CONGRATULATIONS!

You have reached an anniversary at Nationwide Children's Hospital!

Thank you for taking the time to complete your **annual volunteer update**. There are a few forms to complete:

- Update of your personal information
- Confidentiality and Security Agreement
- Health and Tuberculosis Screening
- Boundaries/Therapeutic Relationships

When you need to complete a form you can either:

- Print and complete by hand, or
- Complete on the screen and submit via email as an attachment to volunteering@NationwideChildrens.org.

If you have any questions, please call to office at 614-722-3635 or email, volunteering@NationwideChildrens.org.

Thank you for your continued support and dedication to Nationwide Children's Hospital. We look forward to sharing another year of volunteering with you!

NATIONWIDE CHILDREN'S HOSPITAL
ADULT/TEEN VOLUNTEER UPDATE

DATE _____ Rev 1/11

NAME _____ PHONE _____

ADDRESS _____

CITY _____STATE_____ ZIP _____

CARDKEY # _____DATE OF BIRTH _____

E-MAIL _____ DO YOU CHECK REGULARLY? Y◯N◯

EMPLOYER _____PHONE _____

CAN WE CALL YOU AT WORK? YES◯NO◯ BEST TIME TO CALL _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP _____

VOLUNTEER POSITION _____

DAY _____ TIME _____

COMMENTS?

_____

_____

FRANCHISE OWNER (IF APPLICABLE) _____

_____ _____

SIGN CONFIDENTIALITY AGREEMENT
Nationwide Children's Hospital
Confidentiality and Security Agreement

Name: _____ Dept: FAMILY AND VOLUNTEER SVCS

Training Date: _____ Phone Number: _____

Confidentiality

1. Confidential Information includes, but is not limited to, patient information or medical records, employee information or records, volunteer information or records, and Nationwide Children's business and financial information, in any form (verbal, paper, electronic). Confidential Information may only be used or discussed when required to perform hospital duties.

2. I understand that I may be aware of, and have access to, Confidential Information. I understand and agree that in performing my job duties I must hold all Confidential Information in strictest confidence.

3. I agree to use caution to avoid being overheard when discussing any Confidential Information, including areas such as, but not limited to, hallways, elevators and cafeteria, etc. I understand that any violation of confidentiality may result in disciplinary action.

4. I will not release or disclose Confidential Information, unless required by job duties, and then only in accordance with hospital policies. I will refer all other requests to the Health Information Management Department or other appropriate areas/staff.

5. I will access confidential patient information only if needed to fulfill own volunteer job duties. I understand that retrieving/viewing/printing information (computerized or paper), on friends, relatives, neighbors, celebrities, or co-workers is a breach of confidentiality and federal law and can result in termination and legal sanctions.

6. I understand that access to a computer system(s) is a privilege, and at no time am I authorized to use any system for other than its intended use or for personal gains, or the gains of another.

7. I will make sure the paper or computer record is not left open and unattended in areas where unauthorized people may view it.

8. I will appropriately dispose of Confidential Information and reports, and request supervisory direction regarding proper disposal if necessary. I will never discard confidential or patient identifying information in the regular trash (unless it has been shredded).

9. I understand that it is my responsibility to promptly report any violations to patient confidentiality and computer system security to my manager, or the Privacy Officer or the Corporate Compliance Officer.

Computer System Security

1. I will only use my own password. I understand my password is an electronic signature which will be attached to each transaction I enter into a system. I am legally responsible for the accuracy of the information I enter into a system. All inquires, data entries, and orders performed using my password is permanently recorded and subject to auditing.

2. I will not allow anyone to access a system using my password without my expressed permission. I will not disclose the password to anyone other than Information Services for repair/testing. If I do reveal my password to Information Services during setup/repair/testing, I will reset the password upon completion of setup/repair/testing.

3. I will not use passwords other than my own, nor will I access any system which I am not authorized to access.

4. If I leave a workstation unattended for any reason, I will exit systems (or take other similar preventive measures) containing patient or financial information so no unauthorized person may access or enter information under my password.

5. If I have reason to believe that the confidentiality of my own or another staff member's password has been broken, I will notify my manager immediately, and report any known or suspected breach of confidentiality to a manager, or the Privacy officer.

6. I will not misuse or alter the hospital computer systems in any way. I understand that only approved and officially licensed software may be added to hospital computers and handheld devices. I understand that no copies of hospital licensed software may be transferred or downloaded to a computer for my personal use.

7. I understand my passwords will be deleted from systems as soon as I terminate employment/association with Nationwide Children's or transfer to a position where access is not required. In the event that no one else does so, I will notify Information Services of changes in job class or employment status so that authorized access can be reevaluated.

My signature (typed if submitted online) below indicates I have read, understand and agree to the above confidentiality and security standards. I understand that a violation of any part of confidentiality or security standards could result in discipline, termination or legal action.

_____ _____

Boundaries/Therapeutic Relationships
Nationwide Children's Hospital
Columbus, OH

Why are boundaries important for you and for patients and families?

It is up to you as the volunteer to create a therapeutic (healing, restorative) relationship with a patient. It is **not** up to the patient or the family to know where the boundary lines should be drawn. By creating a one-way relationship, which is supportive of the patient and family you are being:

- empathetic
- compassionate
- an advocate
- patient-centered

Your Family and Volunteer Services Coordinator will assist you any time you have questions about a particular situation or patient. Please don't hesitate to ask.

Boundary Ground Rules

1. Do not accept personal gifts from patients or families.
2. Do not bring food to patients or provide money to patients or families.
3. Do not give gifts to patients or families.
4. Volunteers are discouraged from socializing with patients and families outside the hospital setting.
5. Do not baby sit for patients and families.
6. Do not personally provide transportation to patients and families.
7. Do not give patients and families your home or cell phone numbers, email address, or home address. Do not accept patients or families personal contact information.
8. Maintain patient confidentiality—in the hospital and the community.
9. Refrain from seeking medical information about the patients, other than what is needed to perform your volunteer assignment.
10. Function within assignment description and tasks you have been trained.

I acknowledge training and understanding of Boundaries/Therapeutic Relationships. Violation can result in disciplinary action. Typed if submitted online.

_____ _____

Name Date

Nationwide Columbus Children's Hospital Volunteer Health and Tuberculosis Screening

All volunteers are encouraged to engage in practices that promote health. Having an annual physical exam and staying current with immunizations are positive health practices. Volunteers who have symptoms of an infection are encouraged to seek medical treatment and are requested not to volunteer. Signs of infection may include fever, chills, nausea, vomiting, diarrhea, cough, congestion, swelling, and/or skin disruptions. Volunteers who have *any* sign/symptom of an infection should not volunteer until they have been symptom free for 24 hours, unless the symptoms have been assessed and/or treated and the volunteer is cleared by a physician as being able to volunteer.

With the increase of tuberculosis (TB) in the United States, healthcare volunteers are at risk of being exposed to patients with TB. To increase your awareness and knowledge regarding TB, we discuss TB at orientation and address TB in annual education. Volunteers in Children's facilities are required to annually review and document the development of any signs and symptoms which may be suggestive of active TB. An annual TB skin test is recommended for everyone.

Please review the following signs and symptoms of TB and mark with an **X** the appropriate answer.

In the past year have you had:

	YES	NO
1. Productive cough lasting longer than 2 weeks	☐	☐
2. Coughing or spitting up blood-streaked mucous	☐	☐
3. Unexplainable (unintentional) weight loss of over 10 pounds with in the year	☐	☐
4. Unexplainable fatigue (tiredness)	☐	☐
5. Night sweats	☐	☐
6. Loss of appetite	☐	☐
7. Nausea	☐	☐
8. Chest pain that has not been diagnosed or treated by a physician	☐	☐
9. Swollen glands for more than 2 weeks, especially in the neck area	☐	☐

Please complete the above questions and return promptly to Family and Volunteer Services Department. If you need assistance in completing this form, please contact Family and Volunteer Services (614-722-3635). Please seek medical assistance at any time if you develop any of the above signs or symptoms. Signature typed if submitted online.

_____ _____ _____

NAME (PLEASE PRINT) SIGNATURE DATE

_____ _____

FVS STAFF REVIEWER DATE

5/08

Family and Volunteer Services Department Annual Volunteer Self-Evaluation/Appraisal

Please complete and return to Family and Volunteer Services.

Name _____ Assignment_____

Are there any areas where you desire additional training?_____

_____

How could Family and Volunteer Services or other departments be more supportive of you?

_____

_____

MANDATORY ANNUAL EDUCATION	**Date Completed**	
Standard Precautions and Transmission-Based Precautions		
Corporate Integrity		
Fire/Safety Training		
Hazardous Materials		
HIPAA/Boundaries		
Infection Control & Hand Hygiene		
Tuberculosis		
CORE COMPETENCIES **Rate each competency as C (Competent), NR (Need Review), or RM (Role Model)**	**Rating**	Validation Method
A. Demonstrates and complies with Customer Service Principles • Treat each family as my top priority • Treat each other as valued customers • Take responsibility to resolve customers' concerns • Assure that customer expectations drive behavior • Continually improve the quality of services provided		Self Report
B. Maintain appropriate demeanor • Wear correct uniform and identification • Dependable and volunteer as scheduled • Comply with hospital policies and procedures		Self Report
C. Service specific		Self Report

Signature typed if submitted online.

Volunteer Signature _____Date_____

Reviewer Signature _____Date _____ Title_____

5/08