

Southeast Indiana Health Center Volunteer Application

Prospective Volunteers will receive consideration without discrimination because of race, creed, color, sex, age, national origin or disability.

Full Legal Name:

Date of Birth:

Social Security Number:

Race:

Full Mailing Address:

Contact Number:

Email:

Education/Training/Special Skills:

Areas of interest: Check all that apply.

<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy (Medication Assistance Program)
<input type="checkbox"/> Clerical	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Maintenance
<input type="checkbox"/> Fund raising	<input type="checkbox"/> Greeter	<input type="checkbox"/> Shadow /Observation Only
<input type="checkbox"/> Other		

Availability? (what day and what hours or how often)

Have you ever been convicted of a violation of a law or ordinance other than a minor traffic accident?

YES No If yes, please explain.

Note: Any convictions will be reviewed individually to determine if the offence will have any bearing on the applicant's ability to volunteer.

Please Read and Sign.

I certify that the information provided is true. I understand that if I falsify any part of this application or supporting documents, my volunteer services will be terminated.

I hereby authorize SEIHC to verify, obtain records or gather information pertaining to my application and the pre-requisites of this volunteer position. I understand that if I require testing or screenings that this is at my expense. My signature does not imply that I have been offered a position as a volunteer. However, if accepted as a volunteer I agree to comply with SEIHC rules, policies and procedures. I understand I am volunteering my time, talent and services freely and without compensation.

I understand that volunteering at SEIHC is at SEIHC discretion: my volunteer services can be terminated at any time with or without cause, and with or without notice by SEIHC or myself.

Applicant's Signature: _____ Date: _____

Parental/Guardian Permission Required for volunteers under 18 years of age. I, the undersigned parent or legal guardian of the child named above, do hereby give permission for this child to volunteer with Southeast Indiana Health Center.

Parent/Guardian Signature: _____ Date: _____

Approved for as a volunteer for SEIHC. All paperwork received and in order.

SEIHC Representative's Signature: _____ Date: _____

**Southeast Indiana Health Center
Volunteer Applicant Personal Survey**



Applicant's Full Legal Name: _____

Date: _____

Complete and return this form with your completed application. Please be candid with your responses. If necessary, you may attach comments on a separate sheet of paper.

Volunteer Service Areas: please indicate which opportunities you would be interested in:

Clinical: Nursing
Clinical: Medical Provider
Pharmacy
Clerical
Housekeeping
Other:

Maintenance
Yard Maintenance
Fund Raising
Greeter
Open to any opportunity

Why did you select the areas you indicated?

Please indicate a time range you can volunteer by day of the week you are available:

Sunday: _____

Thursday: _____

Monday: _____

Friday: _____

Tuesday: _____

Saturday: _____

Wednesday: _____

How many total hours can you donate regularly each week? _____

Will you be out of town for certain seasons? Yes No If yes, when? _____

Highest level of education achieved: _____

Special training/education: _____

Hobbies, Skills, Special Interests: _____

Have you ever worked in healthcare before either paid or volunteer? Yes or No

If YES, what specialty area(s)

**Southeast Indiana Health Center
Service Agreement**



As a Southeast Indiana Health Center volunteer, I agree that I am volunteering my time, talent and services freely and without contemplation of any pay or financial benefits.

Volunteer Signature _____ **Date:** _____

Parental / Guardian permission required for volunteer under 18 years of age. I, the undersigned parent or legal guardian of the child named above, do hereby give permission for this child to perform volunteer service with Southeast Indiana Health Center

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

SEIHC Representative Signature: _____ **Date:** _____

**Southeast Indiana Health Center
920 County Line Rd
Suite B
Batesville, IN 47006**

Southeast Indiana Health Center

A Member of the Volunteers in Medicine Alliance **CONFIDENTIALITY AGREEMENT**

I, _____ (printed name of staff/volunteer)

1. I understand and agree that in the performance of my duties as a staff/volunteer of SEIHC, that I must hold all sensitive information in the strictest of confidence. This includes patient's medical and financial information, personal information of co-workers and any financial or operational information of SEIHC.
2. I understand that I must maintain confidentiality at all times. This includes when I am away from my designated area, such as when I am in the hallways or in any other part of SEIHC. I will not leave records or information uncovered, unattended or easily accessed.
3. If I have access to computers within SEIHC, I will only access them for legitimate (SEIHC) business purposes. I will access only those records that I must review, change, compile, and/or copy in order to perform my position responsibilities. I will not leave the computer screen unattended so as to allow unauthorized access to information. I will not, under any circumstances, divulge my password (allowing access to the computer system) to anyone.
4. I understand that electronic mail is not a secure system. Therefore, I will exercise extreme caution when using electronic mail. Any electronic mail that I send will not contain information that could identify, directly or indirectly, any patient, personnel or financial information.
5. I will not retain confidential materials or documents issued to or used by others or myself during the employment period. Nor will I copy any of the information to which I have access.
6. I understand that I do not have the right to discuss private and confidential information about patients, fellow staff/volunteers or SEIHC with my friends or family members at any time.
7. When I leave SEIHC employment/volunteer position, I also understand that I still have a continued responsibility to uphold these rights to privacy at SEIHC.
8. By signing below, I confirm that I have received a copy of SEIHC confidentiality policy and will uphold its contents. I understand that my continued employment/volunteer position at SEIHC may be contingent upon my compliance with this policy and that violations of this policy may result in disciplinary actions, up to and including termination.

Staff/Volunteer Signature: _____

Date: _____

- (E) Possession of child pornography (IC 35-42-4-4(c)).
- (F) Vicarious sexual gratification (IC 35-42-4-5).
- (G) Child solicitation (IC 35-42-4-6).
- (H) Child seduction (IC 35-42-4-7).
- (I) Sexual misconduct with a minor as a *Class A or Class B felony* (IC 35-42-4-9).
- (J) Incest (IC 35-46-1-3), if the victim is less than eighteen (18) years of age.
- (K) Attempt under IC 35-41-5-1 to commit an offense listed in clauses (A) through (J).
- (L) Conspiracy under IC 35-41-5-2 to commit an offense listed in clauses (A) through (J).
- (M) An offense in any other jurisdiction in which the elements of the offense for which the conviction was entered are substantially similar to the elements of an offense described under clauses (A) through (J).

A Subject

- (16) is identified as a possible perpetrator of child abuse or neglect in an assessment conducted by the department of child services under IC 31-33-8; or
- (17) is:
 - (A) a parent, guardian or custodian of a child; or
 - (B) an individual who is at least eighteen (18) years of age and resides in the home of the parent, guardian or custodian; with whom the department of child services or a county probation department has a case plan, dispositional decree, or permanency plan approved under IC 31-34 or IC 31-37 that provides for reunification following an out-of-home placement.

REASON FOR NO FEE REQUEST

Before checking any box below read the defined Indiana Code IC 10-13-3-36

- A. Has been in existence for ten (10) years and has a primary purpose of providing an individual relationship for a child with an adult volunteer, if the request is made as part of a background investigation of a prospective adult volunteer for the organizations; (i.e. Big Brothers & Big Sisters)
- B. Home Health Agency (Copy of license must accompany this request).
- C. Community mental retardation and other developmental disabilities centers, for purposes of IC 12-29. (Copy of CARF Certificate must be submitted with this request).
- D. Is a supervised group living facility licensed under IC 12-28-5.
- E. An area agency on aging designated under IC 12-10-1.
- F. Community action agency (as defined in IC 12-14-23-2).
- G. Owner operator of a hospice program licensed under IC 16-25-3.
- H. Community mental health center (as defined in IC 7-2-38).
- I. Department of Child Services (as defined in IC 1-13-3-27-5).
- J. Is a School Corporation, Special Education Cooperative, or Nonpublic School (as defined in IC 20-18-2-12).
- K. (1) The church or religious society is a religious organization exempt from federal income taxation under Section 501 of the Internal Revenue Code;
- (2) The request is made as part of a background investigation of a prospective or current adult volunteer; and
- (3) The employee or volunteer works in a nonprofit program or ministry of the church or religious society, including a child care ministry registered under IC 12-17.2-6.

WARNING PENALTY FOR MISUSE

A non-criminal justice organization or individual receiving a limited criminal history may not utilize it for purposes other than those stated in the request or which deny the subject any civil right to which the subject is entitled. IC 10-13-3-27: Any person who uses limited criminal history for any purpose not specified in the request commits a Class A misdemeanor offense.

I affirm, under penalty of perjury, that the Limited Criminal History Information requested will be used as specified.

Paul Tyer

PRINT Name of Requester

Signature of Requester

Date (month, day, year)

We accept certified checks and money orders in person only. "NO" personal checks.

All checks made payable to the **STATE OF INDIANA**.

Mail request to:

Indiana State Police, Criminal History Limited Check

P.O. Box 6188

Indianapolis, Indiana 46206-6188