IROQUOIS MEMORIAL HOSPICE
VOLUNTEER APPLICATION

Please Print

Name of Applicant_____ Birthday *(for birthday card list only)*_____

Address_____

City_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____

Employer_____ Occupation_____

Can receive calls at work: ☐ **Yes** ☐ **No** ☐ **Emergency Only**

Person to be notified in an emergency:

Name_____ **Phone**

(_____)_____

Address_____ **City**_____

Zip_____

Education Special Training_____

_____

_____

Work Experience_____

_____

_____

Two Personal References *(excluding family members).* Please provide a complete address, as references are verified by mail.

Name_____ Phone

(_____)_____

Address_____ City_____

Zip_____

Name_____ Phone

(_____)_____

Address_____ City_____

Zip_____

Identified Areas of Interest: *(non-patient does not require 30 hour education course)*

Patient Family Care

☐ In Home ☐ In Nursing Home ☐ In Facility ☐ Transportation ☐ Personal Care

☐ Meal Delivery

☐ Alternative Therapies

Bereavement

☐ Caller ☐ Home Visits ☐ Support Group Co-Facilitator ☐ Transportation ☐ Office/Clerical

☐ Memorial Service Committee

Non-Patient Services

☐ Clerical ☐ Fundraising ☐ Mailings ☐ Events ☐ Marketing ☐ Courier
☐ Switchboard ☐ Data Entry

Do you know a language other than English? ☐ **Yes** ☐ **No**

Language_____ ☐ Speak ☐ Read ☐ Write

Language_____ ☐ Speak ☐ Read ☐ Write

Other special services: (manicurist, hairdresser, masseuse, etc.)

_____

_____

Do you have access to transportation? ☐ **Yes** ☐ **No**

How did you hear about our Hospice volunteer program?_____

_____

Why do you want to be a hospice volunteer?_____

_____

What qualities *(skills, talents, knowledge, and experiences)* **do you feel you can incorporate into your hospice volunteer work?**

_____

_____

Death Dying

What are your thoughts and feelings about death?_____

_____

_____

Have you ever been with someone at the time of their death? ☐ **Yes** ☐ **No**

If yes, please describe briefly:_____

_____

_____

Have you ever provided care to anyone who was dying? ☐ **Yes** ☐ **No** ***(If yes please explain)***

_____

_____

When thinking of your own death, what words best describe death to you?

☐	I do not think about my own death				☐	sorrowful	☐	natural	☐		
frightening		☐	painful								
☐	lonely	☐	joyful	☐	heavy	☐	peaceful	☐	dark		

Other_____

Comments:_____

_____

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume certain responsibilities and expect to account for what I do in terms of what is expected to me.

I understand that any information that is disclosed to me while assisting the Hospice is confidential.

I interpret "volunteer" to mean that I have agreed to work without compensation in money. Having been accepted as a volunteer worker, I expect to do my work according to the standards set forth in the Volunteer Policies and Procedures.

Declaration

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application I authorize inquiries to be made concerning my employment, character and public records for the purpose of determining my suitability as a volunteer. I affirm that I have read the volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with Hospice.

_____ _____

Applicant Signature Date

IMH
Iroquois Memorial Hospital

All Volunteers:

Please read, sign and return to Human Resources. This will be filed in your Volunteer file.

HIPAA PRIVACY AND SECURITY
REASONABLE SAFEGUARDS
45 C.F.R 164.530 c

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. See 45 C.F.R. 164.530 c. It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information by:

1. Speaking quietly when discussing a patient's condition with family members in a waiting room or other public area.
2. Avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality.
3. Isolating or locking file cabinets or records rooms.
4. Providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals, covered entities can build upon these codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

I have read and understand the reasonable safeguards that we must abide by to protect the privacy of our patients.

Volunteer Signature	Printed Name	Date

IMH
Iroquois Memorial Hospital

Background Check Authorization

Pursuant to the federal Fair Credit Reporting Act, I hereby authorize Iroquois Memorial Hospital and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: verification of Social Security number; current and previous residences; employment history, including all personnel files; education; references; credit history and reports; criminal history, including records from any criminal justice agency in any or all federal, state or county jurisdictions; birth records; motor vehicle records, including traffic citations and registration; and any other public records.

I, _____, authorize the complete release of these records or data pertaining to me that an individual, company, firm, corporation or public agency may have. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me to furnish IMH or its designated agents with any and all information in their possession regarding me in connection with an application of employment. I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

I understand that, pursuant to the federal Fair Credit Reporting Act, if any adverse action is to be taken based upon the consumer report, a copy of the report and a summary of the consumer's rights will be provided to me.

_____ _____

Signature Date

Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City _____ State _____ Zip Code _____

Other Names Used _____ Telephone _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____
(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

Race		
	A	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____ (Employee Name) understand that when I am employed as a _____ (Type of Employment). I will become a mandated reporter under the Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect. I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
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Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov