Bradford Regional Medical Center

A Kaleida Health Facility

APPLICATION FOR VOLUNTEER SERVICES

LAST NAME: ___________________________ FIRST NAME: ________________________M.I. _________

NICKNAME: ____________________________ PHONE: _____________________ BIRTHDAY:___/___/___

ADDRESS: ______________________________________ CITY: ___________ STATE: ______ ZIP: _______

E-MAIL ADDRESS: ____

AVAILABILITY	M	T	W	TH	F
MORNING					
AFTERNOON					
EVENINGS					

HEALTH INFORMATION

GENERAL HEALTH: _____________________ ACTIVITY RESTRICTION: ____________________________

NOTIFY IN AN EMERGENCY: ____
Name Relationship Phone

PHYSICIAN: _______________________________________

EDUCATION AND WORK EXPERIENCE

A. HIGHEST GRADE COMPLETED: 9 OR LESS 10 11 12 1 2 3 4 MS, PHD,

OTHER __________________________________

B. WORK: EMPLOYED? YES ______ NO ______

IF YES, PLACE AND OCCUPATION: ____

C. VOLUNTEER EXPERIENCE: ____
Organization Volunteer Role # of Years

____
Organization Volunteer Role # of Years

VOLUNTEER NON-DISCLOSURE AGREEMENT

BRADFORD REGIONAL MEDICAL CENTER HAS A LEGAL AND ETHICAL RESPONSIBILITY TO SAFEGUARD THE PRIVACY OF ALL PATIENTS AND PROTECT THE CONFIDENTIALITY OF THEIR HEALTH INFORMATION. IN THE COURSE OF MY ASSIGNMENT AT BRADFORD REGIONAL MEDICAL CENTER, I MAY COME INTO POSSESSION OF CONFIDENTIAL PATIENT INFORMATION, EVEN THOUGH I MAY NOT BE DIRECTLY INVOLVED IN PROVIDING PATIENT SERVICES.

I UNDERSTAND THAT SUCH INFORMATION MUST BE MAINTAINED IN THE STRICTEST CONFIDENCE. AS A CONDITION OF MY ASSIGNMENT, I HEREBY AGREE THAT, I WILL NOT AT ANY TIME DURING OR AFTER MY ASSIGNMENT WITH BRADFORD REGIONAL MEDICAL CENTER DISCLOSE ANY PATIENT INFORMATION TO ANY PERSON WHATSOEVER OR PERMIT ANY PERSON WHATSOEVER TO EXAMINE OR MAKE COPIES OF ANY PATIENT REPORTS OR OTHER DOCUMENTS PREPARED BY ME, COMING INTO MY POSSESSION, OR UNDER MY CONTROL, OR USE PATIENT INFORMATION, OTHER THAN AS NECESSARY IN THE COURSE OF MY ASSIGNMENT.

WHEN PATIENT INFORMATION MUST BE DISCUSSED WITH OTHER HEALTHCARE PRACTITIONERS IN THE COURSE OF MY ASSIGNMENT, I WILL USE DISCRETION TO ENSURE THAT OTHERS WHO ARE NOT INVOLVED IN THE PATIENT'S CARE CANNOT OVERHEAR SUCH CONVERSATIONS. I ALSO UNDERSTAND THAT I WILL NOT ACCESS ANY PATIENT INFORMATION IN THE ENTERPRISE MEDICAL RECORD EXCEPT FOR ON A NEED TO KNOW BASIS AND IS NECESSARY IN THE COURSE OF MY ASSIGNMENT.

I UNDERSTAND THAT VIOLATION OF THIS AGREEMENT MAY RESULT IN CORRECTIVE ACTION, UP TO AND INCLUDING DISCHARGE.

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SIGNATURE OF VOLUNTEER

____ ______________________________

PRINT NAME OF VOLUNTEER DATE