

SOUTH COUNTY HEALTH

Volunteer Information

Last Name:	First Name:	Middle Initial:	Preferred Name:
List your <u>current</u> address, city, state, and zip:			
List your <u>last, out-of-state</u> address, city, state, and zip (if current address is less than 3 years):			
<input type="checkbox"/> Check here if not applicable			
Telephone #1 (indicate if home, cell, work, etc.)		Telephone #2 (indicate if home, cell, work, etc.)	
Email Address:			
Date of Birth:		Are you a student?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you over 18 years old?		Please list your school or institution (if applicable):	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Will you be volunteering for only one season? (e.g., Spring, Summer)		Anticipated Starting Month and Year:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		Anticipated Ending Month and Year:	
<i>List Vehicles and License Plate Numbers</i>			
Vehicle #1 Make, Model and Color:		Vehicle #2 Make, Model and Color:	
State: Plate #:		State: Plate #:	
<i>List Emergency Contact Information</i>			
Last Name:	First Name:	Relationship:	
Address:	City:	State:	
Telephone #1:		Telephone #2:	
For Internal Use Only: Volunteer Placement	<input type="checkbox"/> Ambulatory Care Center	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Unit Volunteer
	<input type="checkbox"/> Patient Escort	<input type="checkbox"/> Non-clinical Intern	<input type="checkbox"/> Comfort Cart
		<input type="checkbox"/> Auxiliary	<input type="checkbox"/> Reiki

South County Health (SCH) values and upholds each patient's right to confidentiality, privacy, and security of their protected healthcare information (PHI). Security and confidentiality is a matter of concern for all persons at SCH who have access to PHI. In addition, other SCH information that may include but is not limited to financial, business, personnel, or contractual materials may be considered confidential. Each person accessing SCH 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 patient PHI and other organizational information, either through their employment, contract, credentialing, or association with SCH, must read and comply with SCH policies that govern the confidentiality and security of information, as well as sign and comply with this pledge.

1. I understand that in the performance of my duties at South County Health, I may have access to certain patient Protected Health Information (PHI), as well as other organizational information that may be from any source or in any form (i.e.: paper, electronic, oral). I will maintain and protect the security of such information in any form.
2. I will comply with all federal HIPAA regulations, Rhode Island State Laws, policies, procedures, and other rules of South County Health relating to confidentiality of information and user codes including but not limited to the Administrative Policy, [Data and Information Systems Security Policy](#).
3. I will not disclose any confidential information unless required to do so in the official capacity of my employment, association, contract, or business relationship. I also understand that I have no right or ownership interest in any confidential information.
4. I will not take PHI from the premises of SCH in paper or electronic format, without authorization to do so from the Privacy Officer or (data) Security Officer, and only when following secure procedures defined and approved by SCH. The removal of PHI from the SCH premises shall not be done as a personal convenience to perform job duties that could and should otherwise be performed from the SCH premises. I will only remove PHI from the SCH premises if it is a specific requirement of my job; and as such, authorization would not be required.
5. I understand that the information accessed through all South County Health information systems contains sensitive and confidential patient information, business, financial and hospital employee information that should only be disclosed on a need to know basis in the performance of the organization's mission.
6. I will respect the confidentiality of any reports printed from any information system containing patient information, or any written documents, reports, notes, and the like containing patient information, and handle, store and dispose of these reports appropriately.
7. I understand that any papers, documents, records, reports, notes and the like containing patient information shall be disposed of in hospital-approved shred bins only.
8. I will not access or request any information unless I have a need to know this information in order to perform my job. This includes, but is not limited to, co-workers, friends, and acquaintances. Ability to access PHI does not, by itself, imply authorization to do so.

9. I will not seek personal benefit or permit others to benefit personally by any confidential information or use of equipment available through my work assignment or use confidential information in any way that is detrimental to the SCH.
10. I will not access or obtain my own or any family members' PHI unless required in the performance of my job duties. To obtain my PHI, I will sign the applicable authorization and obtain the information from an (other) appropriate staff member in the department of service or from a Health Information Management Department representative.
11. I am responsible and accountable for all entries made and all retrievals accessed under my user code, even if such actions were made by me or by another due to my intentional or negligent act or omission.
12. My user code is equivalent to my legal signature, and I will not disclose this code to anyone or allow anyone to access the system using my user code. I will safeguard my computer password(s) and will not post it in a public place, such as on the computer monitor or a place where it will be easily lost, such as on my employee badge. If I have reason to believe that the confidentiality of my user code has been compromised, I will immediately change my password and notify the Management Information Systems department.
13. I will not impersonate another user or use another person's user-id or password to gain access to programs, data, or other SCH's networks or computer information systems without authorization from immediate supervisor.
14. I will log off of my computer as soon as I am finished with it or if I will be away from it unattended in an unsecured area.
15. I will respect the ownership of proprietary software. For example, I will not make unauthorized copies of such software for my own use, even when the software is not physically protected against copying.
16. I will not install software products, data, or any copyrighted works that are not owned or licensed by SCH.
17. I understand that my use of the system will be periodically monitored to ensure compliance with this agreement.
18. I will report any violations of this agreement to the SCH Security Officer or Privacy Officer.
19. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of employment, association, contract, or business relationship, unless specifically waived in writing by the authorized party.
20. I understand that my obligations under this pledge will continue after termination of employment, association, contract, or business relationship with SCH.

I further understand that if I violate any of the above terms, I may be subject to disciplinary action, up to and including termination, legal action for monetary damages, fines or sanction, or both, or any other remedy available to South County Health.

Printed Name: _____

Date: _____

Signature: _____