COMMUNITY
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Dear Applicant,

Thank you for your interest in Community Health Systems. In order to process your application, we must receive a completed application with all forms and supporting documentation fully executed with original signatures. Incomplete applications cannot be processed and will be returned. Please contact the Clinical Learning Environment (CLE) with any questions or concerns you may have regarding this application.

Receipt of the following is needed to process your application.

1. All Application documents signed - If minor parent/guardian signature is required where indicated.

2. Copy of Photo ID

3. Physician's signature on the *Physician Shadowing Agreement*

4. Background check with-in the last 12 months (Notify the CLE office if you would like the hospital to run background check) Waived if minor

5. Copy of Immunizations: MMR, Varicella, Hepatitis B, Pertussis, Negative TB Test (within the year), Covid 19 (not required provide if vaccinated), current year Flu vaccination if flu season (Sept.-March).

6. If participating in research:
   CITI Certificate in Human Subjects Protection (May obtain through the CLE office)
   CV

Sincerely,
Clinical Learning Environment
(559)459-4901
CRMCClinicalLearningEnvironment@communitymedical.org

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APPLICATION FOR CMC PHYSICIAN SHADOWING/RESEARCH VOLUNTEER

Community Regional Medical Center	**Clovis Community Medical Center**	**Fresno Heart and Surgical**
Medical Staff Office 2823 Fresno Street Fresno, CA 93721 559.459.3948 559.498.8182 Fax	Medical Staff Office **684 Medical Center Drive East, #103** Clovis, CA 93611 559.324.4776 559.324.4894 Fax	Medical Staff Office 15 E. Audubon Drive Fresno, CA 93720 559.433.8048 559.433.8348 Fax

(Please write clearly and legibly)

PERSONAL INFORMATION

FIRST, MIDDLE and Last name: _____

Birth date (month/day/year):_____ Approximate start & end date: _____

SOCIAL SECURITY NUMBER:		
HAVE YOU EVER WORKED UNDER ANOTHER NAME? □ YES □ NO	IF "YES", PLEASE LIST OTHER NAME(S)	
PRESENT STREET ADDRESS	CITY, STATE	ZIP CODE

CELL PHONE #	ALTERNATE PHONE #	E-MAIL ADDRESS

Preceptor Name:

_____

I am interested in shadowing a CMC provider because: _____

_____

I am interested in research because: _____

Check the box that applies to you: I am a Student of: ___Middle School ___High School ___College ___Other

Students Only – Current School Information	**Emergency Contact:**	
School attending:	Name:	Relationship:
Grade or Year:	Address City, State, Zip:	
College Major:	Cell Phone: Email Address:	

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ACKNOWLEDGEMENT

I authorize any person, school, current employer (except as expressly noted), past employer(s), and organizations named in this application form (and accompanying resume or other documentation, if any) to provide the person(s) at Community Medical Centers (CMC) who is making a decision regarding placement in the volunteer program with relevant information and opinion, personal or otherwise. I release all parties from all liability for any damage that may result from furnishing information and opinion, which is truthful, without malice or made in good faith to you.

I understand and agree that this application nor my acceptance of a volunteer position constitutes a contract of continued volunteering, and I further understand that I should not and I agree that I will not, rely upon the foregoing as forming a contract of volunteering or as a guarantee or promise of continued volunteering. I understand and agree that my volunteer position with CMC is for no definite period, and volunteering may be terminated at the will of myself (after completion of my 50-hour commitment) or by CMC for any reason at all or for no reason, with or without notice.

I hereby acknowledge that I have read and understand the above statements. I also certify that I, the undersigned applicant, have personally completed this application. I declare that the facts contained in this application (and any resume or other documents) are true and complete to the best of my knowledge. I understand that any false information or omission will disqualify me from further consideration for volunteering and if discovered at a later date will be justification for my dismissal from volunteering.

Applicant's signature: _____ Date _____
If minor, Parent or Guardian's signature _____ Date _____

CONFIDENTIALITY AGREEMENT

Believing that Community Medical Centers has need of my services as a Volunteer, I agree to: Hold as absolutely confidential all information which I may hear directly or indirectly concerning the medical center, patients, physicians, other professional staff, employees or any volunteer and I will not seek out confidential information in regards to the same. My services are donated to Community Medical Centers without contemplation of compensation or future employment, and given with humanitarian or charitable reasons.

Signature: _____ Date: _____ (print name) _____ _____

CONSENT FOR MINOR

CONSENT FOR MINOR (under age 18) TO PARTICIPATE IN VOLUNTEER ACTIVITIES

This will authorize, a minor, to participate in such volunteer activities at Community Medical Centers as may from time to time be prescribed by the hospital's Volunteer Services. We release Community Medical Centers from any claim or liability for any injury or illness resulting to said minor while participating in such volunteer activities, not occasioned by any fault or neglect on the part of the Hospital. I understand and accept the requirements as set forth in the attached cover letter, and give my permission and assistance in reinforcing the rules and regulations for my child to serve as a volunteer.

Parent or Guardian (please print name) _____ Date _____
Parent or Guardian (signature) _____ _____ Date _____

AUTHORIZATION OF PARENTAL CONSENT TO TREATMENT OF MINOR (under age 18)

(I) / (We), the undersigned parent/legal guardian(s) of _____ , a minor, do hereby authorize Community Medical Centers as agent(s) for undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. The authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until the volunteer's 18th birthday unless sooner revoked in writing delivered to said agent(s).

Parent or Guardian (print) _____ Date _____
Parent or Guardian (signature) _____ Date _____

Physician Shadowing/Research Student Program

Policy & Procedure Number	24500
Policy Manual	Medical Staff
Type	Policy & Procedure
Document Owner	Gong, Katherine Y
Effective Date	09/21/2019
Next Review Date	09/20/2022
Application Scope (Applies to)	CMC Acute Care Facilities except CSTCC and CBHC
Approved By / Approved Date	Thomas A Utecht, MD, SVP Chief Medical-Quality Off: 09/21/2019 04:37PM PST
Status / Rev #	Official (Rev 1)
Keywords	Shadowing, Research Students
Submitted by	McComb, Laura

I. PURPOSE

To establish guidelines for students interested in medical/health professions careers for participation in Physician shadowing at CMC.

II. DEFINITIONS

A. Shadows-students ages 14 or older who want to observe a physician in the medical setting performing some of their duties as physicians. Shadowing for these purposes refers to observing only. Shadowing is limited to no more than one year unless the student remains in good standing and completes the re-application process.
B. Physician Shadowing- a mandatory process of orientation and registration for students who wish to shadow a physician and/or assist a physician with research.
C. Research Student—Students who are ages 14 or older who want to assist a physician with the collection of information for research projects.
D. Physician Participants- Physicians who volunteer to allow a student to shadow them and or provide oversight of research.

III. POLICY

A. Physician shadowing/research is designed to allow students the opportunity to observe a physician through shadowing experiences in a variety of practice areas, in accordance with the regulations and policies of the hospital.
B. No student will be permitted on the unit unless they have completed the required application, orientation and documents. Shadowing/Research is limited to no more than one year unless student remains in good standing and completes the re-application process.
C. Medical Staff Office (MSO) office is the contact department for the physician shadowing/research program and is accountable for tracking all the students. All students are to sign-in and sign-out with MSO office as described in the procedure below. If shadowing occurs on the weekend, the student is to call the MSO office of the hospital he/she is are shadowing at and leave a message.
D. If student participation through a formal school program, the student must also fulfill any school requirements.

IV. PROCEDURE

A. Student Participants must:

1. Complete an application and return to the Medical Staff Office.
2. Complete the orientation process.
3. Read and sign the Physician Shadowing Agreement which includes:
    a. Student Observation and release agreement
    b. Infection Control
    c. Confidentiality
4. The student is to provide documentation of the required communicable disease screening, certifications to MSO office. Screening requirements include:
    a. MMR-Rubeola, Mumps, Rubella-2 vaccines OR serological testing to demonstrate immunity or signed declination
    b. Varicella – 2 vaccines OR serological testing to demonstrate immunity or signed declination
    c. Hepatitis B – Documentation of immunization (series of 3 doses) OR Documentation of titer OR Signed declination
    d. Negative TB Skin Test
    e. Negative History: PPD annually
    f. Students with a known positive TB test must provide a statement, dated within the 12 months prior to rotation, from student's physician stating the student is asymptomatic for TB and, if available, results of the positive skin test (including induration) or quantiferon test and the most recent CSR results.
    g. Pertussis – Vaccination or signed declination.
    h. Influenza – if student cannot provide proof of flu vaccine, student is not permitted to shadow during flu season.
5. For shadow applicants 18 years and older, background check, at shadow applicants expense as required by law AB 655; Cal. Civil Code. The Law also requires hospital to provide written notice that a background check will be conducted and upon conclusion of the background check, a hardcopy of the results will be provided-as requested.
6. Obtain and wear hospital assigned badge at all times when participating in the shadowing program. MSO office will be responsible for providing assigned badge.
7. For the students, sign in and out will be through the facility MSO (CCMC, CRMC, and FHSH). If shadowing occurs on the weekend or after hours, the student is required to call the MSO office of the hospital he/she is shadowing at and leave a message stating the following:

a. Physician Shadow students; Name, school, physician shadowing, time in and time out.
b. For the research students; Name, ID number, physician shadowing, time in and time out.

8. Personal grooming- students are expected to maintain a high standard of bodily cleanliness. Hair must be neat, clean and will-groomed. Perfumes, colognes and fragrances should be light-or not worn at all-and may only be used in non-patient care areas.

9. Dress Standards- hemlines cannot be more than 3" above knee. Miniskirts are not allowed. Shoes must be comfortable and appropriate to wear in a workplace. No thongs, sandals or backless pumps. For safety reasons, no open toed shoes allowed. Shoes should be polished, in good condition and well-maintained. Style of clothing must be simple, professional and appropriate to a hospital setting. Examples of inappropriate attire include, but are not limited to: bare midriff, sheer fabrics, low necklines, spaghetti straps, stretch pants, leggings, shorts, T-shirts, sweatshirts, oversized baggy pants or tops. Student must also follow all dress code requirements if part of a school program.

B. Physician participants must:

1. **Complete and sign the Physician Shadowing agreement.**

2. **Introduce the student as a shadowing student under their supervision and obtain verbal consent from the patient or patient representation. It is strongly recommended that the provider make a note in the chart to document that permission was given.**

3. **If the student shadows into a procedural area, the patient or patient representative must sign the required Consent to Observe document prior to the procedure.**

C. Termination of shadowing program

1. **Upon completion of the program the ID badges must be returned to the MSO office.**

Non-Compliance-if at any time the student does not follow applicable rules and requirements, their shadowing participation will be cancelled.

Physician Shadowing Agreement

To be read and signed by student, student parent (if student a minor) and participating physician.

STUDENT OBSERVATION AND RELEASE AGREEMENT

In consideration of the fact that Community Medical Centers (CMC) has agreed to allow me to be on its premises for a shadowing/observation experience, (the experience), I/We agree to the following terms and conditions required for the experience.

- I/We agree that, at all times relevant to the student participant's presence on CMC campus, the student will be covered by a privately purchased and effective health insurance policy covering the student.
- I/We agree that the student shall complete CMC's required HIPAA training, regarding patient confidentiality obligations, before being allowed to participate in the experience.
- I/We agree that the student will abide to the CMC policies and procedures, including HIPAA, and that the student will conduct himself or herself in a professional manner at all times.
- I/We understand that the experience may involve risks of injuries or health exposures and I/We agree that participation in the experience and risks are being voluntarily assumed.

I/We agree that CMC and any corporations or entities affiliated with the foregoing and all employees, officers, agents representatives, and volunteers of the foregoing (together, the "Released Parties") are hereby released from any and all liability related, directly or indirectly, to the shadowing/observation experience and that I/We agree to hold the Released Parties harmless from any and all liability, causes of action, or other claims related to the student's participation in the experience. I/We agree to assume all risks and be solely responsible for any injury, loss, or damaged sustained or caused by the student while involved in the shadowing/observation experience.

INFECTION CONTROL

It is possible to acquire infections such as HIV, Hepatitis B and Hepatitis C through contact with blood and body fluids. While measures are in place to provide a safe hospital environment, you should always be on the alert for items such as contaminated needles or dressings. If you see a potentially contaminated item, notify a healthcare worker so it can be disposed of properly. Do not handle it yourself.

Hand hygiene is the most important way to prevent the spread of germs. Wash your hands promptly and thoroughly when they are soiled, after touching potentially contaminated surfaces, after using the restroom, and before eating. When your hands are visibly clean, alcohol-based hand rub is an effective alternative to soap and water.

Patients may be placed in isolation for a variety of reasons. Depending on the type of isolation, there are protective measures the healthcare worker must take. For the patient's and your safety please do NOT enter these rooms with the caregiver.

It is important to protect patients from infections. Please do not participate in your shadow activities if you have an infectious disease that could be spread to others (i.e., fever, purulent drainage, unexplained rash, productive cough, etc.)

Thank you for following these instructions. Please contact the Hospital's Infection Control Department @ 459-6553 with any questions.

CONFIDENTIALITY

Patients at Community Medical Centers (CMC) are entitled to confidentiality with regard to their medical and personal information. The right to confidentiality of medical information is protected by state law and federal privacy regulations known as the Health Insurance Portability and Accountability Act (HIPAA). Those regulations specify substantial penalties for breach of patient confidentiality.

1. All patient medical and personal information is confidential information regardless of my education or clinical setting(s) and must be held in strict confidence. This confidential information must not become casual conversation anywhere in or out of a hospital, clinic or any other venue. Information may only be shared with healthcare providers, supervising faculty, hospital or clinic employees, and students involved in the care or services to the patient or involved in approved research projects that have a valid need to know the information.
2. Under strict circumstances, upon receipt of a properly executed medical authorization by the patient or a HIPAA-compliant subpoena, medical information may be released to the requesting party. Inquiries regarding the appropriateness of the authorization or subpoena should be directed to the legal department 324-4001 or Risk Management 459-2639, depending upon the situation.
3. Computer user codes/passwords are confidential. Only the individual to whom the code/password is issued should know the code. No one may attempt to obtain access through the computer system to information to which he/she is not authorized to view or receive.
4. If a violation of this policy occurs or is suspected, immediately report this information to your supervising faculty or sponsor.
5. Violations of this policy will result in disciplinary action up to and including termination from the program. Intentional misuse of protected health information could also subject an individual to civil and criminal penalties.

I have read and agree to comply with the practices, terms and requirements described above.

_____ _____

Student-Print Name Signature

_____

Date

_____

Signature of Parent or Guardian
(if student is a minor)

_____ _____

Physician –Print Name Signature

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ACKNOWLEDGEMENT OF HIPAA

I, _____ _____ *(please print name)*, have received an educational piece on the **H**ealth **I**nformation **P**ortability and **A**ccountability **A**ct (HIPAA). As a volunteer at Community Medical Centers, I understand that Patient Information is among the most sensitive and personal of information collected. Furthermore, I understand that trust is the basis of any provider-patient relationship, and I recognize the importance of the privacy we provide to our patients.

Certificate of Understanding

I acknowledge that I have read and understood the information on HIPAA and Patient Confidentiality and that I am responsible for knowing and adhering to the standards listed.

I acknowledge that I have read and understood Community Health Systems' Commitment to Principles and that I am responsible for knowing and adhering to the principles and standards of this code.

I further certify that to the best of my knowledge and belief I have complied with the hospital's privacy standards and the Commitment to Principles and am not aware of any violation. I further certify that throughout the remainder of my association with Community Health Systems I shall continue to comply with the privacy standards and the Commitment to Principles.

I understand that adherence to these standards is a condition of my volunteer service. I also understand that these standards may be amended, modified or clarified at any time and that I will receive any updates that occur.

Name (please print): _____

Signature: _____

Date: _____

CONFIDENTIALITY OF INFORMATION AGREEMENT

PURPOSE OF CONFIDENTIALITY AGREEMENT

Community Health System endeavors to improve the quality of patient care and the health status of the community, while protecting the confidentiality and privacy of patients.

Community Health System strongly believes in the balance of protecting patient information and privacy, while allowing its employees and other appropriate individuals (e.g., independent contractors, etc.) access to the information they need to successfully do their jobs. To promote excellent quality of care while at the same time protecting patients' confidentiality and privacy, Community Health System requires that all employees and others who need access to patient or Community Health Systems' information read sign and abide by the terms and conditions of this Confidentiality of Information Agreement. The policies contained in this agreement are consistent with policies and all applicable laws and regulations. Please read the agreement carefully and ask questions if you need clarification.

DEFINITIONS

"Confidential" means that patient and Community Health Systems' business information must not be revealed to or discussed with anyone who does not have a legitimate medical and/or business reason to know the information.

"Patient Information" is any information regarding the patient obtained or to which you have access during the course of your work or association with Community Health System. Such information may include, but is not limited to, financial and social data relating to patients, the medical record (i.e., documents relating to an individual's medical history, diagnosis, condition, treatment or evaluation), business records, committee meetings and reports, physician office records, x-ray films, lab results, and incident reports. All such patient information is covered by Community Health Systems' HIPAA Privacy Policy.

"Business Information" is any information regarding the business and operations of Community Health System obtained or to which you have access during the course of your work or association with Community Health System. This may include, but is not limited to, information concerning employees, financial operations, quality assurance, utilization review, risk management, procurement, contracting, and all non-public information covered by the California Uniform Trade Secrets Act.

"Information Systems" include, but are not limited to, computers, telephones, fax machines, software, email, and internet / intranet access and voice mail.

"CDPH" means California Department of Public Health.

"DHHS" means the U.S. Department of Health and Human Services.

CONFIDENTIALITY OF PATIENT INFORMATION

1. I understand that access to patient information is required for me to do my job, and that I am only permitted to access patient information to the extent necessary for me to provide patient care and perform my duties. Therefore, I will treat all patient, physician, employee, and hospital business information (e.g., medical, social, financial, and emotional information) acquired or to which I have access during the course of my work as strictly confidential. I understand that even if a family member or significant other who has signed a release of information authorizing me to be informed of their respective care, I may not review the medical record of my own accord. Instead, I must communicate directly with the physician and/or nursing staff to obtain information about their care.
2. I understand that "confidential" means that patient information must not be revealed or discussed with other patients, friends, relatives, or anyone else outside of the Community Health System health care environment. In other words, a patient's personal and medical information can only to be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off.

3. I will not release or disclose patient information, unless my job requires it, and then in accordance with Community Health Systems' HIPAA Privacy Policy I will disclose only the minimum necessary patient information needed to carry out my responsibilities for the facility. I will not disclose identifying information (e.g. name, date of birth, etc.) if the information can be removed and is not essential to the analysis. If I am not sure whether the information should be released, I will refer the request to the appropriate individual or department (e.g., the Privacy Office).
4. I will appropriately dispose of patient information and reports in a manner that will prevent a breach of confidentiality. I will never discard confidential or patient identifying information in the trash, unless it has been shredded.
5. I understand that I have a duty to protect Community Health Systems' patient information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to immediately disclose to Community Health System any breach of patient confidentiality so that the appropriate disclosures can be made as per Federal and State privacy laws (45 C.F.R. § 164.404; Cal. Health and Safety, § 1280.15.)
6. I will access patient information only when needed in order to do my job, and understand that retrieving/viewing/printing information (computerized or paper), on other patients such as friends, relatives, neighbors, celebrities, co-workers, or myself is a breach of confidentiality and may subject me to immediate termination of employment or association with Community Health System, as well as civil sanctions and/or criminal penalties.
7. I understand I am personally responsible for the content I publish, including photographs, on Social Network Media (e.g., Facebook, Twitter, LinkedIn, etc., including blogs, wikis or any other form of user-generated media). I understand that I am prohibited from referencing or citing any unique hospital patient, client, partner, or customer information without their expressed written consent on social networking media. In all cases, I will not publish any information about a patient either specifically or in general. This includes but is not limited to any information that may be considered a distinguishing characteristic and/or case uniqueness.
8. I understand that under State law, unauthorized or unlawful access to, or use or disclosure of a patient's medical information will be reported by the facility within 15 business days after detection to the patient and/or the patient representative and to CDPH. I further understand that under Federal law, acquisition, access, use or disclosure of protected health information in a manner not permitted by the federal privacy laws and regulations, which compromises the security or privacy of the protected health information will be disclosed within 60 calendar days after discovery to the patient and/or the patient's representative, and will also be reported to DHHS.
9. I understand that I can be held civilly or criminally liable and may be personally fined and/or penalties sought against me personally by licensing agencies or court action by the Attorney General or other counsel if I knowingly and willingly obtain or disclose unauthorized information without patient authorization.
10. I understand as a non-Community Health System, employee, I will access patient information only when needed in order to perform my services, and understand that retrieving/viewing/printing information (computerized or paper), on any other patients, including but not limited to, friends, relatives, neighbors, celebrities, co-workers, or myself is a breach of confidentiality, and can subject me to immediate termination of my access to Community Health Systems' health records or association with Community Health System.

CONFIDENTIALITY OF BUSINESS INFORMATION

1. I understand that information regarding the business, operations and trade secrets of Community Health System is confidential, and that such information is owned by and belongs to Community Health System.
2. I understand that I am only authorized to access business information if it is required for me to perform my duties. This information must not be revealed or discussed with others within or outside Community Health System except to the extent that this discussion is necessary to perform my duties.
3. I understand that I have a duty to protect Community Health System business information from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to Community Health System any breach of business information confidentiality.
4. Upon termination of my employment or association with Community Health System, I agree to immediately return all confidential business information of Community Health System in my possession, regardless of form, including any access codes or passwords required to access such information.
5. I understand that failure to follow this agreement may subject me to immediate termination of employment or association with Community Health System, as well as civil sanctions and/or criminal penalties.

INFORMATION SYSTEM SECURITY

1. I understand that Community Health Systems' information systems are company property and are to be used only in accordance with company policy as set forth in the Community Health Systems' handbook. I also understand that I may be given access codes or passwords to Community Health Systems' information systems, and that that I may use my access security codes or passwords only to perform my duties.
2. I acknowledge that I am strictly prohibited from disclosing my security codes or passwords to anyone, including my family, friends, fellow workers, managers, and subordinates for any reason. I will keep my security codes and passwords in confidence and will not disclose them to anyone for any reason.
3. I agree that I will not breach the security of the information systems by using someone else's security codes or passwords, nor will I attempt in any way to gain access to any unauthorized system. Also, I will not allow anyone else to access the information systems using my security codes.
4. If I leave my workstation for any reason, I will initiate security measures in accordance with established procedures so no unauthorized person may access patient or business information, or enter information under my security codes or password(s); I will make sure the system screen or paper record is not left open and unattended in areas where unauthorized people may view it.
5. I will not misuse or attempt to alter information systems in any way. I understand that inappropriate use of any information system is strictly prohibited. "Inappropriate Use" includes (i) personal use which inhibits or interferes with the productivity of employees or others associated with Community Health System, or which is intended for personal gain; (ii) transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate; (iii) disclosure of Confidential Information to any individual, inside or outside the practice, who does not have a legitimate, business-related need to know; and (iv) the unauthorized reproduction of information system software.

6. I understand that I will be held accountable for all work performed or changes made to the system or databases under my security codes, and that I am responsible for the accuracy of the information I input into the system(s).
7. If my employment or association with Community Health System ends, I will not access any Community Health Systems' information systems that I had access to and acknowledge that legal action may result if I do.
8. I understand that Community Health System reserves the right to audit, investigate, monitor, access, review, and disclose information obtained through the organization's information systems at any time, with or without advance notice to me and with or without my knowledge.
9. I understand that I have a duty to protect Community Health System information systems from loss, misuse, unauthorized access, alteration or unauthorized modification, and that I have a duty to disclose to Community Health System any breach of information system security (for example, if the confidentiality of my or another employee's password has been broken) or any inappropriate use of information systems.
10. I understand that a violation of computer security or any component of this agreement is considered a violation of Policy, and may subject me to immediate termination of employment or association with Community Health System as well as civil sanctions and/or criminal penalties.

ACKNOWLEDGEMENT OF CONFIDENTIALITY OF INFORMATION AGREEMENT

I will ask my manager for clarification if there are any items I do not understand before signing this agreement.

My signature below acknowledges that I have read and understand this agreement and realize it is a condition of my employment/association with Community Health System. I also acknowledge that I have received a copy of this signed agreement.

I am:

☐ Employee of Community Health System

☐ Non-Employee; state how associated (e.g., independent contractor, student, medical staff, vendor, consultant, etc.), company name, and business purpose (if applicable):

_____

_____

_____

Signature:_____ Date:

Print name:_____ _____

Employee Number: _____

DISCLOSURE AND AUTHORIZATION

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. These reports will include checks regarding your criminal history, social security trace, employment and education references, credit history, professional licenses and credentials. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by VICTIG, 14587 South, 790 West, Suite C 201, Bluffdale, UT 84065 Phone: 8668865644, Fax: 8667218263, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your 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 Employer by contacting the consumer reporting agency identified above directly.

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" at any time after receipt of this authorization and, if I am hired, throughout my employment. 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 VICTIG, 14587 South, 790 West, Suite C 201, Bluffdale, UT 84065 Phone: 8668865644, Fax: 8667218263, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

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: Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California Law. ☐

- I am authorizing VICTIG, Inc to conduct the background check(s) described above
- I acknowledge I may request a hard copy of this Disclosure and Authorization form by calling VICTIG at Phone: 8668865644, Fax: 8667218263.

Name

_____

Date of Birth

_____

SIGNATURE

_____

DATE

_____

Address

_____

_____

Social Security Number

_____

COMMUNITY
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COMMUNITY MEDICAL CENTER
VOLUNTEER SIGNATURE PAGE:

I agree that as a volunteer I am performing volunteer services for civic, charitable or humanitarian reasons without promise, expectation or receipt of any compensation for volunteer services.

I have not been offered, promised or guaranteed future employment or compensation as a result of my volunteer services.

Signature Date

Legal Guardian Signature (if under 18) Date

COMMUNITY MEDICAL CENTERS

AIDET – *Standards of Service*

Community Medical Centers is the region's largest and most essential health care provider. We are some 9,000 employees strong, and we see about one million patients annually. Anchored in Fresno County, we proudly serve the greater San Joaquin Valley and beyond, providing the" higher level of care" in many clinical specialties as well as providing a "safety net" delivery system for many individuals. As employees, our conduct not only defines who we are individually but what Community Medical Centers represents. How we conduct ourselves and interact with our customers – patients, families, friends and physicians and each other – makes a lasting impression. Accordingly, Community employees themselves have developed these standards to which all employees commit.

Respect

- Never argue or exhibit rudeness
- Reasonably accommodate customers with communication barriers
- Maintain the privacy, modesty and dignity of our customers
- Knock before entering patient rooms
- Treat our customers' possessions as I would my own
- Am sensitive to the differing cultural backgrounds of our customers
- Involve patients in their care and treatment
- I guard against excessive noise in my work environment
- I provide directions and offer to escort customers to their destination
- I show that I value customers' time; thank them for waiting and apologize for delays
- I treat all customers as I would wish to be treated: Say "please," "thank you" and "I'm sorry" in appropriate situation

Professionalism

- Answer call lights promptly, according to the call light initiative
- Wear my ID badge, above the waistline, at all times
- Be accountable for my work time and comply with all time and attendance policies
- Dress for my work role according to the Corporate Dress Code Policy
- Keep all regulatory licenses and certifications current
- Ensure that all interactions, regardless of circumstances, are without hidden agendas
- Recognize when additional support is needed, and ask for help
- Report and document all incidents promptly

Communication

- Communicate in a courteous, caring manner, verbally and non-verbally, in every customer interaction
- Avoid gossip and rumors
- Give customers my undivided attention
- Educate customers about next steps in the process
- Be a telephone pro; follow the Target 100 telephone etiquette initiative
- Conclude customer conversations by asking, "Is there something else I can do for you?"
- Be proactive in communication; update patients about their status before they feel the need to ask

Teamwork

- Be resourceful; use other team members to solve problems
- Be generous and approachable; convey my willingness to help other team members
- Value other team members' time by encouraging productive meetings and discussions
- Encourage others around me to embrace Target 100 initiatives and standards of service excellence
- Acknowledge other team members for their contributions
- Praise in public and discuss issues in private
- Treat all positions and departments as equally important in our mission to deliver top-notch care and service

Ownership

- Keep my work area and facility clean and litter free
- Ensure, at all times, that our customers' environment is safe
- Be responsible for, and take pride in, the outcome of my work
- Never say, "it's not my job" or "it's not my patient"
- Do everything I'm able to make things right for our customers, or find someone who can
- Be cost conscious, mindful of budget, and make every penny count
- Through my job, make a difference

Excellence

- Assist in efforts to monitor quality, effectiveness and costs
- Understand and utilize departmental progress reports and personal evaluations to improve performance
- Be flexible, and view rational change as an advantage to our organization rather than an inconvenience to individuals
- Be continually responsive to customer assessment of our performance, beyond formal Target 100 measurements
- Share ideas for improving my unit and the health status of the community

MY COMMITMENT

I, _____ , agree to abide by the standards set forth in this document.

Print Name

_____ _____

Signature Date

VOLUNTEER ORIENTATION QUESTIONNAIRE

Instructions: Watch https://youtu.be/HO_8EWxLV7s Answer questions below.

1.	T	F	At Community Medical Centers, we put our patients first, constantly striving to improve the health of our community; we are sensitive, kind, polite and pleasant and expect to treat every person we serve like a friend.
2.	T	F	If I put myself in the patient's place, I will give them the same respect, understanding, privacy and dignity that I would want.
3.	T	F	I never say "no." Instead I take special interest in each person's needs.
4.	T	F	It is my responsibility to call or email my department and the Volunteer Manager if I am ill, on vacation, or need to request a leave of absence.
5.	T	F	As a volunteer, I can address a customer's complaint by notifying a nursing supervisor. It is my responsibility to help resolve issues and/or concerns to the best of my ability.
6.	T	F	I may lift or move a patient by myself.
7.	T	F	A violation of confidential information is a violation of hospital ethics. A volunteer may be dismissed immediately for speaking of confidential information regarding a patient, staff member, physician or other volunteer.
8.	T	F	To build a healthier community and to promote medical education is the mission of Community Medical Centers.
9.	T	F	Dial 18 (unless different at your facility) for an emergency.
10.	T	F	A.I.D.E.T. = Acknowledge, Introduce, Duration, Explain, Thank you
11.	T	F	I am responsible for helping to keep the hospital and its surroundings picked up and tidy.
12.	T	F	There is a dress code for volunteers and there are rules for personal grooming that I must adhere to.
13.	T	F	Customers with disabilities should be treated with the same respect as everyone else.
14.	T	F	Refer to a staff member for direction when a code is called overhead.
15.	T	F	Hand washing is the most critical part of infection control.
16.	T	F	Universal Precautions are to be followed with all patients and all body substances.
17.	T	F	Patients have rights. These rights exist without regard to gender, sexual orientation, disability, cultural, economic, education or religious background, or the source of payment for their services.
18.	T	F	Security provides 24-hour assistance for patient, staff, and volunteers. I may call for assistance at any time by dialing 13, even for an escort to my car.
19.	T	F	Sexual harassment is defined as unwanted sexual advances, or visual, verbal or physical contact of a sexual nature. Volunteers should not receive or give any of these.
20.	T	F	Upon completion of my volunteer services, I must return my picture ID badge to the Volunteer Services office.
21.	T	F	Each culture can have different views of healthcare and treatment options.

22.	T	F	Community Medical Centers offer Interpreter/Translation Services 24 hours a day, 7 days a week to its patients and their family members.
23.	T	F	If a parent/guardian approaches me attempting to abandon their newborn child I will accept the infant. I will remain objective and will not convey blame or wrongdoing.
24.	T	F	It is your responsibility to protect health information by following COMMUNITY MEDICAL CENTERS Privacy Policies, refraining from discussing patient information with those who don't need to know, never disclosing patient information unless authorized.
25.	T	F	As a volunteer, if I have a license or a certificate in the Health Care industry, it is OK to have direct patient contact.
26.	T	F	If I hear, see or suspect something illegal, unethical or questionable I must say something to my supervisor or the Compliance Office, or I can use the Ethics and Compliance Alert Line at 1-888-394-2301 or www.MyComplianceAlertLine.com and report anonymously.
27.	T	F	The Ethics and Compliance Policy does not apply to me since I am not an employee of CMC.
28.	T	F	I must act with honestly and integrity at all times with everyone I interact with.
29.	T	F	At CMC we promote a culture of prevention, detection and resolution of wrong doing.
30.	T	F	As a volunteer I do not have a responsibility to support the Ethics and Compliance Program.

Circle the correct answer to each question below.
Note: Some questions may have more than one correct answer.

31. You are doing a lab run and notice that it was for a close friend. It is OK to:

a) Call his family and see if there is anything you can do to help.

b) Stop by his room to say hello.

c) Ask one of the volunteers in the lobby to check his diagnosis on the computer.

d) Drop off the prescription and continue your regular rounds.

32. You are working on the information desk and are having trouble signing on to the computer. You should:

a) Ask another volunteer to log on for you with her user name and password.

b) Give your user name and password to a fellow volunteer and see if it works for her.

c) Call the Help Desk and ask for assistance.

d) Give up and go home.

33.	You have finished your shift and are having lunch in the cafeteria with several other volunteers. Which of the following statements would be a violation of the privacy law? a) "The patient in room 801 received some beautiful flowers today. I need to find out which florist was used." b) "We had a little excitement in the ER today – the police brought in a guy who had obviously been partying most of the night." c) "I always thought my late husband had an unusual name, but I met a patient this morning who has the very same name!" d) "We did a booming business in the gift shop today! Dr. Smith's wife finally had her baby, and I think every single one of her relatives came in to buy a gift."
34.	The hospital's Code of Ethics prevents volunteers from: a) Accepting tips from grateful patients; b) Using the office copy machine to make copies of their favorite cartoons; c) Reporting possible ethics violations to the Manager of Volunteers; d) Looking up a neighbor's age in the hospital computer.
35.	It is acceptable to ask for the volunteer roster when: a) You are going on vacation and need to find a substitute. b) You are putting together the invitation list for your club's fundraiser. c) You want to check on a volunteer who has been absent for a few weeks. d) Your son is starting a new business marketing timeshares for seniors.

Volunteer Signature _____ Date _____

CERTIFICATION AND ACKNOWLEDGMENT

I acknowledge that during my **Volunteer Orientation** session, I have received education regarding the topics below. I understand that this education does not validate my competency. I also acknowledge that I am responsible for knowing and following the policies and procedures of Community Health Systems. If I require further explanation, I will contact the CLE Office.

Topics covered in the **Volunteer Orientation** Power Point https://youtu.be/HO_8EWxLV7s were as follows:

- Customer Service and the Standards of Service Excellence
- Human Resources Policies and Procedures
- Ethics and Compliance Program
- Safety
- Quality and Risk Management
- HIPAA – Patient Confidentiality and Information Security
- Patient Diversity
- Infection Control
- Adult/Elder Abuse and Domestic Violence: signs, symptoms and reporting
- Rights of Victims of Domestic Violence, Sexual Assault and stalking

_____

Signature

_____

Printed Name

_____

Date