MedStar Southern Maryland Hospital Center

7503 Surratts Road
Clinton, MD 20735
301-877-4553 PHONE

medstarsouthernmaryland.org

Volunteer Services

Dear Friend,

Thank you for your interest in the Adult Volunteer Patient Ambassador Program at MedStar Southern Maryland Hospital Center. The Adult Volunteer Patient Ambassador is a unique position within our Adult Volunteer Program that has been designed to supplement and enhance the quality of care and support provided to our patients and their families.

Enclosed you will find the following documents:

- Overview of the Adult Volunteer Program (pages 2 – 3)
- Position Description for the Adult Volunteer Patient Ambassador (page 4)
- Application for the Adult Volunteer Patient Ambassador Program (pages 5 – 8)
- Confidentiality Form (page 9)
- Health Screen (page 10)
- Authorization Release for Background Investigation (page 11 – 14)

Please feel free to contact one of us if you have any questions about this specific program.

Sincerely,

Joanne H. Johnson
Volunteer Services Coordinator
301-877-4553 Office
301-877-4869 Fax
Joanne.Johnson@medstar.net

Martha Miller
Director of Patient Experience
301-877-5534 Office
Martha.Miller@medstar.net

MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER
ADULT VOLUNTEER PROGRAM – AN OVERVIEW

MedStar Southern Maryland Hospital Center is always accepting adult volunteer applications. Whether you are retired from work, a current college student looking for practical work experience, or currently exploring your career options, MedStar Southern Maryland Hospital Center has a volunteer position for you!

The Application Process:

1) Once a completed application is received, we will send it out for a background check. Incomplete applications will not be eligible for consideration, so please make sure it is complete. The results of the background check take an average of 10 days to receive. Once received, you will be contacted to schedule an interview.

2) The next step is the interview. During this interview, the prospective volunteer and the Volunteer Services Coordinator speak about the prospective volunteer's availability, scheduling, potential work placements, and the rules and expectations of the program. You will receive an orientation packet to read with an attached quiz to complete. You must then turn the completed quiz in at your next appointment (see item number 4).

3) The next steps are t-spot test and titer test. The t-spot test will determine whether or not a person has been exposed to TB. A titer test will reveal whether you lack immunity to certain diseases. These tests are done in Employee Health (free of charge) from 8:00am to 4:00pm Monday thru Friday. If the titer test shows that you are lacking immunity to a certain disease, you must follow-up with your personal physician.

4) Once the Volunteer Office receives the permission to start form from Employee Health, the volunteer applicant will then be called for another appointment. At this appointment, he/she will receive his/her uniform (there is a refundable $25 deposit required in order to receive the uniform), an ID badge, their work assignment, schedule, and start date.

Other Important Notes:

Adult volunteers must be over the age of 18.

Adult volunteers must commit to a minimum of 3 months of service (at least 4 hours of service per week between 8:00 a.m. – 8:00 p.m).

Adult volunteers born after 1956 must show immunity to both Rubeola (Measles) and Rubella (German Measles). The titer test you will receive in Employee Health will help us to determine whether or not you have immunity to these two diseases. If you do not have immunity, you must see your personal physician to receive vaccinations.

During flu season, it is mandatory for all volunteers to have record of a flu shot vaccination on file prior to volunteering at MedStar Southern Maryland Hospital Center. The flu vaccination will be available free of charge in Employee Health.

Volunteers are expected to maintain a professional appearance at all times. Volunteers are expected to wear business casual clothing. Volunteers are NOT allowed to wear jeans, shorts, stretch pants, jogging suits, athletic attire of any kind, or T-Shirts with printing of any kind. **Patient Ambassadors are required to wear a royal blue smock when they are volunteering.**

Volunteers MUST adhere to the confidentiality and privacy of patients and staff. All patient information must be kept confidential.

Volunteer Benefits:

1) Volunteers who work 3.5 hours or more per day are eligible to receive a free meal ticket. Meal tickets are issued by the Volunteer Office.
2) Volunteers are welcome to attend any employee social function or training workshop.
3) Volunteers have an Annual Awards Dinner Banquet every April.
4) Volunteers receive awards pins when they have hit certain hour marks.
5) Free parking.

Submitting Application Options:

- **Hand-Delivery**
  Place application in a sealed envelope marked Volunteer Department. Hand-deliver application to the Guest Services Representative at the Information Desk located in the main lobby of the hospital.

  Weekday Delivery: Monday - Friday 8:30 a.m. – 7:30 p.m.
  Weekend Delivery: Saturday - Sunday 12:30 p.m. – 7:30 p.m.

- **Mail**
  MedStar Southern Maryland Hospital Center
  Volunteer Department
  Attn: Joanne H. Johnson
  7503 Surratts Road
  Clinton, MD 20735

- **Fax** - 301 877-4869 **Email -** joanne.johnson@medstar.net

Volunteer Patient Ambassador Position Description

TITLE: Volunteer Patient Experience Ambassador

PURPOSE: To provide support to the patients, families, and staff in the provision of non-medical care of the patients in a warm caring manner and to provide comfort, compassion, conversation and assistance as needed for the patients and visitors.

DEPARTMENT: Hospital inpatient units or assigned ancillary department

REPORT TO: Volunteer Service Coordinator

QUALIFICATIONS:

- Ability to take the initiative and be flexible assuming different roles
  - ✓ As needed to provide service to patient and their family members
  - ✓ As needed by unit staff
- Demonstration of effective interpersonal skills
  - ✓ Positive
  - ✓ Service-oriented
  - ✓ Personable and friendly
- Demonstration of strong oral communication skills
  - ✓ Ability to effectively communicate with patients at all cognitive levels
  - ✓ Sensitivity to those who are experiencing physical and or emotional distress
- Ability to build relationships and collaborate as a member of the team
- Must be friendly, outgoing, caring and have a desire to be helpful to everyone on the
- Ability to multi-task
- Able to stand and walk during the entire shift
- Maintain confidentiality
- Perform duties independently with limited supervision or guidance

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Knock and introduce yourself to the patient
- Visit each patient to address needs (non-invasive)
- Ensure non clinical information is up to date on the communication boards
  - Day of week/date
  - RN (Nurse) Name & Spectra link number (connect to wireless phone that nurse carries)
  - PCT (Patient Care Technician) Name
- Ensure cleanliness of rooms and common areas as needed or requested, call Environmental Services when necessary
- Ensure room supplies are adequate (toilet paper, paper towels, hand sanitizer, isolation equipment)
- Provide patient with blankets and personal care items as requested (towels, linens, toothbrush, soap)
- Refresh water/ice pitcher
- Verify the patients and families have access to the *Patient & Family Handbook* at the bedside and *We Want to Know* material
- Verify patient and family have knowledge on use of television, call bell and bedside table
- Assist in locating equipment
- Complete wheelchair training to assist with discharging patients *(see Volunteer Department and Education Department)*
- Report all concerns raised by patients to the appropriate person -- Charge Nurse or Nurse Manager or Patient Advocate
- Volunteers must sanitize hands before entering a patient's room, and when exiting a patient's room

MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER

Adult Volunteer Patient Ambassador Application

NAME_____ DATE_____
Last First Middle I.

STREET ADDRESS_____ PHONE_____

CITY_____ STATE_____ ZIP_____

BIRTHDAY_____ EMAIL_____

EMERGENCY CONTACT PERSON: _____

PHONE #_____ RELATIONSHIP TO YOU_____

Have you ever served as a Volunteer in this or another hospital or medical center? _____
If so, where and when did you serve?_____
Have you ever been employed by MedStar Southern Maryland Hospital Center? _____
If yes, when/where?_____
Do you have relatives that are currently employed by MedStar Southern Maryland Hospital Center?_____
If yes, please list_____ Department_____

SCHOOL	NAME & ADDRESS of SCHOOL	COURSE OF STUDY	YEAR COMPLETED	DID YOU GRADUATE	DIPLOMA OR DEGREE
HIGH			**9 10 11 12**	⌋ YES ⌋ NO	
COLLEGE			**1 2 3 4**	⌋ YES ⌋ NO	
COLLEGE			**1 2 3 4**	⌋ YES ⌋ NO	

OTHER TRAINING OR SPECIAL COURSES:

_____

_____

Is volunteer work a requirement for school credit?_____ How many hours? _____

ANY ADDITIONAL INFORMATION YOU CONSIDER PERTINENT TO YOUR APPLICATION FOR VOLUNTEER SERVICE:

_____

_____

WHY WOULD YOU LIKE TO BE A VOLUNTEER PATIENT AMBASSADOR? _____

_____

_____

_____

DAYS AND TIMES AVAILABLE TO WORK? _____

_____

_____

_____

Prior to starting, volunteer patient ambassadors are required to attend an orientation session offered on select days/times during the month. Would you be able to commit to this?_____

Anticipated Length of Volunteer Services* _____
*Please note that new volunteers are required to commit to a minimum of 3 months of service

EMPLOYMENT HISTORY (LIST CURRENT/LAST POSITION)

1.

NAME OF COMPANY | TYPE OF BUSINESS

ADDRESS | JOB TITLE

DATE HIRED: | DATE LEFT:

REASON FOR LEAVING:

PERSONAL REFERENCES (No Relatives)

1.

NAME | RELATIONSHIP | YEARS KNOWN

ADDRESS | PHONE #:

2.

NAME | RELATIONSHIP | YEARS KNOWN

ADDRESS | PHONE #:

MILITARY RECORD

WERE YOU IN THE U.S. ARMED FORCES? ⌋ YES ⌋ NO BRANCH OF SERVICE

DATES FROM TO | DO YOU HAVE ANY EXPERIENCE FROM YOUR MILITARY SERVICE THAT WOULD BE RELEVANT TO YOUR VOLUNTEERING?

DO YOU SPEAK ANOTHER LANGUAGE FLUENTLY OR CAN YOU USE SIGN LANGUAGE? _____

Please list and describe any paid or unpaid activities, honors, experience, or training that might aid you in volunteering, which have not previously been listed. (You may omit any activities, honors, memberships or other items that tend to identify your race, sex, national origin, age, disability, or other personal traits you prefer not to disclose.)

Please add any additional information that you think may be relevant to a decision to include you in our volunteer programs.

AGREEMENT

I hereby affirm that all statements made herein are true and correct to the best of my knowledge. I authorize MedStar Southern Maryland Hospital Center to conduct whatever evaluation they deem necessary to confirm statements submitted on this application. If the evaluation determines any untrue statements are made, I understand this may be sufficient grounds for not being accepted into the volunteer program.

I authorize MedStar Southern Maryland Hospital Center to conduct reference and police record inquiries as it deems necessary. I also authorize and request each former employer and person, firm and corporation given as a reference to answer any and all questions that may be sought in connection with this application.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.

VOLUNTEER PLEDGE: *To Provide Service to the Community and to Supplement and Enhance the Quality of Care provided by Hospital Staff.*

I believe the hospital has a real need for my services. I will be loyal to the hospital and to the volunteer program. I will keep anything I see or hear while on duty as completely confidential. I will be dependable, conscientious, and punctual in the performance of my responsibilities. I will be dignified in my actions, courteous towards others, and considerate of patients. I will accept supervision and receive constructive criticism graciously, striving to make my work of the highest quality. I will do all in my power to help those I serve and those with whom I work, cooperating cheerfully for the task at hand. I will be proud to uphold the standards of this medical center in our community.

In consideration of my volunteer service, I agree to conform to the rules and regulations of MedStar Southern Maryland Hospital Center.

SIGNATURE: DATE:

MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER

CONFIDENTIALITY STATEMENT

As an employee or volunteer of MedStar Southern Maryland Hospital Center, it is my responsibility to maintain confidentiality of all patient information. I understand that as a result of my employment, I may have access to confidential patient information. Any request for patient or employee information should be directed to the appropriate manager (even if the request is accompanied by a court order or any type of legal document). All current or past employee employment reference/verification calls or written inquiries should always be forwarded immediately to the Human Resources Department.

I understand and agree that as a condition of my continued employment, I am required to keep all patient information confidential. Any disclosure of confidential patient information by a staff member or volunteers, verbally, written, or reproduced copies to any unauthorized person is a direct violation of a patient's rights and a breach of confidence. A breach of confidentiality constitutes grounds for immediate termination. Therefore, any unauthorized discussion or willful, intentional disclosure of confidential information will result in immediate termination of my employment.

Similarly, during the course of my employment I may obtain confidential medical information about another employee. Again, that information is to be held in the strictest of confidence and may only be shared with my direct supervisor.

By my signature below, I hereby agree that I have read this confidentiality statement, acknowledge its content and hereby agree to abide by its requirements.

_____

PRINT NAME

_____

SIGNATURE

_____

DATE

MEDST AR SOUTHERN MARYLAND HOSPITAL CENTER VOLUNTEER HEALTH SCREEN		
Last Name :	First Name:	I Middle Initial:
Date of Birth:		
During the last 12 months, were you under the care ofa physician? _Yes _No If yes, please explain:		
Have you recently had or now have:	**YES**	**NO**
1. Any communicable disease		
2. Discharge from eyes, ears, or nose		
3, Swollen glands		
4. Sore throat		
5. Frequent or persistent fever		
6. Respiratory infection		
7. Shortness of breath		
8. Night sweats		
9. Unexplained weight loss		
10. Coughed up blood		
11. Diarrhea		
12. Hepatitis or yellow jaundice		
13. Rash, skin ulcer or other skin lesions		
14. Cold sores		
15. Other (specify)		
Indicate whether you have had the following vaccines/diseases:	**DISEASE**	**VACCINE**
Chicken Pox		
Measles		
German measles (3 day)		
Mumps		
Have you ever had a T.B. skin test? _Yes - No If yes: Year: Results: Positive Negative Date of last Chest X-Ray:		
Volunteer Si2nature:	**Date:**	

Universal
BACKGROUND SCREENING

Request for Background Check

Account #007462

Social Security Number

Date of Birth

First Name	Middle Name	Last Name

Other Names Used

Current Residential Address		
City	State	Zip Code

List each CITY, STATE and ZIP CODE (if known) where you have lived during the past seven years:

City	State	Zip Code	From Date	To Date	

Driver's License Number

State of Issue

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

MedStar Health ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ. 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature	Date

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by MedStar Health ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New "ork Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. c

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled o find out what is in the CRA's file on you with proper identification, as follows:

• In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

• A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

• By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests or certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Signature	Date
Full Name (First/Middle/Last)	Social Security Number (SSN)*
Driver License State *I* Number	Date of Birth*
Current Address	City, State and Zip Code

•ssN and DOB will beused for identificationpurposes and will not be used as selection C!ireM.
FCRA:EMPLOYMENT:007462:201501