



GALVESTON COUNTY HEALTH DISTRICT

Volunteer Registration Form

Personal

Date: _____

Full Name: _____

Address: _____

Day Phone: _____

Evening Phone: _____

Pager: _____

E-mail Address: _____

Are you 18 years or older? Yes No

If no, how old are you? _____

Date of Birth: _____

Gender: Male Female

Do you have any health problems that may limit your ability to fulfill certain volunteer assignments?

Yes No If yes, please explain: _____

Employment

Current Employer: _____

Occupation: _____

Work Hours: _____

May we contact you at work? Yes No

Education, Skills, and Interests

High School Graduate or GED? Yes No

College/University: _____

Major: _____

Degree Earned: _____

Special Training/Certification: _____

Are you bi-lingual? Yes No

If yes, what language(s) do you speak: _____ read: _____ write: _____

Please write a brief summary of yourself (please include skills, interests, hobbies, etc): _____

Please list previous volunteer experience: _____

In Case of Emergency Notify

Name: _____

Relationship: _____

Address: _____

Phone Number:(_____)

Alternate Number:(_____)

Personal References

1) Name: _____

Telephone Number: _____

2) Name: _____

Telephone Number: _____

Volunteering Preferences

Time available: Morning Afternoon Evening

Days available: Mon Tues Wed Thurs Fri Sat Sun

How many hours per week can you commit to volunteering? _____

Who referred you to us? _____ When are you available to start? _____

What area would you like to volunteer for? _____

Do you have access to a vehicle that you can use for volunteer work? Yes No

Volunteering Requirements

Are you volunteering to meet a requirement? Yes No

If so, how many hours of volunteer work do you need to fulfill? _____

What type of requirement? (check one)

school (name of school: _____)

community service

organization (name of org: _____)

other (_____)

Have You Ever Been Convicted of a Felony or Misdemeanor? Yes No

If your answer is "Yes", explain in concise detail on a separate sheet of paper, giving the dates and nature of the offense(s), the name and location of the court, and the disposition of the case. A conviction may not disqualify you, but a false statement will.

Verification and Consent for Reference and Background Check

I verify that the above information is accurate to the best of my knowledge.

I give, Galveston County Health District, permission to inquire into my educational background, references, licenses, police records, and employment and/or volunteer history. I also give permission to the holder of any such information to release it to Galveston County Health District.

I hold Galveston County Health District harmless of any liability, criminal or civil, that may arise as a result of the release of this information about me. I also hold harmless any individual or organization that provides information to the above-named agency. I understand that Galveston County Health District will use this information only as part of its verification of my volunteer application.

Signature

Date

Application received: _____

Interviewed: _____

Volunteer start date: _____

Volunteer end date: _____

The following information outlines the volunteer agreement that volunteers must sign before beginning their volunteer placement.

The agreement affirms that the volunteer placement is meeting the needs of the volunteer. It also emphasizes the need for volunteers to let the Volunteer Coordinator know if needs are not being met so that an appropriate placement can be worked out. Finally, the agreement also confirms that the volunteer is serious about the placement and is committed to making the placement work. Program staff are thrown out of synch and deadlines are missed when a volunteer leaves a placement after a week or two or attendance is sporadic.

Volunteer Agreement

- I have read and understand the responsibilities outlined in my job description.
- I will follow the schedule decided upon between my supervisor and me.
- I will keep my record of volunteer hours current.
- I agree to ask the appropriate person for information and support as needed.
- I agree to sign and follow the Confidentiality Agreement provided by the Health District.
- I accept a commitment to the Galveston County Health District and will discuss it with the appropriate person if my commitment is diminishing.

If I am unable to fulfill the responsibilities outlined in my job description or if I decide to discontinue my volunteer participation, I will notify my supervisor and the Volunteer Coordinator immediately.

I understand that all information regarding clients and staff is strictly confidential whether medical or otherwise, and must never be discussed or repeated. I will not betray this trust. I also understand that confidential information is given to me only if it pertains to my volunteer duties and that no originals or copies of confidential information must ever be removed from the facility. I further understand that if I do not respect and maintain the confidentiality of all information given to me through my volunteer duties, I am personally liable for its release.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date

CONFIDENTIALITY AGREEMENT

I _____ agree that:
Employee/Volunteer Printed Name

- A patient record or any information taken from a patient record is privileged and confidential. In most instances, such information may not be released unless the person identified in the record provides written consent, or the release of information is otherwise permitted by law. A patient record is defined as: a record of the identity and diagnosis of a patient that is initiated and maintained by, or at the direction of a physician, dentist, or someone under the direction or protocols of a physician or dentist.
- I understand that I must not release information from reports, records, correspondence, and other documents, however acquired, containing medical or other confidential information, and that I may not release such information except in a manner authorized by law, such as in a statistical form that will not reveal the identity of an individual or with the written consent of the individual involved.
- I may not release or make public, except as provided by law, individual case information including demographic data and client contacts.
- I will keep all confidential files, including computer diskettes, in a locked file cabinet when not in use.
- When I am working on a confidential file, I will "lock up" the information when I leave my workstation for lunch, meetings, or for the day. I understand that to "lock up" the information includes *logging off* my computer, not merely saving and closing the confidential file.
- I will keep any confidential files I work with out of the view of unauthorized persons.
- I will not discuss confidential information with people who are not authorized, and/or who do not have the need or the right to know the information.
- When I work with files that contain personal identifiers, I will log off my computer when I am not actively using the file.
- To protect confidentiality, I will not discuss the facts contained in confidential documents in a social setting.
- When transporting information that is privileged, confidential or private, I will employ appropriate security measures to ensure the material remains protected.
- I will keep information relating internal and external activities of the district confidential. Such activities include, but are not limited to, risk assessments, survey schedules, food service inspections, business and trade secrets, and personnel actions.
- Where applicable, district policy requires that personnel have individual passwords to access confidential computer files. I will not use another person's password nor will I disclose my own.
- I understand that my supervisor will document any violations of this agreement and he or she will place the documentation in my main personnel file maintained by the Human Resource Department.

- If I am a professional employee/volunteer (e.g., a physician, registered nurse, etc.) or I am an employee/volunteer supervised by or providing support to a professional employee/volunteer, I understand that I may be subject to additional rules of confidentiality. This agreement does not supersede the code of professional conduct and I further understand that a violation of the code of professional conduct may subject the professional employee/volunteer to additional sanctions (e.g. loss of license).
- When I dispose of a document that contains patient or confidential information, I will assure that the document is shredded.
- If I work for a program or office that is covered by the Health Insurance Portability and Accountability Act (HIPAA), and if I may encounter confidential health information in the course of my job, I have/will complete privacy training as required by the Health District's policy on the privacy of individually identifiable health information.

Date HIPAA Training Completed

I have read this Confidentiality Agreement and I understand its meaning. As an employee/volunteer of the Galveston County Health District, I agree to abide by the Confidentiality Agreement. I further understand that should I improperly release or disclose privileged, confidential, or private information, I may be subject to an adverse personnel action, up to and including the termination of my employment or volunteer assignment. In addition, I understand that I may be subject to civil monetary penalties, criminal penalties or liability for money damages for such an action.

Employee / Volunteer Signature

Date

Witness

Date
