Triad SMAT 500 Application

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Introduction

Triad SMAT 500

The Triad Healthcare Preparedness Coalition (THPC) is composed of representatives from the 18 counties that make up the referral region for the Level I Trauma Center Atrium Health Wake Forest Baptist Medical Center in Winston Salem, North Carolina. Members of THPC represent several areas of care: prehospital providers, physicians, nurses, and administrators from the regional hospitals. Other agencies include, but are not limited to, Public Health, Emergency Management, community volunteers.

The terrorist attacks of September 11, 2001 and subsequent anthrax exposures have ignited a renewed commitment in the state of North Carolina to strengthen our readiness and our capacity to respond to a terrorist attack. Numerous local, state, and regional agencies are collaborating on multiple scenarios that exist now that the threat of terrorism is real. Specifically, four agencies have recently joined efforts to consider the treatment and response phase of a terrorist event. The agencies include the North Carolina Office of Emergency Medical Services (NCOEMS), North Carolina Office of Emergency Management (NCEM) and the North Carolina Division of Public Health – Epidemiology & Communicable Disease (NCPH). These agencies represent the management system responsible for coordinating a disaster response, ensuring that treatment and prevention strategies are implemented, as well as disease surveillance and medical preparedness. The goal of this effort is to assure our citizens that when a terrorist attack or natural disaster occurs in North Carolina they will be able to get the medical care services they need to protect their health and prevent the further spread of disease. Priorities include enhancing disease monitoring and investigation systems, improving communication capabilities among health agencies and building the medical response capacity.

The agencies have collaborated to develop a tiered State Medical Response System (SMRS) plan. Within the plan are eight (8) Regional State Medical Assistance Teams. THPC is responsible for the growth and development of the Triad State Medical Assistance Team 500.

Our team is looking for qualified applicants to provide various services to support our deployment and patient care efforts. If you are interested in being part of our team please review the following information, complete the application, and return the application to:

Triad SMAT 500
315 Bethel Church Rd.
Mocksville, NC 27028

Office Hours: Monday –Friday 8:00am-5:00pm

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Make-Up and Structure

Triad SMAT 500

Our team is comprised of two different base structures that are focused on the same program objectives. One structure is the primary SMAT member who is employed with a Hospital, Medical Facility, or EMS agency within the THPC region. primary SMAT members are employed and paid through their host medical facility and reimbursed in the event of a state activation or deployment from the State Emergency Response Team (SERT). Our second basic structure is through the National Medical Reserve Corps (MRC). MRC provides SMAT with a base for introducing volunteers who are willing to volunteer their time to the SMAT program. They are a deployable secondary resource for SMAT, but may not have the time to commit to 24+ hours a year to the SMAT program.

We are recruiting professionals throughout Northwestern Western North Carolina who are willing to provide services to support our efforts. Not all members are Medical Professionals. We are comprised of two (2) general areas.

Medical

- Nurses
- Paramedics and EMTs
- Physicians
- Respiratory Therapists
- Pharmacists
- Mental Health Professionals
- Social Workers
- Advanced Level Practitioners
- Allied Health Professionals

Non-Medical Support

- Fire Fighters
- Hazmat Technicians
- Law Enforcement
- Security Professionals
- Support Staff
- Amateur Radio Operators
- Translators
- Social Workers

SMAT members will be required to complete initial training through NC Terms and maintain 24 hours of SMAT training each year. CEUs (when applicable) will be made available for all medical personnel for their training time.

Each SMAT member must set up an account and be registered through TERMS – the online state disaster volunteer registry at www.terms.ncem.gov/TRS

SMAT operations are a great way to give back to the community that you live and work in, while helping others in their immediate time of need.

Please Check One:
[ ] Medical
[ ] Non-Medical

Have you volunteered with another SMAT team before?
[ ] Yes - _____ [ ] No

Volunteer Personnel Data Form

Triad SMAT 500

We appreciate your interest in volunteering with the Triad SMAT 500 team. We are sincerely interested in your qualifications. Questions on this application are asked for the sole purpose of considering you for volunteer services. We do not discriminate on the basis of race, religion, sex, sexual orientation, national origin, age, or handicap status. The provided information is confidential and will not be distributed.

Full Name (No Initials) (Last) (First) (Middle) (Suffix, Jr., II, etc.) (Maiden)			
Present Home Address (Street) (City) (State) (Zip Code) (County)			
Daytime Phone: ( )	**Home Phone:** ( )	**Cell Phone:** ( )	**E-Mail Address:**
Employer:			
Current Department:			
Supervisor Information: (Name) (Phone) (E-Mail)			
Gender:	**NC Driver's License #:** **CDL [ ] Yes [ ] No Class_____**	**NC Driver's License Expiration Date:** Day _____ Month _____ Year_____	
Please Indicate area of Specialty [ ] Physician [ ] Nurse Practitioner [ ] Physician Assistant [ ] RN [ ] Paramedic [ ] EMT, EMT I [ ] Respiratory Therapist [ ] Pharmacist [ ] Mental Health Professional [ ] Clerical [ ] Support [ ] Other _____			

Emergency Contact(s) Information

Name:	**Relationship:**	**Phone:** ( )
Name:	**Relationship:**	**Phone:** ( )
Name:	**Relationship:**	**Phone:** ( )

(Please answer review and answer the questions on the following page.)

Volunteer Personnel Data Form (Continued)

Triad SMAT 500

If the answer to any of the following questions is "YES" please provide a brief explanation.

1. **Have you ever been subject to an inquiry or investigation by any licensing board or certifying agency**
   [ ] YES [ ] NO
   If so, please explain
   _____
   _____
   _____
   _____
   _____

2. **Have you ever been discharged or asked to resign from a previous employer?**
   [ ] YES [ ] NO
   If so, please explain
   _____
   _____
   _____
   _____
   _____

3. **Have you ever plead guilty to or been convicted of a crime? (Felony or Misdemeanor)**
   [ ] YES [ ] NO
   If so, please explain
   _____
   _____
   _____
   _____
   _____

4. **Do you have any current restrictions on your driver's license?**
   [ ] YES [ ] NO
   If so, please explain
   _____
   _____
   _____
   _____
   _____

Authorization for Release of Information & Records

Triad SMAT 500

Triad SMAT 500
315 Bethel Church Rd.
Mocksville, NC 27028

Office Hours:
Monday –Friday 8:00am-

I, _____, understand that in consideration of my application, an investigation could be conducted. I authorize Atrium Health Wake Forest Baptist, through its agent, **Investigative Associates & Consultants, Inc.,** to conduct such an investigation which may include, but not be limited to, the gathering of information regarding verification of prior employment, references, consumer credit history, driving history, and any criminal history which may be in files of any state, federal, or local criminal justice agencies. I understand that I have the right to request, in writing, a complete and accurate disclosure of the nature and scope of this investigation. I further understand that any time during the course of my volunteer service, Atrium Health Wake Forest Baptist, through its agent, **Investigative Associates & Consultants, Inc.,** in accordance with all applicable state and federal law, may obtain additional or supplemental investigative reports to be used in connection with my retention as a volunteer of Triad SMAT 500. **I understand that the information requested below regarding sex, race, date of birth, and maiden name is for the sole purpose of gathering information accurately.**

_____ _____ Mo._____Day____Yr._____
Last First Middle — Social Security # — Date of Birth
(Please print Full Name – Do not use Initials)

_____ _____ _____ _____ _____
Maiden, previous married, and all other alias names used. — Drivers License # and Class — State — Sex — Race

_____ _____
Applicant's Telephone Number — Applicants Email Address

_____Yr_____Mo_____
Previous Address — City/State — Zip/County — How long?

List all other addresses used for the past 7 years- use additional page(s) if needed.

_____Yr_____Mo_____
Previous Address — City/State — Zip/County — How long?

_____Yr_____Mo_____
Previous Address — City/State — Zip/County — How long?

If you have lived in the following states within the last seven years; Alabama, Arkansas, District of Columbia, Idaho, Iowa, Massachusetts, Minnesota, New Hampshire, New Jersey, South Dakota, or Virginia, you will be asked to complete an additional form in order to complete your application. If you have lived in Delaware, Nevada, Ohio, South Dakota, West Virginia, or Wyoming, you may need to obtain the appropriate fingerprint card(s) in order to complete your application.

A digital or photographic copy of this authorization shall be as valid as the original.

_____ _____
Applicant's Signature — Date

After completing this form, please print, sign, and either mail it to Triad SMAT 500 at the address below or deliver it to our office. In addition, application may be submitted by email to jwwelbor@wakehealth.edu. The on-boarding process of your request to become a Triad SMAT 500 volunteer will not be completed until our office has received this release and it has been returned from Investigative Associates.

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315 Bethel Church Rd.
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Confidentiality Agreement (NDA)

Triad SMAT 500

Advocate Health, Atrium Health Wake Forest Baptist, Wake Forest University Health Sciences and North Carolina Baptist Hospital, along with their subsidiaries (collectively, "AHWFB") have, and will develop further, confidential, proprietary information and trade secrets relating to their clinical, research and educational missions.

These trade secrets and confidential and proprietary information include but are not limited to, information concerning patients, research studies and subjects, animal care and use, faculty, staff, students, planning, financial and donor information, fixtures, research and development methods, projects, data, goals or activities, business strategies, research techniques, the identities or addresses of the Medical Center's employees or their functions, confidential reports prepared for AHWFB by business consultants, or any other information concerning AHWFB or its business that is not readily and easily available to the public or those in AHWFB business (any and all of which shall be referred to in this Agreement as "Information"). In the course of my relationship with AHWFB, I may have access to such Information, and I understand and acknowledge the importance of protecting the confidentiality of such Information.

In consideration of my continued relationship, by signing this Agreement, I understand and agree to the following:

1. I may use Information disclosed to me solely in the course of my relationship with AHWFB. I may not use Information for any other purpose.

2. During and after my relationship, I will hold all Information in the strictest confidence and will not disclose any Information or any portion of the Information to any other firm, entity, institution, or person, except that I may disclose the Information on a confidential basis to other employees and agents of the Medical Center on a "need to know" basis in the course of my relationship with the Medical Center. I understand and agree that my obligation to keep Information confidential forbids me to disclose Information even to family members or friends, and even when identifying details are not revealed.

3. I understand and agree that all property of and data and records with respect to AHWFB and its affiliates coming into my possession or kept by me in connection with my relationship with AHWFB, including without limitation, correspondence, management studies, research records, notebooks, blueprints, computer programs, software and documentation, bulletins, reports, patient lists, student and employment data, costs, purchasing and marketing information, are exclusive property of the Medical Center. I agree to return to AHWFB, all such property and all copies of such data and records upon termination of my relationship or as otherwise directed by AHWFB.

4. I understand that the Information is of a private, internal, or confidential nature and constitutes a valuable, special and unique asset of AHWFB and its affiliates.

5. I understand a material breach of this Agreement will cause irreparable damage to AHWFB and its affiliates, and that such damage will be difficult to quantify and for which money damages alone will not be adequate. Accordingly, I agree that AHWFB, in addition to any other legal rights or remedies available to AHWFB on account of a breach or threatened breach of this Agreement, shall have the right to obtain an injunction against me, enjoining any such breach without the need for posting a bond, and I waive the defense in any equitable proceeding that there is an adequate remedy at law for such a breach.

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Confidentiality Agreement (NDA) (Continued)

Triad SMAT 500

6. I will not access any Information or area of AHWFB that I have not been authorized to access. I will not discuss Information in areas where others who do not have a need to know such Information may overhear the conversation (e.g. hallways, elevators, cafeterias, shuttle buses, public transportation, restaurants, and social events).

7. I will not access any Information for other persons or employees who do not have the right to access the Information themselves. I will not disclose my or any other AHWFB employee's computer password(s) to anyone, nor will I use another person's password(s) instead of my own for any reason unless authorized by my point of contact or unless required by the AHWFB IT Services Department for maintenance reasons. I will inform my point of contact immediately if I know or have a reason to believe someone without proper authority knows or is using my password(s).

8. I will not:

    a. Make any personal or unauthorized inquiries* into any AHWFB computer or system.
    b. Make any personal or unauthorized transmissions of any information.
    c. Modify any information without the authority to do so.
    d. Purge any Information without authority to do so.

9. I will log off, lock, or restart any computer prior to leaving it unattended.

10. I will inform my Medical Center point of contact, or other appropriate personnel of any known or suspected unauthorized disclosure r misuse of Information which I observe or of which I become aware.

11. I will protect Medical Center Information stored on a laptop computer by:
    a. Encrypting all information stored on the laptop,
    b. Temporarily storing Information (during active use only) on the laptop, and
    c. Maintaining a current secure backup of all Information stored on the laptop (network, CD, DVD etc.)

12. Any information that I am authorized to store on removable storage media (e.g., CD's, DVD's PDA's USB/flash drives, external hard drives, etc.) will be store in a secure manner (that is, with password protection and/or encryption).

13. I will immediately report to my AHWFB point of contact if said media or any Information is ever lost or stolen.

14. I will secure (encrypt) all transmissions (email, file transfers, etc.) that contain Confidential Information in accordance with AHWFB Information Security and Privacy Policies.

15. I understand that public (i.e., non-AHWFB) wired and wireless networks should not be considered secure for any reason. Therefore, whenever I am connected to a computer network other than the AHWFB conducting AHWFB business, I will use AHWFB VPN (Virtual Private Network) software to access the AHWFB resources remotely.

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Confidentiality Agreement (NDA) (Continued)

Triad SMAT 500

16. I understand and agree that this Agreement shall be governed by and construed in accordance with the laws of the State of North Carolina and any claim or dispute arising from the terms or performance with this Agreement will be submitted to the jurisdiction of the state or federal courts of North Carolina, and I consent to the exclusive jurisdiction of such Courts.

17. I understand that any violation of the terms of this agreement may result in termination of my relationship with AHWFB and Triad SMAT 500 as applicable. I further understand that all my computer activity, including e-mail and Internet use, is subject to auditing or monitoring by the AHWFB.

I acknowledge that I have read this agreement, understand it's terms, and agree to abide by both this agreement and the Medical Center's Information Security and Privacy Policies and all other polices in effect where applicable concerning the security and privacy of Information.

I further understand and acknowledge that nothing contained in this agreement creates a contract regarding the term of my relationship with the Medical Center, express or implied.

I acknowledge that I have read and understand this agreement.

Name: _____

Signature: _____

Date: _____

Unauthorized inquiries or transmissions include, but are not limited to, reviewing, removing, printing, and/or transferring Information from any medical Center computer or paper filing systems to unauthorized locations, e.g., home computer, personal laptop, USB drives, CD/DVD, or other portable media.

Direct any questions concerning this agreement to the SMAT Team Leader, Justin Welborn at (336) 971-8052

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Badge Procedure

Triad SMAT 500

- All Volunteers will be provided a Triad SMAT 500 ID Badge before beginning their first volunteer assignment.
- Pictures for ID Badges will be taken in the Badging Office of the Triad Regional Healthcare Preparedness Coordination Center.
- Before obtaining a badge, the Volunteer's application must be processed and approved to guarantee that the Volunteer is eligible for a Photo ID.
- The completed form should be attached to the Triad SMAT 500 application packet.
- There will be no charge to the Volunteer for an ID Badge.

I have read and understand the rules concerning ID badge procedures.

_____
Name

_____
Signature

_____
Date

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Physical Fitness Form

Triad SMAT 500

Please check the appropriate response to each question.

[ ] Yes	**[ ] No**	Hypertension (BP Systolic > 150 Diastolic > 90). May provide documentation of prescribed medication in which BP is maintained within a safe range (<150 Systolic, <90 Diastolic).
[ ] Yes	**[ ] No**	Seizure activity within the last five (5) years.
[ ] Yes	**[ ] No**	Hypoglycemic (low blood sugar) events causing unconsciousness or altered mental status in the last five (5) years.
[ ] Yes	**[ ] No**	Pulse < 60, > 120, heart block, arrhythmias (irregular heart rates).
[ ] Yes	**[ ] No**	Morbid Obesity, BMI of 40-50 kg/m2.
[ ] Yes	**[ ] No**	Shortness of breath when climbing 3 flights of steps.
[ ] Yes	**[ ] No**	Claustrophobia
[ ] Yes	**[ ] No**	Any metal health conditions, alcohol use, or drug use, that would restrict your ability to function.
[ ] Yes	**[ ] No**	Limited range of motion in any of the four (4) extremities, including fingers and toes.
[ ] Yes	**[ ] No**	Any recently diagnosed serious medical condition that would place the team or individuals in jeopardy while functioning as a member of the team.

If you checked "Yes" to any of the above, please provide a brief explanation.

_____

_____

_____

[ ] Yes [ ] No - Ability to successfully lift and carry 50 lbs. a distance of 100 feet.

Please list any allergies: _____

_____

_____

Please list your past medical history: _____

_____

_____

_____

Please list your current medications:_____

_____

_____

Do you have any other restrictions not otherwise noted? Please explain: _____

_____

_____

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Manager/Supervisor Team Member Support Agreement Triad SMAT 500

I, _____ for _____

(Print Supervisor/Manager/Director/Chair Name) **(Print Agency or Facility Name)**

As a member of the Triad Healthcare Preparedness Coalition, our company/department agrees to support my employee when involved in SMAT 500 Team activities. This support shall consist of salary, benefits and insurance to include workers compensation, for deployments. I agree that this employee will be considered an employee of my organization when deployed with the Triad SMAT II team. Individual team members have the responsibility to get authorization from their employers before participating in Triad SMAT activities.

_____
Print Team Member Name

_____
Supervisor/Manager/Director/Chair Signature

_____
Justin Welborn
SMAT 500 Team Leader
Assistant HPC – Triad Healthcare Preparedness Coalition

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Member Checklist

Triad SMAT 500

This form is to be completed by a THPC Administrative Officer

Volunteer Information

Name: _____ Specialty: _____
1st Contact : _____ Type: _____
2nd Contact: _____Type: _____
3rd Contact: _____ Type: _____

Initial Meeting

Scheduled For: Date/Time/Location

- ☐ Volunteer Background
- ☐ SMAT/Coalition/SMRS Overview
- ☐ Orientation Process
- ☐ Warehouse Tour
- ☐ Membership Requirements
- ☐ Time Tracking
- ☐ Review of Online Profile or Information Tool
- ☐ Take Photo

Orientation Benchmarks (Attach Copies)

- ☐ Complete SMAT Initial Training Program Online.
- ☐ Complete SMAT Initial Training Program Hands-On.
- ☐ ICS 100
- ☐ ICS 200
- ☐ ICS 700
- ☐ ICS 800
- ☐ CPR Certification
- ☐ Volunteer Personal Data Form
- ☐ Authorization for Release of Informatior
- ☐ Confidentiality Agreement
- ☐ Badge Procedure Agreement
- ☐ Manager/Supervisor Approval
- ☐ VFIS Beneficiary Card
- ☐ VIPER Radio Certification
- ☐ Licensure Verified
- ☐ Tetanus Toxoid Vaccination
- ☐ TB Skin Test
- ☐ Hepatitis B Vaccination

☐ At least 6 Participation Hours Over 12 Months

Date	Description	# of Hours
	Total Hours	

Process Completion

Review of Progress

- ☐ In Person
- ☐ GoToMeeting
- ☐ Phone

Group Assignment

- ☐ Active
- ☐ Inactive

Action

- ☐ Issue Uniform
- ☐ Issue Badge
- ☐ Announcement

Date/Time/Location _____