DEPARTMENT OF HEALTH AND MENTAL HYGIENE
VOLUNTEER SERVICES
APPLICATION FORM

Applicant's Name: _____ Spouse: _____

Home Address: _____ Zip Code: _____

Phone: _____

Occupation: _____ Employer: _____

Birth Date: _____ Social Security No: _____

Female _____ Male _____

Race: American Indian or Alaska Native ____ Asian ____ Black or African American ____

Native Hawaiian or other Pacific Islander ____ White ____

Previous Work Experience:

a) As a Volunteer: _____

b) Other: _____

Education or Special Trainings: _____

Community Affiliations: _____
(churches, clubs, other organizations)

References: _____

_____

Name address of person who should be contacted in case of illness on duty
(relationship)

_____ Phone: _____

Days Preferred: Hours Preferred:

Monday thru Friday _____ A.M. _____ P.M. _____

How did you find out about this Program? _____

Any medical/physical problems or conditions we should be aware of?

_____

_____

(Signature) (Date)

Placement Date: _____ Area: _____

Termination Date: _____ Reason: _____

CLIENT, PERSONNEL AND/OR BUSINESS RECORDS

CONFIDENTIALITY STATEMENT

The Department of Health and Mental Hygiene (DHMH) is committed to protecting the confidentiality of the client, personnel and business data entrusted to its care and which is required to be accessed in the performance of official State business by temporary staffing employees.

During the course of your assignment, any confidential information may only be released to and discussed with authorized personnel. Information considered to be confidential should never be discussed or released, except in the context of official DHMH business. As part of its contract with the Department, your employer has certified "that assigned employees agree that any information, whether proprietary or not, made known to or discovered by them during the performance of or in connection with this contract will be kept confidential and not be disclosed to any person other than the State , its designated officials, employees or authorized agents."

Disclosure of confidential information without proper authorization is a breach of this confidentiality. It is the responsibility of each employee to comply with the above certification and treat confidential information accordingly.

Supervisors of assigned temporary staffing employees are to take all appropriate steps to ensure that temporary staffing employees are completely informed regarding the confidentiality of any data available to them during the course of their assignment.

Employee Acknowledgment and Signature:

I have read and understand the above Confidentiality Statement and agree to treat confidential information accordingly.

_____ _____

Employee's Signature Date

Supervisor Acknowledgment and Signature:

I have read and understand the above Confidentiality Statement and agree to inform the assigned employee regarding proper treatment of any confidential data available to the employee.

_____ _____

Supervisor's Signature Date

Ethics Statement for Volunteers

Believing that the Kent County Health Department and its related programs has a need of my services as a volunteer worker:

I will be punctual and conscientious in the fulfillment of my assigned duties and accept supervision graciously.

I will conduct myself with dignity, courtesy and with consideration.

I understand that I may not verbally or physically abuse, neglect or endanger patient/clients.

I understand that gossiping with patients/clients or other staff members is not permitted.

I will take my problems, concerns and suggestions to the person overseeing me.

I will strive to make my work acceptable and to maintain the highest standards of quality.

I understand that violation of the above and/or violating the confidentiality statement may result in my volunteer privileges being revoked

_____

Signature of Volunteer/Date

_____

Signature of Witness/Date

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PERSONNEL SERVICES ADMINISTRATION

EMPLOYEE DISCLOSURE OF CRIMINAL HISTORY

A record of criminal conviction is not an automatic bar to employment. Each case is considered on its own merits. Factors such as job-relatedness, age at the time of conviction, nature of the offense, success of rehabilitation, number of convictions, and recentness of the conviction(s) are taken into consideration to determine whether a criminal record disqualifies a candidate for employment.

Background and criminal record checks to include fingerprinting are done routinely for all appointments.

Discovery of fraudulent, irregular or inaccurate information will be reported to appropriate State agencies.

Falsification of this form, or any other employment application form, will result in automatic rejection of the employment application, withdrawal of commitment, or immediate dismissal from employment.

HAVE YOU EVER BEEN **CONVICTED**, RECEIVED A **PROBATION BEFORE JUDGMENT**, OR RECEIVED A **NOT CRIMINALLY RESPONSIBLE DISPOSITION** OF ANY CRIMINAL CASE OTHER THAN A MINOR TRAFFIC VIOLATION ?

_____ YES (If YES, give complete details on the second page of this form.)

_____ NO

_____ _____

SIGNATURE (FULL NAME) DATE

_____

PRINT FULL NAME

DHMH Form 4503 (3/03)

Emergency Contact Form

In the interest of the health and safety, we are requesting that you complete the following:

1. Individual's name, address and phone number you wish to be contacted in the case of a medical emergency.

   _____

   _____

2. Name, address and phone number of family doctor.

   _____

   _____

3. List any medical problems, medications, treatments and allergies to medications, food or the environment (bee stings).

   _____

   _____

_____
Name of Volunteer

_____
Date

STATE OF MARYLAND

SUBSTANCE ABUSE POLICY

ACKNOWLEDGEMENT OF RECEIPT

As an employee of the State of Maryland,

I, _____, hereby certify that I have received a copy of the State's policy regarding the maintenance of a drug-free workplace. I realize that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited on the State's owned or utilized premises and violation of this policy can subject me to discipline up to and including termination. As a condition of my employment, I must abide by the terms of this policy and will notify my supervisor of any criminal drug conviction no later than five (5) days after such conviction. I further realize that federal law mandates that the employer communicate this conviction to the federal agency, and I hereby waive any and all claims that may arise for conveying this information to the federal agency.

_____ _____

Employee's Signature Date

_____ _____

Supervisor's Signature Date

EMPLOYEE DISCLOSURE OF CRIMINAL HISTORY

(continued)

PLEASE PRINT

1. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

2. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

3. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

4. CRIME CONVICTED OF: _____

   DATE OF INCIDENT: _____

   DATE CONVICTED: _____

   DISPOSITION OF CASE: _____

2015

CODE OF ETHICS

Name: _____

As a _____ member of the staff _____ volunteer of the A.F. Whitsitt Center, I do hereby affirm by commitment to the following standards of Ethical Conduct:

1. That I will not discriminate against patients or professionals based on race, religion, age, sex, handicap, national ancestry, sexual orientation or economic condition.

2. That I will espouse objectivity and integrity, and maintain the highest standards in the services I offer.

3. That I will uphold the community's legal and accepted moral codes which pertain to professional conduct, including but not limited to:

   A. Avoiding verbal or physical abuse, neglect or endangerment of patients which includes any touching which is uninvited or not for therapeutic purposes; profane or harsh verbal treatment or ridicule; not scheduling or keeping appointments for treatment; denial of needed treatment.

   B. Avoiding disclosures of personal information to patients for any purpose other than the patient's benefit; discussing with a patient information about other patients or staff members.

   C. Avoiding the expression of feelings or opinions detrimental to a patient's recovery or showing favoritism among patients. These behaviors are particularly inappropriate when they are based on race, religion, sex or age.

   D. Not using alcohol or drugs in violation of the law or State of Maryland policy, which includes presenting oneself for work with the smell of alcohol on the breath or appearing to be under the influence while working.

   E. Avoiding the portrayal of oneself to a patient as functioning outside of the designated job description (i.e., attempting to provide treatment when one not qualified or authorized to do so).

   F. Avoiding sexual contact and/or intimate personal relationships of any kind with a patient; sexual harassment of patients, flirting or suggestive behavior toward patients; attempting to date, cohabitate or have sexual relations with patients or former patients.

   G. Not taking money, services, or other items from consultants, practitioners, or others who make equipment, products, or services available for use by the Center; similarly, neither money nor gifts will be accepted for providing information about or assistance with gaining admission to the Center.

   H Not giving to or receiving from a patient money or gifts in any form; not lending money to or borrowing money from patients.

   I. Not referring patients to one's own private practice or anywhere that is not in the patient's best interest.

   J. Avoiding non-professional relationships with patients, such as business or social relationships. Examples include (but are not limited to) contractual or employer-employee relationships; entertaining (or being entertained by) patients socially; spending leisure time with patients (such as hunting, boating, etc.).

   K. Accurately representing the professional services available through the Center.

   L. Assuring that patients and their families are aware of their financial responsibilities and of the Center's billing practices and the mechanisms available to resolve conflicts arising thereto.

   M. Not smoking while on the Center's premises.

4. That I will respect the integrity and protect the welfare of the person or group with whom I am working.

5. That I will treat colleagues with respect, courtesy and fairness and will afford the same professional courtesy to other professionals.

6. That I will embrace as a primary obligation, the duty of protecting the privacy of patients and, within the provisions of the law, will not disclose confidential information acquired while serving as a member of the staff or as a volunteer for the Center.

7. That I understand information regarding the admission and treatment of any A.F. Whitsitt patient is confidential and protected under Federal laws and regulations. The patient=s very presence in the facility or program is confidential information.

In addition, Pre-admission, Inpatient, and Continuing Care Records, any information you may hear, or personal situations revealed to you may not be discussed outside of the work situation. Releasing information, identifying a person as an alcohol or drug abuser verbally or in writing other than through prescribed procedures is a serious matter and is cause for disciplinary and/or terminate of employment.

Personnel may not discuss an individual patient nor give a medical record or any portion thereof or any treatment information whatsoever to any unauthorized person. All requests for information should be handled according to prescribed procedures.

Every person working for the Whitsitt Center must comply with the confidentiality policies and procedures.

SIGNATURE OF STAFF MEMBER/VOLUNTEER _____ DATE _____

SIGNATURE OF SUPERVISOR _____ DATE _____

ANNUAL REVIEW OF CODE

SIGNATURE OF STAFF MEMBER/VOLUNTEER _____ DATE _____

SIGNATURE OF STAFF MEMBER/VOLUNTEER _____ DATE _____

SIGNATURE OF STAFF MEMBER/VOLUNTEER _____ DATE _____

SIGNATURE OF STAFF MEMBER/VOLUNTEER _____ DATE _____

CODE OF CONDUCT
ACKNOWLEDGMENT STATEMENT

I hereby acknowledge that I have received **and agree to read** the DHMH Corporate Compliance **Code of Conduct**. I fully understand that, as an employee, I have an obligation to fully adhere to the obligations and principles of the Code and that I consent to comply with this Code and to recognize the consequences that may occur should I breach this Code.

For Medical Personnel:

I confirm that I have not been excluded by the federal government from participation in any governmental health care program, nor, to the best of my knowledge, have I been proposed for exclusion. I agree to notify the Compliance Officer or my immediate supervisor upon my receiving written or verbal notification that I am proposed for exclusion from any governmental health care program.

EMPLOYEE SIGNATURE DATE

PRINTED NAME (Last, First, Middle)

ORGANIZATION UNIT (ADMINISTRATION/DIVISION, FACILITY, LOCAL HEALTH DEPARTMENT)

(This Acknowledgement Statement will be kept in the employee's DHMH Personnel File.)