THANK YOU FOR Deciding to Make a Difference And choosing to be a part of our VOLUNTEER TEAM

Volunteers Inspire by Example
WHAT’S A HOSPITAL VOLUNTEER?
They are a special, wonderful kind of person who offers his or her time, free of charge, to help others.

WHY ARE HOSPITAL VOLUNTEERS IMPORTANT?
Because they provide many EXTRA services that supplement the basic, essential functions of the staff . . . services that add to the comfort, care and happiness of the patient! Volunteers add to the quality of health care by helping the patients, their families, the staff and visitors.

BUT WHAT DOES THE VOLUNTEER GET OUT OF THIS?
A chance to learn new skills, develop new interests, make new friends and most of all, a chance to enjoy that rare satisfaction that comes from helping others.

WHAT KIND OF PEOPLE ARE VOLUNTEERS?
Men and women of all ages, all backgrounds, and all abilities. They may be students, housewives, working people or retired people.

WHAT QUALIFICATIONS ARE NEEDED?
You need to be interested, have a good attitude, be dependable and be discreet.

PREPARATION FOR THE JOB.
First we will interview you to match your interests, talents and schedule to the hospital’s needs. We will then orient you to the hospital and its goals, uniform requirements, policies and procedures. Once you have completed all our requirements, you will be introduced to your assignment and contact person. Then you will be ready to begin volunteering!

And many thanks to you for your interest in volunteering at our hospital.
Volunteer Services

Dear Applicant:

Thank you for your interest in volunteering at South Bay Hospital. We consider all applications from persons interested in being part of our South Bay Hospital Volunteer Services team. In order to be considered for placement, please complete the following process:

1) **Complete a Volunteer Application**
2) **Return the Medical Release Form to us after physician has signed**
3) **A copy of recent TB Test.** If you need TB testing, South Bay Hospital will provide at no cost. Preferred times are Tuesday from 9:30am-10:00am. If you need to make other arrangement call Ellie, Employee Health/Infection Control Coordinator at 634-0385.
4) **Oct – May is flu season. Flu Shots are available free to volunteers by end of September.** If you have had a flu shot please bring proof and we will add to our system.
5) **Complete Background Investigation Questionnaire: And authorization form**
6) **Have an interview** with member of the Volunteer Services Department and **take part in a hospital orientation program.**

Once you have completed all of the above requirements you will be considered for placement as a volunteer in one of our programs or individual placement as opportunities permit.

Please mail your completed application package to:

**Volunteer Services Department**  
South Bay Hospital  
4016 Sun City Center Blvd, Sun City Center, FL 33573-5256, or bring it to our office located off the main hospital hallway. Should you have any questions or need additional information, please call at (813) 634-0187.

Again, thank you for your interest in being part of our program. We look forward to hearing from you and receiving your materials.

Sincerely,

![Signature]

Paula Hange  
Volunteer Services/h2u Manager
SOUTH BAY HOSPITAL ADULT
VOLUNTEER APPLICATION

(Please Print Clearly)

Date: ______________________

Name: ______________________

First MI Last

Address: ______________________

Street City/Zip

Phone: ______________________ Birthday: Month ______ Day ______ Year______

E-Mail Address: ______________________

Social Security Number: ____________ - _______ - __________

Are you now employed? □ Yes  □ No  If yes, type of work/position: ______________________

Name of Employer: ______________________ Phone: ______________________

List any specialized training, hobbies and interests:

List volunteer experience:

Educational Background:

Assignment Desired (If Known): ______________________

Times available  □ Morning  □ Afternoon  □ Evening

How much time can you give? Days per week _______ Hours per day_______

Check days that you are able to volunteer: □ Mon. □ Tues. □ Wed. □ Thurs. □ Fri. □ Sat. □ Sun

Are you a yearly resident? ______ Yes  No______

If no, what are the approximate dates you are gone?

From__________________________ To__________________________.

PERSON TO CONTACT IN EMERGENCY:

NAME:__________________________ PHONE: ______________________

Relationship to volunteer: ______________________

Have you ever been convicted of a felony? □ Yes  □ No

If yes, describe:__________________________

List two local references:

Name Phone Number

Name Phone Number

I understand that accepting a volunteer position I will not be receiving compensation.

Volunteer Signature ______________________

Return to: Volunteer Services, 4016 Sun City Center, Sun City Center, 33573 (Ph: 634-0187)
IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT:

1. I shall hold as absolutely confidential, all information that I obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information.

2. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious or charitable reasons.

3. I shall submit to an annual tuberculin skin test and any other health examination which may be necessary as part of my volunteer service.

4. I understand that it is required I take safety and educational classes yearly.

5. I shall be punctual and conscientious, conduct myself with dignity, courtesy and with consideration of others, and endeavor to make my work professional in quality.

6. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

7. I shall at all times uphold the philosophy and standards of the hospital.

8. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work appearance; or (d) any other circumstances which, in the judgment of the department director, would make my continued services as a volunteer, contrary to the best interests of the hospital.

I have read each of the above conditions and I agree to be bound by them as well as all hospital policies and procedures with South Bay Hospital.

Volunteer Signature                                                                                          Date

To be completed by the Volunteer Services Department

Interviewed: ________________________ Orientation: ________________ TB Test: ________________

Assignment: ________________________ Day/Time: ________________________

Assignment: ________________________ Day/Time: ________________________

First Day Scheduled: ________________ Supervisor Notified: ________________
Volunteer Tuberculosis Screening

Print Name: __________________________ Date: ____________

Primary Care Physician: ____________________________________________

Last PPD: __________________________ □ Negative □ Positive

TB Signs & Symptoms Review

Yes No

Persistent Cough (over 3 weeks Duration) ___ ___

Night Sweats ___ ___

Persistent Low Grade Fever ___ ___

Persistent Weight Loss w/o Dieting ___ ___

Fatigue ___ ___

Loss of Appetite ___ ___

Coughing up Blood ___ ___

Chest Pain ___ ___

Volunteer Signature: ____________________________________________

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Available Tuesdays from 9:30am – 10:00 am.
Employee Health is located in suite 111 in Haverford Plaza directly behind ER.
Return the Medical Release Form to us after physician has signed

MEDICAL RELEASE FORM
VOLUNTEER SERVICES

Volunteer Name: __________________________________________________________

Address: __________________________________________________________________

Physician's Name: __________________________________________________________

Address: __________________________________________________________________

This individual would like to begin or continue doing volunteer work at South Bay Hospital. They will not be accepted without a full recommendation by you, their physician. Please circle yes or no for each question.

Yes  No  He/she **IS ONLY CAPABLE** of limited physical exertion (receptionist, filing, answering phones).

Yes  No  He/she **IS** capable of considerable walking or standing, (assisting nurses delivering mail, photo copying).

Yes  No  He/she is capable of carrying an 8 pound meal tray to patients.

Yes  No  He/she is capable of pushing a wheelchair with a patient in it.

Yes  No  He/she is capable of pushing a gurney with a patient on it.

Yes  No  His/her physical and emotional health **IS** acceptable for working around patients.

Yes  No  Additional limitations: ________________________________

________________________________________
Volunteer Signature

Return to: South Bay Hospital
Volunteer Services
4016 Sun City Center Blvd
Sun City Center, Florida 33573

9/2013
Confidentiality and Security Agreement

Note: this form to be used for HCA employees and HCA workforce members.

I understand that the HCA affiliated facility or business entity (the “Company”) for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

General Rules
1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company’s policies.

Protecting Confidential Information
4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.
8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
9. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

Following Appropriate Access
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient’s record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
Using Portable Devices and Removable Media
12. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards.
13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data (e.g., Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
a. Require the use of only encryption capable devices.
b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
e. Restrict access to any mobile application that poses a security risk to the Company network.

Doing My Part – Personal Security
14. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
15. I will:
a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
b. Use only approved licensed software.
c. Use a device with virus protection software.
16. I will never:
a. Disclose passwords, PINs, or access codes.
b. Use tools or techniques to break/exploit security measures.
c. Connect unauthorized systems or devices to the Company network.
17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
18. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
a. my password has been seen, disclosed, or otherwise compromised;
b. media with Confidential Information stored on it has been lost or stolen;
c. I suspect a virus infection on any system;
d. I am aware of any activity that violates this agreement, privacy and security policies; or
e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

Upon Termination
19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

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<th>Employee/Workforce Member Signature</th>
<th>Facility Name and COID</th>
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<td>South Bay Hospital 37941</td>
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<tr>
<th>Employee/Workforce Member Printed Name</th>
<th>Business Entity Name</th>
<th>Volunteer Services</th>
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VOLUNTEER DISCLOSURE & AUTHORIZATION

FULL NAME

Any Other Names Used

Social Security No / / Date of Birth

Current Address

City State Zip

Driver’s License State No.

Address:

Have you ever been convicted of a crime? Yes No

Offense County State When

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.

1. City State Dates From: To:

2. City State

3. City State

4. City State

5. City State

6. City State

7. City State

8. City State

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The prospective organization ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. 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. These reports may contain information regarding your credit history, 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 after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd, Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] 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 throughout the course of your employment, volunteering, contract, privileges or appointment to the extent permitted by law.

The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

Nevada Private Investigator License # 1618

Rev. July 2010
ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the 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 the Company at any time after receipt of this authorization and throughout the term of my employment, contract for services, privileges volunteering or access to an organization, 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 PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, 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.

STATE LAW NOTICES

**Minnesota or Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

**California** applicants or employees only: Please mark the following field 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. The report will be mailed to the current address indicated above: _____

**California** applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

**New York** applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____

**Maine** applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

**Massachusetts** applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

**Washington State** applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. 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.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature ___________________________________________ Date ______________________

Parent or Guardian Signature __________________________________ Date ______________