# How do I become a Student Volunteer at Wilson Health?

Print and fill out the Student Volunteer Application

Bring your completed Application to the Human Resources Department (Location: 3rd floor of the Yager Bldg, Suit 303)

Complete the 2-Step TB Skin Test

(You can do this on the same day you turn your paperwork in, no appointment is necessary!)

Come to the Human Resources Department for a brief orientation

Begin Volunteering as a Student Volunteer at Wilson Health!

WILSON HEALTH

A wide range of volunteer tasks are available to suit your individual needs, interests, skills, career goals, and time schedule. Opportunities such as delivering mail and flowers to patients, freshen and refill water pitchers for patients, and assisting with clerical duties are just a few of the many ways our Student Volunteers are able to help.

**Responsibilities of a Student Volunteer:**

- Patient confidentiality is a **TOP PRIORITY.**
- Student Volunteers are **NOT** permitted to do direct patient care.
- Upon arrival in the department you are assigned to, be sure you are wearing your name badge, and that your clothes and shoes are appropriate. Check in with the secretary.
- If you have a cell phone, be sure it is on vibrate or turned off. Please note, in some areas your cell phone may interfere with monitoring equipment. If so, you will need to turn it off. Should it be necessary to talk to someone while you are working, please ask to be excused and go to a place that will be more private away from patient care areas.

**Duties of a Student Volunteer:**

- Clear bedside tables prior to meal times so they food tray can be put down.
- Help deliver food trays to patients after staff has determined diet is correct.
- Pick up food trays when patients are finished eating after patient care staff has documented intake.
- Freshen and refill water pitchers for patients.
- Tidy up patient rooms.
- Assist staff with making unoccupied beds after Environmental services has cleaned them.
- Restock supplies in patient rooms and storage areas.
- Take care of flowers in patient rooms.
- Cleaning chores.
- Run errands for the staff to other departments (example: run specimens down to the Lab).
- Clerical duties as requested by staff (making up packets, making copies for booklets, etc.)
- Other duties and responsibilities as deemed necessary by the department manager.

**Other things to remember:**

- You are only allowed to do what you have been trained to do.
- You may not do direct patient care (giving a patient a bath, taking a patient to the bathroom, etc.)
- Each department is different, so you will learn a lot in each one!
- **If you do not volunteer for 6 months you may be asked to re-apply.**

We request the following information to help us make the best possible placement. You should complete all portions of this application that pertain to you. All information given will be held in strict confidence.

**APPLICATION**
**STUDENT VOLUNTEER PROGRAM**
**WILSON HEALTH**

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET CITY STATE ZIP CODE

PHONE: _____ BIRTH DATE: _____
MONTH DAY YEAR

EMAIL: _____

PARENT(S) NAME(S) AND ADDRESS(S)

_____

_____

PLEASE DESCRIBE ANY PAST VOLUNTEER EXPERIENCE:

_____

_____

PLEASE EXPLAIN YOUR REASON(S) FOR WANTING TO BE A STUDENT VOLUNTEER AT WILSON HEALTH:

_____

_____

DO YOU HAVE ANY SPECIAL TRAINING, PREVIOUS APPLICABLE WORK EXPERIENCE, SKILLS, INTEREST, HOBBIES, ETC.:

_____

_____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? IF YES, PLEASE GIVE THE DATES AND DETAILS BELOW.

□ YES □ NO

_____

_____

ARE YOU VOLUNTEERING TO SATISFY A COURT REQUIRED COMMUNITY SERVICE? IF YES, PLEASE LIST YOUR PROBATION OFFICER'S NAME AND PHONE NUMBER.

□ YES □ NO

_____

EMERGENCY CONTACT
IN THE CASE OF AN EMERGENCY WHOM SHOULD WE NOTIFY?

_____
FIRST NAME LAST NAME RELATIONSHIP

PHONE: _____

_____ _____ _____
PRINTED NAME OF STUDENT VOLUNTEER SIGNATURE OF STUDENT VOLUNTEER DATE

MY/OUR SON/DAUGHTER HAS MY/OUR CONSENT TO SERVE AS A STUDENT VOLUNTEER AT WILON HEALTH.

_____ _____ _____
PRINTED NAME OF PARENT(S)/GUARDIAN(S) SIGNAUTRE OF PARENT(S)/GUARDIAN(S) DATE

**DEPARTMENT OF INTEREST**

TO HELP US DETERMINE WHICH ARE OF THE HOSPITAL WOULD BE BEST SUITED FOR YOU, PLEASE SELECT 3 DEPARTMENTS YOU WOULD BE INTERESTED IN VOLUNTEERING IN. NUMBER THE DEPARTMENTS YOU ARE INTERSTED IN 1-3, WITH 1 BEING YOUR TOP CHOICE.

_____ Acute Care
_____ Birth Center
_____ Dietary
_____ Emergency Department
_____ Finance
_____ Home Health/Hospice
_____ Housekeeping
_____ Human Resources
_____ InfoComm
_____ Laboratory
_____ Marketing and Communications
_____ Medical Records
_____ Occupational Health
_____ Occupational Therapy
_____ Patient Access
_____ Patient Accounts
_____ Patient Experience and Process Excellence
_____ Physical Therapy
_____ Plant
_____ Radiology
_____ Respiratory
_____ Sleep Lab
_____ Special Events
_____ Sports Medicine
_____ Urgent Care
_____ Wilson Health Medical Group

***** A limited number of spots are available in each department.

---

**AVAILABILTY**

| | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
|---|---|---|---|---|---|---|---|
| Morning: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Afternoon: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Evening: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**STUDENT VOLUNTEER CODE OF CONDUCT**

I PROMISE

I WILL BE:

| | |
|---|---|
| **Dependable** | I will carry out my assignments and do what I agreed to do. If I cannot make an assignment I will let my supervisor know ahead of time. |
| **Anxious to Learn** | I will try to learn all I can about the hospital, its rules and its services. If I do not understand, I will ask questions. |
| **Quiet** | I will work, walk, and talk quietly so I do not disturb patients. |
| **Courteous** | I will listen to others, think of others, and help others. |
| **Neat and Clean** | I will be well groomed, clean in person and in dress. |
| **Pleasant** | I will be tactful and calm with everyone, have a friendly smile for everyone, and a sense of humor. |

I WILL NOT:

| | |
|---|---|
| **Discuss Patients** | and their illnesses in or out of the hospital, or discuss illness with the patient. EVERTHING I see or hear on duty will be kept confidential. |
| **Ask For** | or try to get free medical advice for myself or others from doctors on duty. |
| **Chat** | or visit with others, except in the line of duty. |
| **Make Personal Calls** | except to family in an emergency or for transportation. |
| **Leave** | my assigned post without permission or go into restricted rooms or areas of the hospital. |
| **Take an Assignment** | for which I have not been trained |

_____ _____

Printed Name of Student Volunteer Signature of Student Volunteer

_____

Date

# HIPAA and Confidentiality Training

The 1996 Health Insurance Portability and Accountability Act (HIPAA) helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling and privacy. In addition, HIPAA requires that all patients be able to access their own medical records, correct errors or omissions, and be informed how personal information is shared and used.

**T**he key components of HIPAA affect WILSON HEALTH healthcare workers:
Privacy: how and to whom personal health information is disclosed
Security: how data is stored and accessed
Transactions and Code Sets: implementation of national electronic claims submission and uniformity

**Every patient has a right to privacy - - and confidentiality !!!**

Examples of confidential information included:
Details about illnesses or conditions
Information about treatments
Photographs or videos of a patient
A health-care provider's notes about a patient
Conversations between a patient and health-care provider

**Confidential information should not be revealed to any unauthorized person including**:

Employees who have NO "need to know". This would be you, if you were looking up your own lab work. This information should come to you from the health care provider who ordered the testing to be done. Employees don't automatically have a right to see or hear confidential patient information. To see a patient's information an employee must need it to:

* Provide care
* Perform his or her job (billing, record keeping, etc)

Unauthorized friends and family. No matter what their intention, friends and family do not have an automatic right to adult patients' confidential information. Be sure you have the approval of the patient before you give information to anyone, even loved ones.

**Tips for protecting patient confidentiality**

Follow proper procedures
Get proper authorization
Protect all records
Don't talk about patients in public
Use care with phones, fax machines and computer screens

**HIPAA** stands for Health Insurance Portability Accountability Act

**PHI** stands for Protected Health Information

**Examples of PHI are:**

- Individual's name or address
- Social Security or other identification numbers
- Physician's personal notes
- Billing information

Every day, our private health care information is being collected, shared, analyzed and stored. Technology has allowed our personal information to travel quickly from physicians to hospitals to insurance companies. The HIPAA Privacy Rule ensures privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information.

**What does HIPAA do?**

- Regulates uses and disclosures of patients protected health information (PHI)
- Grants patients certain rights regarding their PHI
- Requires covered entities to implement administrative systems. Wilson Health's HIPPA officer is Julie Covault (VP of Finance). She is in charge of overseeing that we meet and follow all of the HIPAA regulations
- Regulates marketing and fundraising, and conversation with family/friends
- Regulates relationships with consultants, contractors

**We are permitted to use or disclose PHI**:

- For treatment, payment, and healthcare operations
- With authorization or agreement from the individual patient
- For disclosure to the individual patient
- For incidental uses such as physicians talking to patients in a semi-private room

**What is unsecured PHI?**

- Patient charts or other identifying papers left on counters where someone could see who has no need to
- Written or printed discharge information accidentally being given to the wrong patient
- Screen protectors not being used when information can be seen by the public
- Not logging out of computer systems where there is patient information
- Looking at your own medical information on hospital computers
- Sharing of PHI to vendors and contractors
- Information in the mailroom that has patient identifying information on it that is not in an envelop
- Faxes sent to the wrong fax number

**Patient Rights**

Patients have a right to see their own information, to request changes to their Personal Health Information and to know who the hospital has disclosed their information to. Patients also have the right to place restrictions on uses and disclosures and the right to confidential communications.

**Family and Friends**

How freely you communicate with family and friends involved in a patient's care may be limited. You must have the patient's permission to share information with their family and or friends. If the patient is not present or competent, use your judgement as to whether it is in the patient's best interest to share this information.

**Acknowledgement of Receipt of HIPAA Training**

I, _____, do hereby acknowledge and confirm that I have received HIPAA (Health Insurance Portability and Accountability Act) training from Wilson Health. I do agree that while I am an employee, agent, or consultant of this hospital, I have a duty to act in such a way that will protect and enhance the rights of consumers, their confidentiality, patient privacy, and medical information security.

I agree to fully comply with my organization's HIPAA program.

_____
Signature

_____
Date

## CONFIDENTIALITY AGREEMENT

As an employee or volunteer of Wilson Health, I understand that I will be working with information that contains patient, employee or financial data. I understand that patient files and medical records are kept to enhance patient care and are the property of Wilson Health. The information contained within these documents belongs to the patient and the hospital. Patients, employees and medical staff trust me to hold all information in confidence. I understand that both Federal and State laws apply to some incidents of release of information and that violation of hospital policies and procedures may also be a violation of these laws.

Employee information, administrative reports, correspondence and financial data are also considered confidential. It is my responsibility to disclose this information only when directly involved in transacting hospital business. This information may include, but is not limited to, sentinel events or risk management issues, legal issues, employee files, social security numbers, pay rates, disciplinary actions, performance evaluations, financial reports and strategic and marketing plans. Some Patient information may be kept in shared folders where more than one user can access patient information. Employees should only view information on patients that they have a need to know.

The use of the hospital's Information Systems provides access to highly sensitive information. I agree that my password is the equivalent of my signature and is not to be given to another person. When I am required to change my password, I will do so promptly. I will access only the information which I have been authorized to use in the performance of my job duties and will not release or discuss any information unless directly involved in hospital business. I will never attempt to obtain the password of another employee or medical staff member or use their terminal while they are signed on. If I have reason to believe that the confidentiality of my password has been broken, I will contact Information Systems immediately.

I will not discuss Wilson Health or patient-related information or business with the news media unless an interview has been prearranged through the Marketing/Public Relations Department. If I am directly contacted by a representative of the news media (television, radio, newspaper, etc.); I will not answer questions or make comments about hospital or patient-related information or business. I will refer the media call to the Marketing/Public Relations Department. Exceptions to this would be only if it is an integral part of the job, i.e. nursing supervisor, Emergency Department staff, etc.

I have read the above statements and accept the responsibility of abiding by the confidentiality policies and procedures of Wilson Health. I understand that if at any time I violate these guidelines, I am subject to disciplinary action up to and including termination of employment.

My signature is an acknowledgement of my commitment to adhere to these policies.
I am aware that this signed statement will become a permanent part of my employee file.

_____
Print Name

_____ _____
Signature Date

**WILSON HEALTH**
**STUDENT VOLUNTEER – PARENT/GUARDIAN**
**MEDICAL CONSENT FORM**

I/we have read:

1. I/we recognize and appreciate that by the very nature, hospital volunteer service may lead to the Student Volunteer's exposure to certain illness and disease, some of which could be contagious.

2. Further, I/we realize that prior to service as a Student Volunteer, the Student Volunteer may be required to give a medical history and may be required to undergo a physical examination to insure that the Student Volunteer meets the Hospital's requirements for general health and immunizations. I/we also understand that the Student Volunteer will be required to have a Mantoux TB skin test and may be required to submit to certain tests and immunizations for the Student Volunteer's protection and the protection of the Hospital's patients. I/we understand that any tests and immunizations which are provided to the Student Volunteer as a condition of the Student Volunteer's participation in the Student Volunteer program will be administed by the Hospital at no cost to the Student Volunteer and/or the Student Volunteer's parent(s) or legal guardian.

3. During the Student Volunteer's time on duty, I/we recognize and understand that a Student Volunteer could contract an illness, injury or medical condition which is caused and/or occasioned by the Student Volunteer's service in the Hospital. If this should occur, I/we understand that the Hospital will provide treatment for the Student Volunteer in accordance with the established procedures then in effect for the treatment of Hospital employees.

4. I/we understand that for the protection of the patients, if the Student Volunteer reports for service in a medical condition which the Hospital, in its discretion, deems unacceptable, the Student Volunteer may be sent home.

_____ _____
PRINTED NAME OF STUDENT VOLUNTEER SIGNATURE OF STUDENT VOLUNTEER

_____
DATE

_____ _____
PRINTED NAME OF PARENT(S)/GUARDIAN(S) SIGNAUTRE OF PARENT(S)/GUARDIAN(S)

_____
DATE

**WILSON HEALTH**
**STUDENT VOLUNTEER – PARENT/GUARDIAN**
**TB SKIN TEST CONSENT FORM**

I/we hereby consent to the Hospital's performance of a Mantoux TB skin test upon _____ (please print name of son/daughter) and further consent to the Hospital's performance of qualification health tests and the administration of immunizations which the Hospital deems necessary for the dual protection of the Student Volunteer and the Hospital's patients. I/we further understand that any physical examination, tests and/or immunizations which are required to continue the participation of our son/daughter in the Student Volunteer program will be performed and administered at no cost to me/us or our son/daughter. I/we further realize and understand that any treatment provided to our son/daughter for sickness, illness or other condition not caused and/or occasioned by participation in the Student Volunteer program will be performed at my/our expense.

We have read the above provisions and understand them.

__ _____
Street Address City State Zip Code

_____ _____
Medical Insurance Carrier Identification Number

_____ _____
Group Number Employer

_____ _____
PRINTED NAME OF STUDENT VOLUNTEER SIGNATURE OF STUDENT VOLUNTEER

_____
DATE

_____ _____
PRINTED NAME OF PARENT(S)/GUARDIAN(S) SIGNAUTRE OF PARENT(S)/GUARDIAN(S)

_____
DATE

*THIS FORM IS TO BE GIVEN TO THE EMPLOEE HEALTH NURSE WHEN YOU ARE ADMINISTERED YOUR SKIN TEST.*