



## GUIDELINES FOR ADULT VOLUNTEER DRIVERS

The Volunteer Driver Program for MedStar St. Mary's Hospital is designed to provide transportation for paid staff during inclement weather or during a Code Brown (severe weather) situation.

### Requirements and General Guidelines:

1. The Volunteer Driver Program is open to all persons 25 years of age or older who have access to a four-wheel drive vehicle, possess a valid driver's license, and have up-to-date insurance coverage on the vehicle.
2. All applicants for the Volunteer Driver Program are required to complete an application. Once you have completed the application, please mail or deliver it to:

Volunteer Office  
MedStar St. Mary's Hospital  
25500 Point Lookout Road  
P.O. Box 527  
Leonardtown, MD 20650

3. All volunteer drivers will be interviewed prior to approval.
4. **Background checks & review of driving records will be performed on all drivers.** Driving records will be reviewed annually for continuation of previously approved drivers.
5. A hospital identification badge, issued by MedStar St. Mary's Hospital (MSMH), will be provided to approved drivers during a Code Brown event. This badge must be worn/carried at all times when transportation services are being provided. The badge identifies the driver as emergency personnel for the hospital during snow or emergency road conditions.
6. As a smoke free healthcare facility, drivers are required to follow our no smoking policy during activation.
7. Family members and other passengers are not allowed in the vehicle when transporting hospital staff unless they have been cleared through the Volunteer Driver Program.
8. Due to the COVID-19 pandemic, additional infection control procedures will be in place for drivers during the 2020-2021 driving season. Infection control practices include, but are not limited to; wearing masks, disinfecting vehicles before/after pick-up and delivery, and daily COVID symptoms checks. Detailed information and requirements will be provided for all drivers participating in the program. Disinfecting supplies and masks will be provided by the hospital.

### Benefits for Drivers:

1. Volunteers are welcome to attend any employee or volunteer social function or training workshop.
2. Flu shots are offered annually to all volunteers free of charge.
3. Drivers will be reimbursed mileage. Mileage will be calculated based on current tax standards using driver's logs and MSMH documentation. A completed W-9 is required to receive reimbursement.
4. Volunteer drivers are eligible for Free Meals in the MSMH cafeteria during activation.  
*(See Volunteer Free Meal Policy.)*

Mary B. Cheseldine, Volunteer & Student Services Coordinator  
MedStar St. Mary's Hospital  
301-475-6453  
Mary.Cheseldine@MedStar.net

**MEDSTAR ST. MARY'S HOSPITAL  
VOLUNTEER OFFICE  
P.O. Box 527  
Leonardtown, MD 20650  
301/475-6453**

**ADULT VOLUNTEER DRIVER APPLICATION**

**TO THE APPLICANT:** All questions must be fully answered before an application will be considered. A background check and driving record search will be conducted on all applicants.

*Please print legibly.*

**PERSONAL DATA**

Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
(Physical address) Street  
City State/Zip Code

\_\_\_\_\_  
(Mailing address) Street  
City State/Zip Code

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Telephone Number: \_\_\_\_\_  
*(Cell phone will be primary contact with drivers during an emergency event)*

E-Mail Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Driver's License State & Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please check the applicable response below:**

**GPS in my vehicle or through my cell phone     Yes     No**

Have you ever been employed or volunteered at this Hospital?    Yes \_\_\_\_    No \_\_\_\_

If yes, under what names and dates: \_\_\_\_\_

Have you ever applied to be a volunteer driver at this hospital or other hospitals in the past?  
Yes \_\_\_ No \_\_\_

If yes, please list names of hospitals and dates of application:

<b>Hospital</b>	<b>Date</b>
_____	_____
_____	_____
_____	_____

Identify any relative(s) presently employed at MedStar St. Mary's Hospital or MedStar Health:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

On what date can you begin? \_\_\_\_\_

If asked to drive during inclement weather (Code Brown), please estimate how quickly you could respond to a call:

Immediately       30 – 60 minutes       1-2 hours       over 2 hours

Can you perform the functions of a volunteer without accommodations? Yes \_\_\_ No \_\_\_

If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

**In case of emergency, please notify:**

Name: _____	Relationship: _____
Telephone: _____	
<b><u>Alternate Contact</u></b>	
Name: _____	Relationship: _____
Telephone: _____	
Family Physician: _____	Telephone: _____

**EMERGENCY MEDICAL INFORMATION:**

List any allergies you have to drugs, foods, or environmental agents (i.e., pollen, dust, mold, chemicals, etc.). Describe reactions you have had to substances you are allergic to: \_\_\_\_\_

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List the medications and prescriptions you take on a routine basis: \_\_\_\_\_

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**VOLUNTEER EXPERIENCE:**

Other previous volunteer experience(s), skills, training, education, and hobbies: \_\_\_\_\_

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Have you driven for any other organizations?     \_\_\_ Yes \_\_\_ No

*(List organizations and dates)*

Organization: \_\_\_\_\_ Date: \_\_\_\_\_

Organization: \_\_\_\_\_ Date: \_\_\_\_\_

Organization: \_\_\_\_\_ Date: \_\_\_\_\_

1.	Have you ever been convicted of a criminal or civil offense other than a minor traffic violation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2.	Have you ever been fined for a criminal or civil offense other than a minor traffic violation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3.	Have you ever had a DWI or DUI charge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4.	Have you had a moving traffic violation within the past 7 years?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

*If you answered Yes to any of the four questions above, describe when the conviction, fine, or charge occurred; the facts and circumstances; and any facts pertaining to rehabilitation, if applicable. Do not list any criminal charges for which the records have been expunged. A criminal offense will not necessarily bar you from serving as a volunteer.*

When: \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When: \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identify all states for which you have had a driver's license during the past seven calendar years:

\_\_\_\_\_  
\_\_\_\_\_

**Attach a copy of the following items to this application:**

1. Valid driver's license
2. Current automobile insurance identification card \*
3. Vehicle registration\*

\*(For all vehicles that you might drive during a Code Brown emergency event)

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*MedStar St. Mary's Hospital has strict hygienic and confidentiality standards that must be met by all volunteers. These standards are defined in more detail in the Driver Volunteer Handbook which each volunteer driver receives as part of the orientation package once accepted into the program.*

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**ATTACH A PHOTOCOPY OF DRIVER'S LICENSE,  
CURRENT REGISTRATION AND INSURANCE**

*(registration and insurance for each vehicle that may be driven during an emergency event)*

**Please provide this information for any vehicle that you may drive during a Code Brown.**

1) Color/Make/Model of Vehicle: \_\_\_\_\_  
\_\_\_\_\_

Number of Passengers that can wear seatbelts: \_\_\_\_\_

2) Color/Make/Model of Vehicle: \_\_\_\_\_  
\_\_\_\_\_

Number of Passengers that can wear seatbelts: \_\_\_\_\_

3) Color/Make/Model of Vehicle: \_\_\_\_\_  
\_\_\_\_\_

Number of Passengers that can wear seatbelts: \_\_\_\_\_

Geographic Area that can be served: \_\_\_\_\_  
\_\_\_\_\_

Driver's License Number: \_\_\_\_\_

## **CODE BROWN SEVERE WEATHER EMERGENCY PLAN**

### **Volunteer Driver Insurance Coverage Agreement**

As a Volunteer Driver for MedStar St. Mary's Hospital, I understand and agree that my vehicular insurance is "primary" in the event of an accident.

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Printed Name of Volunteer Driver

Date: \_\_\_\_\_

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Signature of Volunteer Driver

**PLEASE VERIFY WITH YOUR SIGNATURE THAT ALL THE INFORMATION YOU HAVE GIVEN ON THIS APPLICATION IS TRUE AND ACCURATE.**

Applicant's Statement (please read carefully before signing):

*I certify that the answers given herein are true and complete to the best of my knowledge. I also certify that I have not knowingly withheld any information that would affect this application unfavorably. I understand and agree that any false statement or omissions as addressed above with respect to the information required on this application is grounds for refusal to use my services as a volunteer or for withdrawal of my offer of volunteer assignment made to me or for the termination of my volunteer assignment at MedStar St. Mary's Hospital.*

*I authorize MedStar St. Mary's Hospital to investigate all matters covered by this application as well as all statements made by me on this application.*

*I authorize a background check (inclusive of a check of my driving record), reference checks, and investigation of all statements contained in this application that are necessary for a decision of my qualifications as a volunteer driver.*

*I also agree, if assigned, that I am to volunteer faithfully and diligently, to be careful and avoid accident, to come to my assignment promptly, and to execute the duties assigned by my supervisor or designee.*

*I agree to abide by all present and subsequently issued policies and rules of MedStar St. Mary's Hospital's Volunteer Department.*

*I understand that I will be required to maintain and protect the confidentiality of patient information, medical records, patient and Hospital financial data, and any patient, employee, physician, and Hospital information obtained through my volunteer assignment with MedStar St. Mary's Hospital.*

*I understand that my own personal motor vehicle insurance policy is expected to provide the primary coverage for any and all accidents which occur during my service as a volunteer driver for MedStar St. Mary's Hospital during inclement weather (Code Brown) situations.*

*I further certify that I have read the attached Guidelines and agree to adhere to the policies and standards of MedStar St. Mary's Hospital as outlined in the Guidelines if accepted as a volunteer.*

*I hereby acknowledge that I have read and do understand the above statements.*

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Confidentiality Statement - For Volunteers

I understand and agree that as part of my volunteer duties on the premises of, or on behalf of, MedStar Entity, Inc. or any of its subsidiaries or affiliates (collectively “MedStar”), I may, both prior to, and while on the premises, have access to, or come in contact with, Confidential Information.

I understand that Confidential Information includes, but is not limited to, any of the following information or materials owned by, or in the possession of MedStar (including any such information created by me in connection with my position): All business information, personnel information, quality improvement information, utilization management information, risk management information, operational policies or procedures, patient data or information, medical records, promotional and marketing programs, business plans, product specifications, manufacturing processes and operations, information about techniques, analytical methodology, safety, testing data and results, future market and product plans, billing and financial data and information, computer passwords/access rights, trade secrets, work product, intellectual property, and other information of a technical, scientific, or economic nature relating in any way to MedStar.

I understand that all Confidential Information created, obtained, received, reviewed, or which I may have contact with in connection with my role as a volunteer, is confidential in nature. I further understand and agree that I shall, at all times ensure the confidentiality of all Confidential Information I have contact with, that I shall not re-disclose such Confidential Information to any other person or entity without prior written approval from MedStar, and that I shall comply with all applicable laws including the obligation to maintain patient privacy. I further agree that I shall only review or access Confidential Information as specifically permitted by MedStar.

I agree to promptly inform appropriate representatives of MedStar of any breach of confidentiality for which I become aware and to reduce the effect of such breach by retrieving any inappropriately disclosed Confidential Information and taking any other actions necessary to minimize the effect of such disclosure or use of such Confidential Information. I understand that a failure to comply with the terms of this agreement may result in disciplinary actions, including but not limited to immediate dismissal, criminal or civil sanctions.

I have been informed of and I am in complete understanding of this policy.

Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Volunteer

Date: \_\_\_\_\_

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**Witness Printed Name:** \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(A witness signature is required on this form. A legal witness is someone over 18 years of age and not a parent or close relative, and is present when the person listed above signs the form.)*

**FCRA NOTICE AND ACKNOWLEDGMENT**  
IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

**NOTICE REGARDING BACKGROUND INVESTIGATION**

St. Mary's Hospital ("the Company") may obtain information about you from a 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, but is not limited to: employment and education verifications; social security number verification; criminal and civil court records; personal interviews; driving records; and/or any other public records or any other information bearing on your character, general reputation, personal characteristics and trustworthiness. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report.

The report will be generated by Universal Background Screening (4000 North Central Avenue, Suite 1000, Phoenix, AZ 85012, 1-877-263-8033) or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

**New York applicants only:** 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.

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION (above) and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT (separate document) 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" at any time after receipt of this authorization and, if I am hired, throughout my employment. 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, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

**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. [  ]

**Applicants of New York Employers only:** I acknowledge that by signing below, I have also received a copy of Article 23-A of the New York Correction Law, in compliance with Article 25 Section 380-g of the New York General Business Law.

**California applicants only:** By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge 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 / Number

**Social Security Number**

□	□	□	—	□	□	—	□	□	□	□	□
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**Date of Birth** - used for identification purposes only

□	□	—	□	□	—	□	□	□	□
MONTH			DATE			YEAR			

<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Other Names Used</b> (maiden name, AKA names, etc.)		

<b>Current Residential Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>

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	
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

<b>Driver's License Number</b>	<b>State of Issue</b>
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