Volunteer Application

Indiana University Health

Contact Information

Name	
Street Address	
City ST ZIP Code	
Home Phone/cell phone	
Work Phone	
Date of Birth	
E-Mail Address	

Availability

During which hours are you available for volunteer assignments and which location?

___ Weekday mornings
___ Weekday afternoons
___ Weekday evenings
___ Other

Volunteer Location

___ IU Health Arnett
___ IU Health Frankfort
___ IU Health White

Interests

Tell us in which areas you are interested in volunteering

___ Ambassadors/Greeters
___ Events
___ Emergency Department
___ Fundraising
___ Patient care area
___ Surgery Waiting Area
___ Volunteer service area chairman

References

List two people other than relatives who would be willing to serve as personal references.

Name	
Street Address	
City ST ZIP Code	
Home Phone	
E-Mail Address	
Name	
Street Address	
City ST ZIP Code	
Home Phone	
E-Mail Address	

Statement of understanding:

I hereby authorize my references listed on this application to give any information they may have regarding me. I hereby release them from all liability for issuing same.

Name (printed)	
Signature	
Date	

Special Skills or Qualifications

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

Previous Volunteer Experience

Summarize your previous volunteer experience.

Person to Notify in Case of Emergency

Name	
Relationship	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as an Indiana University Health volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. If accepted to volunteer I understand I am required to abide by all IU Health rules and regulations.

Name (printed)	
Signature	
Date	

Our Policy

Indiana University Health considers all applicants for volunteers in accordance with State and Federal Laws and does not discriminate on basis of age, religion, race, sex, national origin or disability.

Thank you for completing this application form and for your interest in volunteering with us.

PINKERTON®

Candidate Information

Name:

FIRST															Middle									
LAST												Maiden												

Social Security Number: ___ - ___ - ____

Date of Birth: ___ - ___ - ____

Drivers' License Number: _____ **(State)** ___

Current Address: (Street) (City) (State/Zip)

_____

_____

Previous Employment: (Employer) (City) (State)

_____

(Contact Name) (Contact Phone Number)

_____

(Title) (Salary) (Start Date 00/00) (End Date)

_____ _____ ____ - ____

Education: (Institution/ School Name) (City) (State)

_____

(City) (State) (Graduation Date)

_____ ___ ____

(Highest Degree Obtained) (Major)

_____

Professional License: (Type/Number) (State) (Year)

_____

Account: IU HEalth **For Internal Use Only:**

IU Health Gold Package	☐	IU Health Silver Package	☐
IU Health Self-Pay Student Package	☐		☐

PINKERTON®

DISCLOSURE AND AUTHORIZATION - Volunteer

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Indiana University Health ("The Organization") may obtain information about me in connection with my application for services with the Organization from a third party consumer reporting agency. Thus, I may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about my character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as my neighbors, friends, or associates. These reports may contain information regarding my credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of my education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to my duties and responsibilities with the Organization. I have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about me and disclosure of the nature and scope of any investigative consumer report and to request a copy of my report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard my services with the Organization is an investigation into my education and/or employment history conducted by Pinkerton Consulting and Investigations, 11019 McCormick Road, Suite 200, Hunt Valley, MD, 800-635-1649, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Organization to obtain information from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of my services to the extent permitted by law. As a result, I will carefully consider whether to exercise my right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by **Indiana University Health** by contacting the consumer reporting agency identified above directly. You may also contact the Company to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which the Company shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by **Indiana University Health**, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that the Company has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my services with the Organization, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Pinkerton Consulting and Investigations, 11019 McCormick Road, Suite 200, Hunt Valley, MD, 800-635-1649, another outside organization acting on behalf of the Organization, and/or the Organization itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Print Name: _____

Signature: _____ Date: _____

Rev. 2013 05

Indiana University Health

IU HEALTH NON-EMPLOYEE FORM

The purpose of this form is to activate or inactivate Lawson access for IU Health Non-Employees.
In order to complete this request the below IS/Confidentiality form **must** also be completed.
For any questions contact HR Shared Services at 317-962-7900 or toll free at 877-849-5724.

To **activate** Lawson access
Fill out the top portion completely.

ACTIVATE:

Legal Name:		**Full SSN/PAN#**	**D.O.B.:**	
Maiden Name:		**Previous Name:**		
Address:		**City/ST:**	**Zip:**	**County:**
Start Date:		**Duration of Assignment:**		
Department # or Cost Center#:		**Non-Employee Process Level:** Choose One…		
Job Code/Job Title: Choose One…	**Work Location:**	**Supervisor:**		
Comments:				

To **inactivate** Lawson access
Fill out the bottom portion only.

INACTIVATE:

Lawson EEID #:	**Legal Name:**
End Date:	**End Date Reason:**
Comments:	

APPROVAL:

Manager Signature:	**Manager Printed Name:**	**Date:**

Return completed form to the Human Resources Shared Services:
Deliver to: Gateway Bldg. 3rd Fl. (950 N Meridian St.) | Fax: 317-962-7535 | Email: HRNonEmployees@IUHealth.org

Responsibility Statement and Data Stewardship Agreement

--

INFORMATION SECURITY AND CONFIDENTIALITY

Indiana University Health ("IUH" is committed to protecting the privacy and security of its confidential information. As an IUH physician, employee, workforce member or other system user you play a crucial role in ensuring the privacy and security of this confidential information. IUH owns, control and stores paper, digital and electronic data about services, programs, systems, finances, patients, families, employees, physicians, payers, and other personally identifiable information ("Data") – most of which is CONFIDENTIAL information. Access to such Data is available through different formats and media and this Statement and Agreement applies to ALL of the data regardless of how it is accessed.

You have requested access as a user of _____ [application/software system.] As a user and steward of IUH's Data, including in some instances protected health information about its patients ("PHI") – as that term is defined in the HIPAA Privacy Rules - you must agree to the following terms and obligations before being granted access – please read your responsibilities carefully before agreeing to them by signing below:

1) I understand that in order to perform my clinical and administrative duties at IUH I may be granted access to proprietary, patient or protected health information ("Data"). I agree that privacy and security of Data is my personal duty and responsibility.

2) I agree to take reasonable precautions to protect Data from unintentional or unauthorized inquiry, update, alteration, access, use, disclosure, destruction or removal; I understand that such precautions apply both while I am on and off duty.

3) I agree that I will only use, access or disclose Data as minimally necessary for my IUH-related business operations or treatment obligations.

4) I agree that I will protect my identity and passwords to maintain my individual authentication to Data ("credentials") and will not disclose my credentials to anyone else.

5) I agree that I am personally responsible for completing IU Health's privacy and security training at least annually [contact IU Health's Human Resources Department if you need access to annual training] and for complying with IUH's privacy and security policies and procedures.

6) I agree that it is my responsibility to obtain appropriate direction when I am unsure of the confidentiality or security precautions that apply to certain Data.

7) I agree to immediately report known or suspected confidentiality breaches to my manager, the IU Health Trust Line or the IU Health Privacy Officer.

8) I agree not to use or disclose IUH's PHI except as minimally necessary to provide health care to patients, process payments or for authorized health care operations (this does NOT include the use of PHI for research – PHI may be obtained for research through a separate process).

9) I agree to use or access PHI using only IUH owned or approved equipment.

10) I agree not to download or transmit PHI using equipment that is not owned or approved by IUH.

11) Except as otherwise authorized in writing by IUH, I hereby represent that I do not have any IUH PHI in my possession, electronic or otherwise, for any purpose other than direct patient care. (Should I have any IUH PHI in my possession for which I do not have written authorization, I will immediately notify IUH's Data Management Board).

12) In order to maintain the integrity of IUH's Data, I agree that I will not access, disclose, or copy my own PHI, except through a system that is read only (i.e. for which I do not have update capability).

13) I agree that I will not access PHI of friends or family members except as otherwise permitted (e.g. to provide care as part of my IUH responsibilities or in accordance with a duly executed Authorization to Release form).

14) I will not use or disclose PHI for marketing or fundraising purposes except as specifically approved by IUH.

15) If I must store or transmit electronic PHI for patient care or other H authorized purpose, then I shall ensure that it is encrypted at all times (e.g. PHI on any mobile device: thumb drive, smart phone, or laptop computer).

16) I agree to access PHI using only the credentials I have been given by IUH and that I will keep those credentials confidential.

17) I agree that when my employment, affiliation, privileges, or assignment with IUH ends, I will not take any PHI with me. I agree to immediately report to IUH any suspected unauthorized use or disclosure of PHI, such as the theft of a mobile device containing PHI or inappropriate use or access.

18) I understand that if I do not maintain the privacy and security of IUH Data and PHI that I may be subject to immediate disciplinary or corrective action, up to and including suspension or termination of employment or clinical privileges and termination of my access to IU Health systems.

19) I understand that unauthorized use or disclosure of PHI may violate federal or state law and could result in criminal or civil penalties.

I have had the opportunity to read and understand this Responsibility Statement and Data Stewardship Agreement and agree to its terms and conditions as indicated by signing my name below:

_____	_____	_____
Printed Name – User	Signature	Date
_____	_____	
IU Health Employee Number (if any)	IU/IUSOM ID Number	
_____	_____	
Physician Number	Non-IU Health Last 5 SSN	

Indiana University Health

New Volunteer Health Assessment

IU Health West Central Region
Employee Health Services (EHS)

Central Office Indiana University Health Arnett
Hospital Site; 5165 McCarty Lane
Lafayette IN 47905
Ph: 765-838-5842 Fax:765-838-4771

Employee Health Services (EHS) is happy to assist you with your journey as you become a volunteer at Indiana University Health. Please find forms attached, along with instructions for forms and additional information you will need for your visit.

1) **Immunization records** providing dates given for the following:
   a) 2 Measles/Mumps/Rubella (MMR) vaccines or proof of positive titer, if your date of birth is January 1, 1957 or more recent
   b) One MMR vaccine or proof of positive titer, if your date of birth is before January 1, 1957
   c) TB skin test within last 3 months
   d) Varicella [chicken pox] titer or 2 vaccines
   e) Flu (Influenza) vaccine
   f) Tdap (Tetanus, diphtheria & pertussis) Vaccine

   TB testing is required. You must have two tests placed a minimum of two weeks apart. Proof of MMR immunizations is required. You may look for this information from your physician, your old high school, your college, or even from your parents. **If you are not able to find this information, you will be required to receive the vaccination(s) or have blood drawn for proof of immunity.**

   2) All completed forms and immunization and TB test documentation must be brought with you to your Health Assessment Appointment. All requirements must be met before clearance for volunteering can begin.
   a) **Personal Information Form**
   b) **Volunteer Health Questionnaire**
   c) **HIPPA Form**

EHS hours are: Monday – Friday 8:00 AM to 5:00 PM by Appointments

Indiana University Health

Volunteer Data Entry Form

PLEASE PRINT – FILL IN ALL BOXES

Last Name:	First Name:	Middle:
Home Address:	City / State / Zip Code:	
Home Phone (Area Code & Number):	Social Security Number:	
Date of Birth:	Volunteer	

Indiana University Health

VOLUNTEER HEALTH QUESTIONNAIRE

DO YOU HAVE OR HAVE YOU EVER HAD?

	YES	NO	NOW
1. Chicken Pox	_____	_____	_____
2. Fainting	_____	_____	_____
3. Falls	_____	_____	_____
4. Nervous breakdown	_____	_____	_____
5. Depression	_____	_____	_____
6. Alcohol or drug treatment program	_____	_____	_____
7. Convulsions/seizures	_____	_____	_____
8. Thyroid disease	_____	_____	_____
9. Asthma/Shortness of Breath	_____	_____	_____
10. Diabetes	_____	_____	_____
11. Tuberculosis/Chronic cough	_____	_____	_____
12. Pacemaker/Defibrillator	_____	_____	_____
13. Chest pain/Heart problem	_____	_____	_____
14. High blood pressure	_____	_____	_____
15. Kidney problems	_____	_____	_____

Please list the medications you are currently taking:

Name Dosage

Allergies:_____

Name, Address, & Phone number of Personal Physician

Person(s) to notify in case of emergency

Name:_____ Phone number:_____ Relationship:_____

Name:_____ Phone number:_____ Relationship:_____

Patient Name: _____

Social Security Number _____-_____-_____

Privacy Notice Acknowledgement Statement
I acknowledge that I have received a copy of Indiana University Health Occupational Services' Notice of Privacy Practice and understand that I may request a version of this privacy notice at any time.

_____ _____
Signature of Patient (Legal Guardian, if minor) Date