HCA MIDWEST HEALTH

MENORAH MEDICAL CENTER

Dear Prospective Volunteer,

Thank you for your willingness to become part of the Menorah Medical Center Volunteer Team! We value your time, commitment and desire to help our patients and their family and friends have the very best experience while they are here.

Our Vision Statement says it best; *Together, we will be the premier healthcare destination for all we serve*. The word 'together', in this case, means teamwork, we cannot be successful without each and every one of us!

Our Mission Statement says; *Above all else, we are committed to the care and improvement of human life.* Whether that be the patient or their loved ones, we are committed to serving each one of them.

Our Value Statement sums it all up;

Integrity, Compassion, Always, Respect, Excellence

I * C * A * R * E

Please complete the accompanied New Volunteer Application Packet. Once we receive that back, we will do a background check and ask you to complete a standard new employee physical at CareNow. Once we get all the information back, we will have you come in for orientation to get your feet on the ground and then get you to work.

I am excited to see what the future has in store for Menorah Medical Center and what part you will play. If there is anything we can do for you, please do not hesitate to call or email us. Thank you!

Sincerely,

Debalina Majumder
Patient Relations Coordinator
913-498-6062
913-498-6237
debalina.majumder@hcamidwest.com

HCA MIDWEST HEALTH
MENORAH MEDICAL CENTER

Emergency Information

Volunteer Name: _____

First Contact:

_____ _____

First Name Last Name

_____

Address

_____ _____

Cell Phone Work Phone

_____

Relationship

Second Contact:

_____ _____

First Name Last Name

_____

Address

_____ _____

Cell Phone Work Phone

_____

Relationship

Confidentiality and Security Agreement

Note: this form to be used for HCA employees and HCA workforce members.

I understand that the HCA affiliated facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, credentialing, intellectual property, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

General Rules

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

Protecting Confidential Information

4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
9. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

Following Appropriate Access

10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Using Mobile Devices, Portable Devices and Removable Media

12. I will not copy or store Confidential Information on mobile devices, portable devices or removable media such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards.

13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (*e.g.*, Company email) may contain Confidential Information and as a result, must be protected as required by Company Information Security Standards.

Doing My Part – Personal Security

14. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
15. I will:
    a. Use only my officially assigned User-ID and password (and/or token (*e.g.*, SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
16. I will never:
    a. Disclose passwords, PINs, or access codes.
    b. Allow another individual to use my digital identity (e.g., 3-4 User ID) to access, modify, or delete data and/or use a computer system.
    c. Use tools or techniques to break/exploit security measures.
    d. Connect unauthorized systems or devices to the Company network.
17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
18. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
    a. my password has been seen, disclosed, or otherwise compromised;
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;
    d. I am aware of any activity that violates this agreement, privacy and security policies; or
    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

Upon Termination

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Workforce Member Signature	Facility Name and COID	Date
Employee/Workforce Member Printed Name	Business Entity Name	

Menorah Medical Center New Volunteer Health Assessment

Name:			**Date:**		
Home Phone:			**Last 4 of SSN:**		
Position/Department:	**Volunteer Department**		**DOB:**		

Welcome,
We are very excited at Menorah Medical Center to have you joining us here to volunteer and support the patients.

Employee Health will need the following information for the hospital to be compliant when you come on campus.

Please provide any documentation you have from childhood or more recently to Employee Health Office 4th floor, fax to 913-498-6039, or e-mail to shana.leonard@hcamidwest.com.

- Measles, Mumps, Rubella MMR vaccinations
- Varicella (Chickenpox) Vaccinations
- TDaP (Pertussis) as an Adult over 18 years of age. (You can receive on CARENOW visit)
- Influenza Vaccination copy is required starting Oct. 1 through March 31st. (You can receive through Menorah during the month of October for free).

If you have had the diseases- Mumps, Measles, Rubella and Varicella please just sign here to indicate that you are protected: Name: _____ Signature: _____

You will be going to CARENOW with your Authorization Form provided by Volunteer Leader. They will be drawing lab work called a T-Spot that will be testing for Tuberculosis. If for any reason the lab test comes back positive, CARENOW will call you to have a Chest X-ray to tell us that you do not have active Tuberculosis. Please contact me in Employee Health 913-498-7133 for a follow up discussion after the chest x-ray.
This is a state requirement for all hospitals for anyone coming on campus.

BELOW are a few questions Employee Health would request you answer:

Please answer the following questions as accurately as possible: (circle one: explain any "yes" answers)

Have you ever had a positive TB skin test?	☐ No	☐ Yes	_____
Do you currently have a persistent (2-3 week) cough or bloody sputum?	☐ No	☐ Yes	_____
Have you recently had fever, night sweats, loss of appetite?	☐ No	☐ Yes	_____
Have you recently been evaluated for any unexplained illness?	☐ No	☐ Yes	_____
Do you currently have an infectious rash?	☐ No	☐ Yes	_____

_____

Thank you for your cooperation. If you have any employee health questions please contact me.

Shana Leonard MS APRN

Menorah Employee Health Department

4th Floor

913-498-7133

CareNow Urgent Care — HCA Midwest Health

Authorization for Occupational Health Services

This is authorization to examine or treat: *(applicant or employee name)*	Date:

Authorization Signature: *(required)*	Authorizer Name: *(print)*
Debalina Majumder	Debalina Majumder
Company Contact: Shana Leonard, EHN	**Company Name:** Menorah Medical Center
Phone: 913-498-7133	**Fax:** 913-498-6039
Billing Address: 5712 W 119th Street Overland Park, Kansas 66209	
WC Insurer:	**WC Adjuster:**
Phone:	**Fax:**

Services Requested

Workers' Compensation Claim Medical treatment of injury or exposure. Please describe:

_____

_____

_____

Is Alternative work available? ☐ Yes ☐ No **Fax Return to Work form to:** _____

Drug Free Workplace Testing (ID required)

Choose one:

☐ DOT 5-panel *(must specify testing authority agency below)*

☐ DOT Breath Alcohol
☐ Breath Alcohol
☐ 5-panel
☐ 8-panel
☐ 10-panel
☐ 11-panel Instant
☐ _____

☐ Blood Alcohol
☐ Hair Testing
☐ Instant
☐ eScreen
☐ Saliva

Also Choose:

☐ Pre-employment
☐ Post-accident
☐ Return to work
☐ For-cause
☐ Random
☐ Collection Only: _____

Physical Examinations

☐ Basic Employment Physical

☐ OSHA surveillance
☐ Respirator clearance
☐ Other: _____

☐ DOT physical
☐ Fitness-for-duty
☐ International travel

☐ Other: _____

Vaccines and Ancillary Service

☐ Tuberculosis test (PPD)
■ Laboratory: T-Spot Lab Draw
☐ Vaccination: MUST GO BEFORE 2PM!
■ Tdap ☐ Hepatitis A
■ Flu ☐ Hepatitis B
☐ Other: _____

☐ Urine analysis
☐ EKG (heart)
☐ Spirometry (lungs)
☐ X-ray 1 view
☐ X-ray2 view
☐ Other: _____

Testing Authority Agency: *(Required for DOT Drug Screen)* ☐ HHS ☐ NRC ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG ☐ _____

Kansas City Locations and Hours:

kansascity.carenow.com

New Location: Corbin Park-Metcalf & 138th St.
13761 Metcalf Avenue
Overland Park KS 66223 913.814.3788
8am – 2PM Volunteer Visit Time ONLY

Menorah Medical Center Volunteers # 8370

VOLUNTEER DISCLOSURE & AUTHORIZATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1]_____

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The prospective organization ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. 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. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. 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 PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your volunteering with the Company to the extent permitted by law.

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 the term of my volunteering, 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 PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] 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.

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ **Date** _____

Parent/Guardian Signature: _____ **Date** _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

Volunteer Services
Menorah Medical Center
5721 West 119th Street
Overland Park, KS 66209

HCA MIDWEST HEALTH
MENORAH MEDICAL CENTER

Volunteer Services Application

Name: _____ Date: _____
(Last) (First) (Middle)

Home Address: _____ Home Phone: _____
(Street)

_____ Cell Phone: _____
(City) (State) (Zip Code)

Email: _____

Date of Birth: _____ Who referred you to us? _____
(Month) (Day) (Year)

Education (Circle last year completed) High School: Freshman Sophomore Junior Senior
College: Freshman Sophmore Junior Senior Other: _____

Are you presently a student? Yes ☐ No ☐ Name of School: _____

Are you presently employed? Yes ☐ No ☐ If yes, hours per week: _____

Employers Name and Address: _____

Previous Work Experience: _____

Previous or present volunteer jobs: _____

What kind of volunteer jobs are you interested in? _____

Time you have available for volunteer work: Days _____ Hours _____
(Morning) (Evening)

In case of emergency, who should be notified? _____
(Name) (Relationship) (Phone)

Signature _____ Date _____