KENT CITY HEALTH DEPARTMENT

201-G E. ERIE ST., KENT OH 44240 (330) 678-8109 FAX (330) 678-2082

VOLUNTEER APPLICATION

PERSONAL INFORMATION: (please print)

Name (Last, First, Middle): ____________________________________Date of Birth: ___________________

Current Address: ____

City: ________________________ State: __________ Zip Code: ________________

Personal Phone Number: (_____) _________________ Work Phone Number: (_____) ________________

Permanent Address (if different from above): ____

City: ________________________ State: __________ Zip Code: ________________

Permanent Home Phone Number: (_____) ________________

Area(s) of interest:

____

____

____

____

Date you can start: ____/____/____

Hours Available:

Mon. ____ Tues. ____ Wed. ____ Thur. ____ Fri. ____ Sat. ____ Sun. _____

EDUCATION: (If you need more space please include another sheet)

Name of School: ________________________________ Years Attended: _________________

Highest Level Completed: _______________________ Subject Studied: _________________

Name of School: ________________________________ Years Attended: _________________

Highest Level Completed: _______________________ Subject Studied: _________________

(If more to list, please attach resume)

VOLUNTEER EXPERIENCE:

Have you ever volunteered before for Kent City Health Department? ____Yes ____No

Other skills or training: (fluency in language, word processing skills, etc.)

____

____

____

MOST RECENT EMPLOYER:

Dates Employed: _____________ Position: _________________ Phone number: (_____) _______________

Name and Address of Employer:

____

May we contact them: ______ Yes ______ No

REFERENCES: (please provide two references)

Name and Phone Number

1.

2.

EMERGENCY CONTACT PERSON IN CASE OF EMERGENCY:

Name: ____Relationship: ____________________________

Phone Number: ____________________________

Have you ever been convicted or plead guilty in court (even if you did not have a trial) for anything other than a misdemeanor or minor traffic violation? ______Yes _____ No

If yes, please explain:

____

____

____

AUTHORIZATION:

Your signature indicates that the facts contained in this application are true and complete to the best of your knowledge. False statements on this application shall be grounds for dismissal from the volunteer program. You authorize approval to check references. The organization is not obligated to provide a volunteer placement, nor are you obligated to accept it. Your signatures also indicates that you are volunteering for humanitarian purposes to benefit the public good and without compensation.

Applicant's Signature: ______________________________________ Date: ______________________

SCOPE OF SERVICES FOR KENT CITY HEALTH DEPARTMENT VOLUNTEERS

Volunteer Name: ____

The following duties may be performed by the above named volunteer while serving as a volunteer to one of the Kent City Health Departments programs. All volunteers who perform the duties initialed below will be trained by a Kent City Health Department staff member prior to performing duties with the exception of certain duties that require documented licensure:

- Volunteers may attend community events and provide informational brochures to the community.
- Volunteer may provide health and wellness information to the public.
- Volunteers may assist with health department in clerical tasks in support of health programs, i.e. mailings, organizing health information, etc.
- Volunteers may assist with hanging flyers or other health department information
- Volunteers may assist us with compliance activities such as tobacco cessation programs and tobacco 21 compliance checks.
- Volunteers are permitted to setup community information tables at events
- Other duties as assigned.
- ____
  ____
  ____
  ____

Volunteers will be responsible for appropriate conduct at all times while working on city property. Volunteers will be professional and courteous to clients. Volunteers report directly to:

Name: ____

Title: ____

I understand that violation of this agreement could result in disciplinary action, up to and including my dismissal from the volunteer service program with KCHD.

VOLUNTEER SIGNATURE

Print Name: ____

Signature: ____

Date: _________________________

Approved By: _______________________________________ Date: ___________________________

Human Resources Approval: __________________________ Date: ___________________________

KENT CITY HEALTH DEPARTMENT VOLUNTEER AGREEMENT OF CONFIDENTIALITY

As a Volunteer for Kent City Health Department (KCHD), I may have access to "Strictly Confidential' material. Client information is strictly confidential and must be safeguarded. Client information may not be disclosed or shared with anyone other than those designated by the KCHD. Client information may only be disclosed or shared for purpose directly connected with my assignments for the KCHD.

"Disclose" Means communication of client information, including an acknowledgement that information exists.

I agree to comply with and be bound by all applicable provisions of state and federal law concerning confidential information. I understand that sharing or disclosing such information unlawfully could result in discharge from the KCHD, fines, civil liability for actual damages, and/ or imprisonment for up to 90 days.

If a KCHD client is known to me as a relative or friend, I realize that this person needs to know that confidential information from medical records will not become known to me without his/her consent. I will avoid handling the medical records of relatives and friends whenever possible, and I will not read these records under any circumstances.

As an volunteer of the KCHD and as a condition of my duties, I acknowledge the following terms and am aware that I will be held accountable for my conduct in accordance with the following:

1. I understand that I am responsible for complying with the KCHD Policies and Procedures, which are available to me, including those privacy and security policies and procedures developed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2. I will follow the highest ethical standards in the performance of my duties, in keeping with the KCHD Public Health Code of Ethics, which calls for me to safeguard sensitive information about vendors or potential vendors and not to show prejudice or favoritism toward vendors or potential vendors. I will not share information with any person or entity that may result in an unfair advantage for any vendor in a KCHD procurement.

3. I will treat all information received in the course of my volunteer service with KCHD as confidential and protected health information.

4. I will use and disclose health plan member information only as necessary and appropriate to perform my duties, consistent with KCHD Policies and Procedures.

5. I will not use e-mail to transmit confidential and protected health information or sensitive information about vendors unless I am authorized to do so under the KCHD Policies and Procedures, which assure appropriate safeguards for the information.

6. Upon separation from my employment with KCHD, I agree to continue to maintain the confidentiality and privacy of any information I learned while I was a KCHD employee and I agree to turn over any documentation or information.

I understand that violation of this agreement could result in disciplinary action, up to and including my dismissal from the volunteer service program with KCHD.

VOLUNTEER SIGNATURE

Print Name: ____

Signature: ____

Date: ___________________________

WITNESS

Print Name: ____

Signature: ____

Date: ___________________________

WAIVER AND RELEASE FORM RELEASE OF LIABILITY

In return for being allowed to participate in Kent City Health Department (KCHD) volunteer activities and all related activities, including any activities incidental to such participation ("Volunteer Activities"), the undersigned Volunteer or Parent/Legal Guardian of Volunteer if Volunteer is under age 18 (hereafter referred to using "I", "me", or "my") releases and agrees not to sue the KCHD or its officers, directors, employees, sub-contractors, sponsors, agents and affiliates ("the Foundation") from all present and future claims that may be made by me, my family, estate, heirs, or assigns for property damage, personal injury, or wrongful death arising as a result of my participation in the Volunteer Activities wherever, whenever, or however the same may occur.

I understand and agree that the Foundation are not responsible for any injury or property damage arising out of the Volunteer Activities, even if caused by their ordinary negligence or otherwise.

I understand that participation in the Volunteer Activities involves certain risks, including, but not limited to, serious injury and death. I am voluntarily participating in the Volunteer Activities with knowledge of the danger involved and I agree to accept all risks of participation.

I also agree to indemnify and hold harmless KCHD for all claims arising out of my participation in the Volunteer Activities.

I understand that this document is intended to be as broad and inclusive as permitted by the laws of the state in which the Volunteer Activities take place and agree that if any portion of this Agreement is invalid, the remainder will continue in full legal force and effect.

I also acknowledge that the KCHD have not arranged and do not carry any insurance of any kind for my benefit or that of Volunteer (if Volunteer is under 18), my parents, guardians, trustees, heirs, executors, administrators, successors and assigns. I represent that, to my knowledge, I am in good health and suffer no physical impairment that would or should prevent my participation in Volunteer Activities.

I also understand that this document is a contract which grants certain rights to and eliminates the liability of KCHD. I am of legal age and am freely signing this agreement. I have read this form and understand that by signing this form, I am giving up legal rights and remedies.

VOLUNTEER SIGNATURE

Print Name: ____

Signature: ____

Date: ______________________________

WITNESS

Print Name: ____

Signature: ____

Date: ______________________________

I am the parent or legal guardian of the Volunteer. I am of legal age and am freely signing this agreement. I have read this form and understand that by signing this form, I am giving up legal rights and remedies.

SIGNATURE OF PARENT/LEGAL GUARDIAN IF VOLUNTEER IS UNDER THE AGE OF 18

Print Name: ____

Signature: ____

Date: ______________________________

WITNESS

Print Name: ____

Signature: ____

Date: ______________________________