Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

February 1, 2019

Dear Prospective Volunteer:

We would like to take a moment to thank you for considering volunteer opportunities within Western Connecticut Health Network. Whether you are interested in working as a volunteer at Danbury, New Milford or Norwalk Hospitals we welcome and appreciate your interest in learning more about the many opportunities we have to offer.

Our volunteers come from all walks of life from students pursuing potential career fields to recent retirees determined to maintain an active lifestyle and everywhere in between. We require that all volunteers be at least 16 years of age to volunteer.

Our number one goal is patient satisfaction linking top-notch quality of care centered on our patients and families while providing services with compassion, empathy and dignity. Our department serves the network via a multidisciplinary approach to support both clinical and non-clinical roles within the organization.

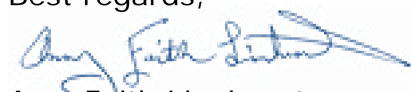
In order to maintain some continuity with our volunteers, we require volunteers to make a serious commitment of at least one full school semester of service (once a week for at least three hours per shift) and a minimum of six months of continuous service for adult volunteers not enrolled in school.

Please find the attached application packet containing all necessary forms to be completed, signed and either emailed or printed and returned to our office.

Once you have completed these forms and returned them to our office, we will review your application and contact you should we find an appropriate match. IF accepted into the program, you will be expected to complete our hospital orientation and any additional training required.

Should you have any questions, please feel free to reach out to us via email at volunteer@wchn.org or call 203-739-7384.

Best regards,



Amy Faith Lionheart
Network Manager of Volunteer Services

Department of Volunteer Services Student Volunteer Application Summer Youth Program

Where are you are applying to volunteer?
Danbury Hospital
New Milford Hospital
Norwalk Hospital

Name	Phone	Date

Address	Town	State	Zip

Notify in Emergency (Daytime)

Parent_______________________________________Phone_________________________
Parent_______________________________________Phone_________________________
Other_______________________________________ Phone_________________________

School Currently Attending	Present GPA	Date of Birth

Career Interests____
Paid Work Experience____
Volunteer Work Experience____
Hobbies, Skills, Languages____
Do you, or might you have a job that could interfere with volunteering? Yes No
If so, describe____
Do you need the same time schedule as anyone else? Yes No If so, who?__________________
If the above could not volunteer, would you still be able to come to the hospital? Yes No
Please indicate below the days and hours you would prefer.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Full Day 9-5							
Morning 9-1							
Afternoon 1-5							

Choice of Volunteer Assignments:

1.____
2.____
3.____

Please do not write in spaces below

Date Received	Confidentiality	HAQ	Sign-Off	Computer	Shirt	Name Badge

Notes

References:

Please list at least 2 recent references: (References must be a former/current employer or someone other than friend or family who can vouch for your character).

Name	Address	Telephone Num.	Years Known	Relationship

How did you hear about volunteer opportunities at Danbury Hospital?

Please tell us why you feel you should be selected to participate in this year's program; what you hope to learn from this experience, and highlight what others would say makes you unique.

"I certify that the information in this application is correct to the best of my knowledge. I authorize the investigation of all matters contained in this application and agree that any misleading or false statements shall be cause for rejection of this application and will be cause for immediate dismissal."

_______________________________ _________________

Applicant's Signature Date

Western Connecticut Health Network

New Volunteer
HIPAA Information Security and Privacy

Federal HIPAA Privacy regulations govern how patient information may be used within an organization and what may be disclosed outside of an organization. You play an important part in protecting patient confidentiality and privacy.

The Western Connecticut Health Network Privacy Security Official is Wayne A. McNulty, Senior Vice President and Chief Compliance, Audit & Privacy Officer. He may be reached at 203-739-7110 for questions or to report privacy or security violations. In addition, you may contact the Compliance HelpLine 203-739-7676 at if you wish to make a report and remain anonymous.

<u>Confidential Information</u>

- Clinical information is not the only thing that is considered confidential. Demographic information, financial information, billing information and employee benefit information is protected by HIPAA. This information is considered <u>Protected Health Information</u> (PHI).
- Confidential information is not just medical records, but includes faxes, telephone or face-to-face conversations, e-mail, message pads and computer information.
- Confidential information may not be disclosed except in accordance with Hospital policy and the applicable State and Federal laws, and accrediting organization standards.
- *Just the fact that someone is in the Hospital is confidential information.*
- For example:
  - You may not browse the admission listing out of curiosity to see if someone you know has been admitted.
  - If you happen to discover that someone you know is in the Hospital as part of your job functions, you may not discuss it with anyone, including your family or other volunteers, and you cannot assume that it is okay to go and visit the person.

<u>No Disclosure of Patient Identity or Location</u>

- You may not disclose that an individual is a WCHN patient, nor the individual's room location/phone number, in the case of a Hospital patient, to anyone <u>unless</u> you are specifically authorized as part of your job duties to disclose this information and the patient has not objected to the disclosure. For example, Information Desk or Hospital Operator staff.

<u>Minimum Necessary Requirements</u>

- HIPAA allows you to see only the Protected Health Information you need to do your job. You may only discuss this information with another volunteer or employee if it is directly related to their job and they have a need to know.
- Unauthorized access to Protected Health Information is a serious violation of HIPAA and WCHN policy. If you access information inappropriately it is a violation, even if you keep the information to yourself.

Right to Receive a Privacy Notice

- Anyone coming to the Information Desk asking for a Notice of Privacy Practices can be given a copy.
- If a patient asks you a question about the Notice try to answer the question. Refer any questions you can't answer to Western Connecticut Health Network Privacy Officer,

If you have knowledge of a suspected privacy violation at WCHN contact

- Your supervisor or manager; or
- Privacy Officer, Joseph Campbell; or
- The Compliance HelpLine.

Sanctions for Violations

- It is a violation to access information that is not directly needed to perform your job functions.
- The sanctions for violating HIPAA and/or WCHN's privacy policies are severe. WCHN takes confidentiality violations very seriously. Failure to abide by the HIPAA law and/or WCHN policy could result in the following:
  - Lawsuits against you and/or WCHN
  - Annual fines of up to $250,000 and 10 years in prison
  - Licensure sanctions and other licensure problems
  - Termination

HIPAA Do's and Don'ts

- Do not disclose any information except as directly outlined in your responsibilities.
- Use yellow shred bins to dispose of confidential information.
- Log-off your workstation if you will be away from your desk for an extended period.
- Verify fax numbers when dialing and periodically on programmable machines.

Password Management

- Pick good passwords; do not pick something that can be easily guessed.
- Change your password if someone knows it!
- Do not post or leave accessible.
- SHARING USER ACCOUNTS OR PASSWORDS IS PROHIBITED.

I understand and agree to all the terms set forth in this Agreement.

______________________________	______________________________
Employee/Volunteer/Student/Contractor Signature	Printed Name
______________	Volunteer Services
Date	Area/Departent

5/2018

Confidentiality and Information Access / Usage Agreement Form

Security and confidentiality is a matter of concern for all persons who have access to Western Connecticut Health Network's information systems. Each person accessing Western Connecticut Health Network's data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access data and resources, both through organizational information systems and through individual department local-area networks and databases, must read and comply with Western Connecticut Health Network's policy.

I hereby certify and agree that I will:

1. Understand that all access to systems (including network, applications, card swipe and phone) IS ELECTRONICALLY MONITORED.
2. Respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for the performance of my job.
3. Respect the ownership of proprietary software. For example, not make unauthorized copies of software for personal use, even when the software is not physically protected against copying. I will not operate any non-licensed software on any computer provided by Western Connecticut Health Network.
4. Prevent unauthorized use of any information in files maintained, stored or processed by Western Connecticut Health Network.
5. Not seek personal benefit or permit others to benefit personally by any confidential information or use of equipment available through my work assignment.
6. Not exhibit or divulge the contents of any record or report except to fulfill a work assignment and in accordance Western Connecticut Health Network's policy.
7. Not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
8. Not remove any record (or copy) or report from the office where it is kept except in the performance of my duties.
9. Report any violation of this code.
10. Not release user identification code or password to anyone, or allow anyone to access or alter information under my identity, nor will I release my badge or other device to anyone.
11. Not utilize anyone else's access code or card in order to access any Western Connecticut Health Network's system.
12. Respect the confidentiality of any reports printed from any information system containing patient/member information and handle, store and dispose of these reports appropriately.
13. Understand that information provided to the news media regarding the condition, care, or treatment of a patient will be given solely by the Department of Public Affairs.
14. Understand that in combination with my PIN, this will be my electronic signature for all medication transactions in the MedSelect system. It will be used to track all of my transactions with a date and time stamp. These records will be maintained as per Hospital and State Drug Control policy and will be available for inspection by the Drug Enforcement Administration (DEA) and the CT Department of Consumer Protection, Drug Control Division.
15. Understand that I may have access to confidential information that may include, but is not limited to, information relating to:
    - Patients/members (such as records, conversations, admittance information, patient/member financial information, etc),
    - Employees/volunteer/students (such as salaries, employment records, disciplinary actions, etc.),
    - Western Connecticut Health Network's information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.) and
    - Third party information (such as computer programs, client and vendor proprietary information source code, proprietary technology, etc.).
16. Use confidential information only as needed to perform my legitimate duties as an employee/volunteer/student/contractor affiliated with Western Connecticut Health Network. This means, among other things, that:

Confidentiality and Information Access / Usage Agreement Form

- I will only access confidential information for which I have a need to know and I am authorized to know. No attempt will be made to inappropriately access unauthorized information concerning family members, friends, coworkers or other parties not related to my job responsibilities; and
- I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of my professional activities affiliated with Western Connecticut Health Network; and
- I will not misuse confidential information or carelessly care for confidential information.

17. Accept responsibility for all activities undertaken using my access code and other authorization.
18. Use discretion when discussing patient information to ensure that conversation is not overheard by those who should not have access to that information.
19. Report activities by any individual or entity that I suspect may compromise the confidentiality of confidential information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
20. Understand that an employee has the right to challenge anyone requesting access to confidential information (including a patient's medical record) in order to be assured that the person has the right to view such information.
21. Understand that my obligations under this Agreement will continue after termination of my employment. I understand that my privileges hereunder are subject to periodic review, revision and if appropriate, renewal.
22. Understand that I have no right or ownership interest in any confidential information referred to in this Agreement. Western Connecticut Health Network may at any time revoke my access code, other authorization, or access to confidential information. At all times I will safeguard and retain the confidentiality of all confidential information.
23. Be responsible for my misuse or wrongful disclosure of confidential information and for my failure to safeguard my access code or other authorization access to confidential information. I understand that my failure to comply with this Agreement may also result in the denial of access to the relevant computer systems and networks, disciplinary action, up to and including loss of employment at Western Connecticut Health Network, loss of privileges, imposition of criminal / civil sanction, and/or notification to licensure authority.
24. Not use my name as my password.
25. Understand that my electronic signature is intended to be the legally binding equivalent of my traditional handwritten signature.
26. Immediately notify the appropriate party in the event that I become aware of lost, stolen or otherwise compromised password information or electronically signed documents.

I understand and agree to all of the terms set forth in this Agreement.

______________________________ Employee/Volunteer/Student/Contractor Signature

______________________________ Printed Name

______________________________ Date

Volunteer Services
______________________________ Area/Department

DANBURY/NEW MILFORD HOSPITAL

DEPARTMENT OF VOLUNTEER SERVICES

If you are under 18 years of age, you will need to have your Parent/Guardian complete this form to be able to volunteer

_______________________________________HAS MY PERMISSION TO SERVE AS A DANBURY/NEW MILFORD HOSPITAL STUDENT VOLUNTEER.

I UNDERSTAND THE COMMITMENT HE/SHE HAS MADE, AND I WILL SUPPORT THIS COMMITMENT.

PRINT NAME OF PARENT OR GUARDIAN: ____________________________________

SIGNATURE: ____________________________________

RELATIONSHIP TO STUDENT: ____________________________________

DATE: ____________________________________

1-Feb-19

WESTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES CONSENT TO PHOTOGRAPHY/INTERVIEW, AND AUTHORIZATION TO RELEASE INFORMATION TO THE NEWS MEDIA INCLUDING WAIVER AND RELEASE BY *EMPLOYEE, PHYSICIAN, VOLUNTEER OR STAFF MEMBER*

Before you sign this consent, please feel free to ask any questions that you may have with respect to the pictures or interviews and their contemplated use.

In this document, Western Connecticut Health Network and its affiliates (including The Danbury Hospital, Norwalk Hospital, New Milford Hospital, the Western Connecticut Medical Group, and all of their respective officers and directors, employees, staff, and agents), are collectively and individually referred to as "Network."

A copy of this consent should be retained, and another copy should be provided to the employee/staff member.

Print Name ____________________________ Date ____________

☐ I consent to and authorize the Network to photograph (including any still photo, films, digitized imaging, videotape, recording, or any other process used for producing or storing images and any artwork or animation using such photographs) me in the course of performing my work for the Network and to use such photographs as described below.

☐ I agree to be interviewed by a news reporter permitted by Network.

All photography and or interviews will be taken/conducted by the Network's Marketing and Public Affairs Department or by those news media representatives authorized by the Network's Marketing and Public Affairs Department.

Such photographs and/or interview may be used (and may be published) by the Network or by news media representatives for the following purposes - check relevant purpose(s):

☐ For publicity, education, outreach, public information, or paid or free advertising or marketing

☐ For use on a Network website, Network social media, or in a Network publication

☐ To display in a Network hospital or physician or clinic waiting room

☐ All of the above

☐ Other external use (describe fully):
[E.g. Physician collaboration and outreach]____
____
____

I understand and agree that all photographs taken, including negatives, duplicates and digital images, and any artwork or animation using such photographs, shall remain the property of the Network's Marketing and Public Affairs Department or the news media representatives who took such photographs or conducted an interview. I agree not to make any claim for payment in connection with the use or publication of photographs of me or interviews that I participate in, and waive any right to payment for or copyright or other ownership interest in such photographs and/or interviews.

I understand that Network is unable to provide me with hard copies or digital versions stored in any format of photographs, interviews, news stories or other media.

I have read and understand this consent, including the "Important Notes" below, or it has been read and explained to me, and all of my questions have been answered to my satisfaction. This consent and authorization is being signed by me without any guarantee or coercion.

I hereby certify that I am at least l8 years of age.

________________________ ____________________
Signature Date

________________________ ____________________
Signature of Witness Date

If employee/staff member is not 18 years of age, a guardian must sign on behalf of such employee/staff member.

________________________ ____________________
Signature of Guardian Date

________________________ ____________________
Print Name of Guardian Relationship to Employee/Staff Member

________________________ ____________________
Signature of Witness Date

***IMPORTANT NOTES**:

This consent may be revoked in writing sent to pubrel@wcthealthnetwork.org, and such revocation will be effective upon receipt. Unless revoked, this consent shall not expire. Please note that any release of information prior to the date of revocation shall not be affected by the revocation.

Information (pictures and/or interviews) that are disclosed are beyond the control of Network, and have the potential to be subject to re-disclosure and/or further use. 10-21-15

TO: ALL PROSPECTIVE VOLUNTEERS*

FROM: VOLUNTEER SERVICES

SUBJECT: TUBERCULOSIS TEST (PPD)

As part of the health assessment, all volunteers must have a two-step test for tuberculosis (PPD). Employee Health is located on the first floor of the Tower building and will do this test free of charge for volunteers. Testing is done on **Mondays**, **Tuesdays,** and **Wednesdays** from 7:30 a.m.-noon to 3:30p.m. Please plan to arrive during the above listed days and times. You must then return 48-72 hours later to have the test results read and recorded. The clinician will tell you when to return for your reading and then you will return one week later for the second PPD.

Please note:

1) You may not volunteer unless this test is current.
2) Testing is renewable annually (Every 12 months)
3) If you are under the age of 18, the form must be signed by your parent or guardian.

05/16, 12/17

EMPLOYEE HEALTH CARE
VOLUNTEER PPD PLANT & RESULTS

PRINT FULL NAME: ____

DATE OF BIRTH: ______________________

****

Dose: 0.1 cc 5 tu PPD

Date given:____________________ **Date Read:**_________________

SITE: **RESULTS:**

RFA___________ **Negative**___________
LFA___________ **Positive**____________

Administered by: ______________________ **Read by:**___________________

PPD DECLINATION:
I have been offered the tuberculin PPD skin test by Employee Health Care. All my questions have been satisfactorily answered regarding Tuberculosis transmission. I understand a PPD will be offered to me again next year.
I decline to be tested at this time. (Please note you can't volunteer unless you have the PPD)

Sign here if declining:___________________________**Date:**______________

Under Age 18
Parent/Guardian Signature:______________________Date:______________

Western Connecticut Health Network

HEALTH ASSESSMENT QUESTIONNAIRE -- VOLUNTEER

Western CT Health Network requires that all prospective volunteers obtain medical clearance. This information will be safeguarded as confidential in accordance with all legal requirements. Please print this form out and affix copies of childhood immunity records and proof of flu vaccination.

A key factor to consider while completing this questionnaire is to understand that a volunteer may be assigned to work directly with patients or in an assignment that would require physical exertion such as pushing or walking. Volunteers should have the stamina to stand for three-four hours.

Name: ______________________ Date of Birth: ______________

Address: ______________________ Apartment: ______________

City: ______________ State: ______________ Zip: ______________

Home Phone # ______________ Cell # ______________ Business # ______________

Email Address: ______________________

Have you volunteered for the Western Connecticut Health Network before? ☐ Yes ☐ No

If so, when did you last volunteer? ______________ Do you have any physical or medical limitations that would affect your performance on the job? Yes: ____ No: ____ If yes, please specify: ______________________

Notify in case of emergency: ______________________

Email Address: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________

Personal History: (Please check)

	Yes	No		Yes	No
Asthma			Fainting Spells		
Allergies (Med or Food Only)			Heart Disease		
Back Injury			High Blood Pressure		
Diabetes			Psychiatric History		
Epilepsy (Seizures)			Visual Problems		

Immunization History:

	Date	Result
If born before 1957, MMR vaccine and/or titers are not necessary for volunteers in non-patient care areas.		
MMR #1 (Affix copies)		
MMR #2		
Chicken Pox (Varicella)		
TB-TST (Mantoux test)		
History of BCG (TB inoculation as a child in a foreign country)		

Date of last physical exam: ______________ **Today's Date:** ______________

To protect the health and well-being of our patients, WCHN requires proof of a current negative TST/Mantoux test for Tuberculosis (or negative chest x-ray), and proof of MMR immunization from all volunteers. ***New volunteers are required to have two PPDs (within approximately one-two weeks of each other) before they can begin their assignments.*** In lieu of the two step TB test, volunteers may opt to have their doctor administer the QuantiFERON®-TB Gold test (QFT-G) blood test at their cost.

1st TST Lot # __________ Date Administered: ______ Date of Exp. __________ Left Arm ☐ Right Arm ☐ ______________ **Signature**

2nd TST Lot # __________ Date Administered: ______ Date of Exp. __________ Left Arm ☐ Right Arm ☐ ______________ **Signature**

TST (skin test for TB) (Youth Only Need One TST)	2nd TST	Chest x-ray (If indicated)	MMR: (Measles & Rubella) Proof of inoculation **must** be attached in order to be considered valid. Results must come from the doctor/facility that completed the inoculation and must include the date(s) administered.
Date Administered ________ Date Read __________ Result: Neg _____ Pos_____ **Signature:**	Date Administered____ Date Read _____ Result: Neg ____Pos_____ **Signature:**	Date _________ Result: Neg ___Pos____	☐ Vaccination ☐ Immune Titer

-OVER-

TO BE FILLED OUT BY PROSPECTIVE VOLUNTEER

I, ____________________________________, authorize that my medical information be released for medical reference to the Volunteer Services Department at Western Connecticut Health Network.

_____________________________ _____________________

PATIENT'S SIGNATURE DATE

FOR DOCTORS USE ONLY:

Dear Physician or Health Center,

The above named person is in the process of applying as a volunteer at Western Connecticut Health Network. Volunteers provide companionship, socialization, clerical support, and assist with a variety of activities throughout the Network.

In order to protect the health and well-being of patients, clients, staff, volunteers, and visitors at the facility, it is our policy and a recommendation of the CTDOH that all incoming volunteers have a two-step test for tuberculosis prior to volunteering. This test would require that anyone seeking work as a volunteer must provide proof of having had two current negative TST/Mantoux tests for Tuberculosis (or negative chest x-ray) within ten days to two weeks of each other. It this is not completed, volunteers will **NOT** be permitted to work. Volunteers must also provide proof of measles immunization (if born after 1/1/57), proof of rubella immunization or immune rubella titer, and a statement of good health are required for anyone seeking access to Western Connecticut Health Network as a volunteer.

To Be Completed by Physician or Nurse Practitioner

I certify that the above volunteer is in good health, is free and clear of communicable disease and is medically able to perform his/her volunteer duties.

RESTRICTIONS:

____

____

____

____

Apply Office Stamp Here

_____________________________ _____________________

CLINICIAN'S SIGNATURE DATE

____

OFFICE ADDRESS CITY STATE ZIP

____

TELEPHONE FAX

FOR PARENTS USE ONLY (FOR JUNIORS UNDER 18 ONLY):

I give permission to allow my child to volunteer at WCHN. I am also authorizing WCHN or the above doctor/nurse practitioner to administer the TST for Tuberculosis required by CT State law when volunteering in a health care facility. This test must be read within 48-72 hours by a medical professional after it is administered. If you have any questions please call the volunteer office at (203) 739-7384.

_____________________________ _____________________

PARENT'S SIGNATURE DATE

SUMMER STUDENT VOLUNTEER COMMITMENT LETTER

If I am accepted as a volunteer at Western Connecticut Health Network, I agree that:

- I am making a serious commitment to serving as a volunteer during the Summer Youth Enrichment Program (8 weeks).
- I promise to make every effort to fulfill my commitment to the organization by completing all assignments to the best of my ability.
- I will notify my immediate supervisor if I am unable to work as scheduled.
- If my family is planning a vacation during the program I will notify you of the dates during the interview process
- I agree not to accept tips from patients and/or their families; instead I will ask them to write a letter of compliment and send it directly to patient relations about my volunteer service
- I understand that the Volunteer Services Department reserves the right to terminate my volunteer status at any time as a result of:
    - Failure to comply with policies of the organization
    - Absences without prior notification
    - Unsatisfactory attitude or appearance; all summer volunteers are required to wear the proper uniform
    - Inappropriate actions in sharing protected health information
    - Any other instances where, in the judgement of WCHN staff, would make my continued success contrary to the best interests of the organization

I have read each of the above statements and agree to be bound by them.

_________________	_________________	____________
Print Name	Signature	Date
_________________	_________________	____________
Printed Name of Parent/Guardian	Signature	Date