not discriminate against qualified persons on the basis of race, color, religion, sex, national origin, age, disability, veteran status or other factors identified and protected by federal, state or local legislation. This application will be active for one year, after that time a new application or resume may be required for future consideration.

VOLUNTEER ORIENTATION (office)

Date

- ☐ 1. Mission of WCA Hospital _____
- ☐ 2. Volunteer Name Badge/Uniform _____
- ☐ 3. Volunteer Dress Code _____
- ☐ 4. Hour Sheet _____
- ☐ 5. Call-ins _____
- ☐ 6. Problems & Concerns _____.
- ☐ 7. Volunteer Resignation Notice _____

VOLUNTEER CHECKLIST

Name: _____ Date: _____

Service Area Assignment: _____ Date Assigned: _____

Date

- ☐ 1. Application Completed _____
- ☐ 2. Interviewed _____
- ☐ 3. Parent Permission Signed _____
- ☐ 4. References Checked _____
- ☐ 5. Working Papers (Jr. Volunteer only) _____
- ☐ 6. Physical (if applicable) _____
- ☐ 7. Orientation Date _____
- ☐ 8. Confidentiality Statement Signed _____
- ☐ 9. Service Area Identified/Notified _____
- ☐ 11. Uniform _____
- ☐ 12. Computer Set-Up _____

Signature of Volunteer Applicant_____ Date: _____

Volunteer Coordinator: _____ Date: _____

(DF-9/13) INT1530

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WCA HOSPITAL
207 FOOTE AVENUE

JONES MEMORIAL HEALTH CENTER
51 GLASGOW AVENUE

CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as an employee of WCA Hospital, that I must hold all patient-related and privileged information confidential. (Policy A-56 Privacy and Confidentiality). This information includes, but is not limited to, all individually identifiable patient health information, quality assurance and utilization review information, strategic planning, as well as access codes, log-in IDs, passwords to WCA's computer and electronic communication systems (electronic mail, voice mail, internet, intranet, and telephone communications-including cellular phones and pagers). I understand that information stored on any of these computer or electronic communication devices is the property of WCA and that WCA reserves the right to monitor my use of such systems to ensure that ethical business practices and confidentiality are upheld (Administrative Policy A-98 Electronic Communications.)

I understand that I am not to discuss or reveal any confidential information without permission from my supervisor or any individual authorized by WCA. My supervisor may grant me permission to access/disclose confidential information, to be used only for WCA business or healthcare operations

I agree to follow Policy A-205, Minimum Necessary Access to PHI, which states that I will not access any privileged information that is not necessary to perform my job. The information which I have access to is outlined by the assigned access privileges.

I will not discuss confidential and privileged information with anyone except in direct connection with the performance of my job. I understand that when it is permissible to discuss this information, it will be done in a private area. It is not acceptable to discuss confidential information in areas where the conversation can be heard by individuals not involved in the care of the patient (i.e. hallways, elevators, cafeteria or other public areas).

I understand that I am required to follow Policy A-215, Patient Right to Access PHI, to access the medical information regarding my family, friends, or myself. Requests will be directed to Health Information Management for processing.

I agree to not copy or reproduce, or permit any other person to copy or reproduce, in whole or in part, any confidential information other than in the regular course of the services I am authorized and requested to perform for the facility.

I agree to report immediately to my immediate supervisor, any unauthorized use, duplication, disclosure, and/or dissemination of confidential information by any person, including myself.

I understand that any violation of this confidentiality statement may result in the immediate discharge of my employment.

_____

(Printed employee name) (Signature) (Date)

_____

(Printed supervisor name) (Supervisor signature) (Date)