HSHS
St. Elizabeth's
Hospital

Volunteer Services Department
One St. Elizabeth's Blvd.
O'Fallon, Illinois 62269
618-234-2120 ext. 11280

DEAR PERSPECTIVE VOLUNTEER/INTERN,

Thank you for your interest in our volunteer program. Volunteering in a hospital is a very rewarding experience. In addition to the satisfaction you receive from helping others, you also provide valuable assistance to the patients and staff. Remember not all volunteer assignments involve direct contact with the patients yet each and every assignment is important to the overall functioning of the hospital.

To be a volunteer you must:

1. Be physically capable of doing volunteer work. If you have any physical limitations, please inform Volunteer Services so that your volunteer assignment will be kept within your abilities
2. Be responsible for purchasing/renting and maintaining a volunteer uniform vest in adherence to the Volunteer Department's dress code (a refundable deposit is required to rent the volunteer uniform vest) The uniform vest as well as a volunteer badge must be worn while volunteering
3. Be responsible for providing your own transportation
4. Attend the appropriate initial orientation and training sessions as well as any additional training that may be required as a volunteer
5. Complete the application containing your signature

Volunteer orientations are held on a regular basis, and are informational and educational in nature. It is mandatory that you attend an orientation and receive the proper training before you are eligible for placement. Please complete the attached application and mail it back to the hospital. Once your application has been received an interview will be set up with People Services.
Thank you once again. I look forward to meeting you.

Sincerely,

Donna Meyers
Director Mission Integration/Volunteers
St. Elizabeth's Hospital

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VOLUNTEER/INTERN APPLICATION

Please Print

Date_____

Name_____
Last First Middle

Home Address_____
Street City State/Zip Code

Home Phone_____ Cell Phone _____

E-mail Address_____

Social Security Number_____ Birth Date_____

Marital Status_____ Male____ Female____

Employment Status:

Employed____ Unemployed____ Re red____ Homemaker____

In an emergency, Contact:_____
Name Phone Number

Educa onal Background:

	Name of School	Specialty/Major	Degree/License
High School	_____	_____	_____
College	_____	_____	_____
Bus./Voc.	_____	_____	_____

Do you have previous experience as a Volunteer? Yes____ No____

Where? _____

Please list the names and addresses of two people we can contact to submit a personal/ confiden al reference for you:

Name _____

Address _____

City, State, Zip Code _____

Name _____

Address _____

City, State, Zip Code _____

Please give careful considera on to your schedule before comple ng this sec on. Volunteer assignments are primarily on a weekday basis.

Please list your three choices in order of preference:

	DAY	TIME
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

Comments:

_____

_____

Hobbies, Interests, Training, Previous Hospital Work:_____

_____

_____

Community affilia ons (Church, Clubs, etc.):_____

_____

_____

How did you hear of our Volunteer Program?_____

_____

Why do you want to be a Volunteer at St. Elizabeth's Hospital?_____

_____

_____

Name and phone number of family physician:_____

_____

Have you ever been convicted of a crime? Yes____ No____

This above ques on must be answered 'YES' if you have ever been convicted of, found guilty of, or pleaded guilty to any crime of any kind. This includes convic ons as a juvenile, traffic offense, court supervision or proba on, or convic ons that are dismissed a er comple ng court supervision or proba on. Failure to list any criminal convic on may result in termina on if volunteering or ineligibility to volunteer.

I have reviewed and understand the informa on for comple ng this sec on of the Volunteer applica on.

Applicant Signature_____

Hospital Sisters
HEALTH SYSTEM

Confidentiality and Security Agreement

I understand that Hospital Sisters Health System ("HSHS"), including its Local Systems and Affiliates, has a legal and ethical responsibility to safeguard the privacy and security of all patients and the confidentiality of their protected health information. This responsibility includes but is not limited to all data related to HSHS People Services, payroll, fiscal, research, computer systems, and any protected health information ("Confidential Information".) Therefore, I understand my employment or assignment with HSHS is contingent upon my agreement that:

1. During the course of my employment/assignment with HSHS, I recognize that I may become aware of and have additional responsibilities for protecting Confidential Information in verbal, written, or electronic form.
2. I will not disclose Confidential Information to unauthorized parties or access any Confidential Information not required to do my job. This means not accessing my own, friends, family, or co-workers information without a job related need. This also means that patient information is not to be released to anyone without a patient's written consent nor should any information contained in the patient's record be read, obtained or discussed without having a specific business purpose.
3. I will not share my personal access code(s), user ID(s), or password(s) or knowingly use or try to learn another person's personal access code, user ID, or password for any reason.
4. I will safeguard Confidential Information from intentional or unintentional unauthorized access, modification, loss, destruction or disclosure. This means I will not in any way repeat, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of my professional activities associated with HSHS.
5. I understand that all of my actions on HSHS information systems, including HSHS provided email accounts are the property of HSHS and are subject to audit without regard to my privacy.
6. I will lock or log off any workstation prior to leaving it unattended.
7. I understand that phone calls made through HSHS phone lines may be monitored or recorded.
8. I will not make any unauthorized transmissions, emails, inquiries, texts, audio, imaging or modifications of Confidential Information. I will not remove any Confidential Information from any HSHS facility without proper authorization.
9. I will not download or upload any unauthorized software or copyrighted materials to any HSHS owned device or over any HSHS data network.
10. If I have electronic signature capabilities, I certify that my user ID and password represent my signature and carry all the ethical and legal implications of a written signature. I will not disclose this password to anyone for any reason.
11. I will comply with all HSHS HIPAA Privacy and Security policies.
12. I will immediately report to my supervisor, the HIPAA Privacy Officer, or the HIPAA Security Officer any activity that is a violation of this agreement or a violation of any HSHS HIPAA Privacy or Security policies.
13. I will immediately take steps to change my password if I have reason to believe the confidentiality of it has been compromised.
14. I understand that email, texts, audio, imaging and internet access is to be used for business purposes. Unless expressly authorized by my supervisor to use a social networking site for business purposes, I will not use, access or post to any social networking site including, Facebook, MySpace, LinkedIn, Twitter or similar program regarding patient, provider or hospital/facility information or activity. I understand that email, texts, audio, imaging, internet and overall system usage is subject to monitoring to identify inappropriate access to obscene or other objectionable materials as well as to identify excessive non work-related activity. I will comply with HSHS Colleague Social Networking policy.
15. Upon termination of employment or assignment, I will immediately return any documents, equipment, or other media containing Confidential Information to HSHS. I also agree to turn over any keys, access cards, or any other devices that would provide access to any HSHS facility or its information.
16. I understand that my obligations under this Agreement will continue after the termination of employment or assignment.
17. I understand that violation of this Agreement will result in disciplinary action, up to and including suspension, loss of privileges, and/or termination of employment or assignment and that I may be subject to criminal and/or civil prosecution in the event I circumvent any of the above.

My signature below acknowledges that I agree to and will abide by these provisions and that I will only access information systems for authorized patient care or business functions according to policies.

Name (Print)	Signature
ID# (if applicable)	Date Signed

This signed document is to be scanned into Information Services shared file or HealthStream.

Rev August 2014

HSHS
St. Elizabeth's
Hospital

Reminders prior to arriving for your physical:

1.) Bring a photo ID (driver's license or any other state issued photo ID)
2.) Bring any vaccination records with you, including if you have had any previous Tuberculosis or Hepatitis inoculations. If you are unsure about any vaccinations you may have received and cannot obtain medical records a blood test can be performed the day of your physical in the hospital's lab.

New Volunteers need the following:

MMR- 2 dates or positive titers for the Rubeola and Rubella virus. If not available, R and R titers can be drawn at our lab.

Hepatitis- 3 dates

Chicken Pox history- had the disease or proof of 2 Varicella vaccines.
Can be sent for titers if none of the previous available.

2 step TB- we can accept one outside TB if it was given within the previous 12 months and verification can be provided with the date given, results, and date read.

TB given and then read 2-3 days later
2 weeks after the first the 2nd TB given and read in 2-3 days.

HSHS St. Elizabeth's Hospital

INITIAL HEALTH EVALUATION

Name: _____ Date of Birth: _____ Age: _____ Male: ____ Female: ____

Address: _____ State: _____ Zip: _____ Phone #: _____

Emergency contact / relationship: _____ Phone #: _____

Your physician, include address: _____

Job title: _____

Social Security #: _____ _____ _____

MEDICAL HISTORY

Please check any of the following medical conditions/symptoms that you have EVER had:

Condition	If YES, please describe:	Condition	If YES, please describe:
☐ Thyroid disease		☐ Heart disease	
☐ Arthritis/Bursitis		☐ High Blood Pressure	
☐ Back Pain/Sciatica		☐ Heart murmur	
☐ Numbness/Tingling of an extremity		☐ Unexplained weight loss/gain	
☐ Depression/Anxiety disorder		☐ Chest pain	
☐ Epilepsy/Seizures		☐ Ankle swelling	
☐ Tuberculosis/Positive skin test		☐ High cholesterol	
☐ Diabetes		☐ Peptic ulcer/Reflux disease	
☐ Chemical exposure		☐ Jaundice/Liver disease	
☐ Hives/Eczema/Skin disorder		☐ Frequent headaches	
☐ Carpal tunnel syndrome		☐ Loss of consciousness	
☐ Blood or Plasma Transfusion		☐ Severe dizziness	
☐ Wear glasses/contacts		☐ Insomnia/Sleep disorder	
☐ Visual symptoms		☐ Broken bones/dislocations	
☐ Hearing difficulty		☐ Joint/Tendon injury or pain	
☐ Allergies/Hay fever		☐ Hernia	
☐ Wheezing Asthma		☐ Difficulty urinating	
☐ Chronic Cough		☐ Kidney or bladder disease	
☐ Shortness of breath		☐ Cancer	
☐ Chicken Pox			

At the present time, are you:

1. Undergoing treatment for any health problems? ..... ☐ YES ☐ NO
2. Restricted in any way from physical activity? ..... ☐ YES ☐ NO
3. Restricted from driving vehicles? ..... ☐ YES ☐ NO

Explain any above questions answered "YES": _____

_____

1. What medicines or drugs (prescription or non-prescription) do you routinely take? State "none" if none.

_____

2. List any known allergies to medications or other things. State "none" if none.

_____

3. List any surgeries and the year. State "none" if none.

_____

4. What best describes your smoking/tobacco habits?

☐ Never smoked/chewed ☐ Used to smoke/chew ☐ Still smoke/chew

How many cigarettes/cigars - per day _____ per week _____

5. How many alcoholic beverages do you consume per week (beer, wine, or mixed drinks)? _____

6. List the date and reason for hospitalizations/surgeries not previously mentioned. _____

_____

_____

	Current Job	Previous Job	Previous Job
Employer			
Years worked			
Job title			
List any exposure to hazardous substances			

Please answer the following Yes/No questions:

Do you have any hobbies or other activities that involve hazardous substances? ..... ☐ YES ☐ NO

Have you ever been ill due to your work? ..... ☐ YES ☐ NO

Have you ever have a job involving repetitive motion? ..... ☐ YES ☐ NO

Do you have any hobbies involving repetitive motion? ..... ☐ YES ☐ NO

Have you ever used vibrating hand tools? ..... ☐ YES ☐ NO

Do you regularly participate in any sport that stresses the hand, arms, and shoulders? ..... ☐ YES ☐ NO

Have you ever had a skin problem in response to wood, metal, or chemicals? ..... ☐ YES ☐ NO

Have you ever had breathing problems from chemical fumes? ..... ☐ YES ☐ NO

I certify that all the above questions were answered correctly. I understand that any misrepresentation or omission of facts may be cause for immediate dismissal. I agree that further medical examinations required by St. Elizabeth's Hospital are made with my consent. I further agree to abide by the policies and practices of St. Elizabeth's Hospital governing employee and student health. I understand that my physical and mental health must be adequate to perform my job/student requirements.

Applicant signature: _____ Date: _____ Time: _____

I have interviewed the above named applicant.

☐ Approved for hire

☐ Further screening from Health Care Provider requested.

EHS staff signature: _____ Date: _____ Time: _____

PHYSICAL SCREENING per Employee Health Staff

(To be completed by Employee Health Staff)

Height: _____ Weight: _____

Blood Pressure: _____ Respirations: _____

Vision:

20/_____ ☐ corrected

☐ uncorrected

Color: ☐ Pass ☐ Fail

HSHS
St. Elizabeth's
Hospital

Employee Health Services
211 South Third Street
Belleville, IL 62220
618-234-2120 ext 1489

HEPATITIS B VACCINE SERIES

HISTORY & REVIEW

The undersigned certifies that he/she has read the following document and has had an opportunity to ask questions. The benefits and risks of the vaccine are outlined in the Hepatitis B Vaccine Series Informed Consent.

The vaccine will be provided free of charge for hospital staff who are considered "high risk" as defined by IC/EHS Policy VI.

The vaccine is a series of three deltoid injections. Hospital staff not in the defined "high risk" group may obtain the vaccine at cost by contacting EHS.

Hepatitis B Vaccine will not be administered to those that are acutely ill at the time of immunization, those that have allergies to yeast products, or those that are pregnant.

PLEASE COMPLETE ONE OF THE FOLLOWING RESPONSES:

_____ I request the Hepatitis B Vaccine Series, since I have not previously completed the Hepatitis B Series and it is my understanding that my job assignment places me in a defined "high risk" group.

_____ I have previously received the Hepatitis B Vaccine Series. Please include date of series. _____

_____ I am requesting the vaccine to be provided at cost since I am not at "high risk" and I have not previously completed the Hepatitis B Series.

_____ I decline the Hepatitis B Series at this time. (IF THIS OPTION IS CHOSEN, AND THE EMPLOYEE IS DEFINED IN A "HIGH RISK" CATEGORY, THE "HIGH RISK" HEPATITIS B DECLINATION FORM MUST BE COMPLETED.)

_____ _____

Name Date

St. Elizabeth's
HOSPITAL

EMPLOYMENT APPLICANT
CONSENT FORM FOR DRUG TESTING

I have been advised of St. Elizabeth's Hospital Drug Free Workplace Directive regarding applicants who have received a conditional offer of employment. I hereby voluntarily consent to submit to a drug test as required for employment at St. Elizabeth's Hospital. I also voluntarily consent to allow the Employee Health Nurse to arrange for the collection of one or more specimens from me as necessary. I understand and acknowledge that failure to test when requested, an alteration, adulteration, or substitution of the specimen, or a positive result of the drug test will result in the withdrawal of my conditional job offer. I also understand that I will not be eligible to make application for employment at St. Elizabeth's Hospital for a period of 1 year, should I test positive for this drug screen.

_____
Name of Applicant (Please Print)

_____ _____
Signature of Applicant Date (to be completed by Applicant)

_____
Name of Witness to Signature of
Applicant (Please Print)

_____ _____
Witness Signature of Applicant Date (to be filled in by Witness)

St. Elizabeth's HOSPITAL

Consent for Release and Treatment

Name:_____

Address:_____City_____State_____Zip_____

Home Phone:_____Cell Phone:_____

Social Security Number_____-_____-_____ DOB:_____/____/_____ Age:_____

EMPLOYER: St.Elizabeth's Hospital – 211 South Third – Belleville, IL 62220 – (618)-234-2120

Department_____ Supervisor_____Extension_____

CONSENT FOR RELEASE AND TREATMENT

I authorize agents of St. Elizabeth's Hospital to provide and perform medical treatment, physical evaluations, tests and procedures and to obtain medical information including from other sources deemed necessary for the purpose of evaluation of health status. I have been reasonably informed of the nature of the evaluations/tests.

I hereby authorize St. Elizabeth's Hospital to release information regarding the above evaluation to my (potential) employer or assigned agent of the employer. This consent for release of information is subject to revocation at any time except to the extent that the action has already been taken. This consent expires upon the satisfaction of the completion of all employer requirements pertaining to pre-employment, worker compensation treatment/screening.

I also authorize St. Elizabeth's Hospital to obtain from other medical facilities, medical records, and physicians, medical information on myself, including but not limited to medical records, x-rays, slides and/or tissue samples for the purpose of evaluation and treatment of worker compensation injuries and pre/post employment evaluations.

I have read the above information and understand its content and significance.

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date

St. Elizabeth's
HOSPITAL
BELLEVILLE, ILLINOIS
AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

New Hire Information Sheet
Welcome to St. Elizabeth's Hospital

Volunteer Services Department Policies & Procedures

1. Confidentiality policy – Any patient information (including name, personal health information, numbers) MUST not leave this hospital or be used in a conversation in hallways, elevators, cafeteria, etc. In other words, anything regarding patient information that is said here or listed here must stay here & not be discussed in open areas. When patients come to us they are putting their trust in the organization, staff, and volunteers and we respect that and want to do everything we can to make them feel comfortable and have a quality healthcare experience. Consequences of violating this policy could result in termination of volunteer service and/or legal action.

2. Parking policy – volunteers may park in the visitors garage or any of the lots around the Hospital Campus. If parking in the garage, please park on the upper levels (levels 1 and 2 are for patients & visitors) and then enter the hospital on the 2nd/Main Floor.

3. Dress Code policy – All employees and volunteers MUST follow the Hospital's general dress code and their department-specific dress code. Volunteers are required to wear a black Volunteer Services vest. The vest can be rented or purchased from the Volunteer Coordinator. More information will be given to you at the time of your interview. **Please remember that your appearance reflects the attitudes and standards of St. Elizabeth's Hospital.** Volunteers should wear under the volunteer vest business casual clothing and comfortable but practical closed toe shoes. You will also be issued a Photo ID badge, which is a very important part of your uniform and must be worn each and every time you volunteer. Jeans of any color are prohibited.

4. Sign-in/Sign-out policy – Volunteers should arrive on time for their scheduled work time and sign-in at any of the Time Clocks and then report to their assigned department. At the end of their shift, volunteers should sign-out at any of the Time Clocks. The Time Clocks will then be your electronic time card, which helps the Hospital and Volunteer Office keep track of important data for organizational & departmental purposes. This also will enable the department to produce a record for each volunteer if a request should be made for an official document needed for scholarship application, resumes, etc.

5. If volunteers are not be able to make their scheduled shift for whatever reason (sick, car won't start, out-of-town), please try to notify the Volunteer Office as much in advance as possible of their absence in order that the Office is able to notify their stationed department and attempt to find coverage if possible. (234-2120 x1280)

6. A benefit of volunteering at St. Elizabeth's Hospital, is a free meal ticket (good for $5 or less) which is earned when volunteers work at least 4 hours in a shift. Cards are issued by the Volunteer Coordinator or Volunteer Department Manager only. Lunch breaks are 30 minutes. Volunteers also receive discounts in the gift shop as well as free access to the SIHI gym and a free flu vaccination each fall.

7. Employees & volunteers are required to participate & complete annual training sessions, known as CBL's (Computer Based Learning) in order to keep up to date with Hospital polices and procedures as well as receive Joint Commission Accreditation. It is important for volunteers to be aware of what is happening in the Hospital and how their roles contribute to the mission & core values of the Hospital.

St. Elizabeth's
HOSPITAL
BELLEVILLE, ILLINOIS
AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

ST. ELIZABETH'S HOSPITAL SERVICE STANDARDS

I commit to participating in positive interactions. This is the spirit of RESPECT.

- I always bring positive energy to our customers and co-workers by providing an excellent experience.
- I always listen actively and show empathy and consideration.
- I always respect diversity.
- I always value all team members regardless of role or title.
- I always hold private information and interactions in confidence.
- I always use resources (time, personnel, equipment, and supplies) carefully to promote financial success.
- I always am collaborative and cooperative with customers and co-workers.
- I always give a friendly and respectful greeting to everyone.
- I always respect our campus and community by taking initiative in maintaining cleanliness and safety.

I commit to do for others as I would have others do for me. This is the spirit of CARE.

- I always show all those I come into contact with that I care by expressing concern and using the best resource available to solve problems.
- I always listen and acknowledge others' ideas and concerns.
- I always recognize that the words "busy" and "short staffed" are not words to use with customers and co-workers.
- I always understand body language and tone of voice convey more of the message than actual words.
- I always remain calm, caring, and compassionate in pressure situations.
- I always resolve a complaint successfully, either on my own and /or with the assistance of my immediate supervisor.
- I always answer call lights promptly when I see a light.
- I always respond to my customers/co-workers needs promptly.

I commit to be knowledgeable in my role and know I affect our success. This is the spirit of COMPETENCE.

- I always perform my work with excellence.
- I always take responsibility for my work and follow through with all tasks.
- I always believe the best solution is found in teamwork.
- I always seek out learning opportunities to enhance my skills and the ability to serve.
- I always share my knowledge with others without hesitation.
- I always recognize the need for performance improvement and embrace change.
- I always stay current with St. Elizabeth's Hospital communications.
- I always model service excellence behavior.
- I always present information that is accurate and easy to understand.

I commit to showing my smile. This is the spirit of JOY.

- I always bring enthusiasm to work.
- I always am a positive member of my team.
- I always make eye contact and speak in ways that are easily understood.
- I always answer the phone courteously, give my name, work area and ask how I may help.
- I always help people find their way by escorting them to their destination when possible.

I, _____, am renewing my commitment to using the Service Standards in my daily work at St. Elizabeth's Hospital.

I understand that practicing these Service Standards is a condition of volunteering at St. Elizabeth's Hospital.

_____ _____ _____

Volunteers Signature Volunteers Number Date