Athens-Limestone Hospital

Onboarding Checklist

Ambassadors: Academic Year (September-April)
Chaplains: Year-round
Adult Volunteers: Year-round
Junior Volunteers: Summer (June-July)

Chaplains, Ambassadors*, Junior* & Adult Volunteers

- Application
- Non-Employee Badge Request
- Background Check* (Ambassadors & Junior Volunteers may skip)
- Affirmation Statement on Security and Privacy of Information
- Covid-19 Vaccine Documentation
- Seasonal Influenza Vaccine Declination (flu season only)
- Volunteer Agreement

Ambassadors & Junior Volunteers Only

- Affirmation Statement on Use of Slack Application
- Phone Use & Behavioral Standards Acknowledgement
- Extracurricular Activities Form

To be completed by Service Excellence/Placement Supervisor

- System Access Request Form (SARF) for computer-based placements - SE
- Training Checklist – PS
- Placement Instructions - PS

Athens-Limestone Hospital

Volunteer Application

Applicant Information			
First Name	Last Name	DOB	Age
Address	City	State	Zip Code
Email Address		Phone Number	

Emergency Contact			
First Name	Last Name	Relationship to Applicant	
Address	City	State	Zip
Email Address		Phone Number	

Availability

Please fill in start and end times for each day of the week you are available to volunteer. If you are not available on a particular day, please leave boxes blank. Attach any competing schedules (work, school, sports, other volunteer obligations, etcetera).

	Sun	Mon	Tue	Wed	Thu	Fri	Sat	*Please use AM and PM when completing preferred shift times*
Start Time								
End Time								

Special Skills, Qualifications or Limitations

Please summarize special skills and qualifications you have acquired from past employment, volunteer work or other activities including hobbies or sports. Please include any special accommodations that should be considered when assigning placement.

Interests

Please check all that apply:

☐ I am a student interested in a career in healthcare.

Area of interest:	Are you interested in job shadowing this area if there are no volunteer placements? ☐ Y ☐ N

☐ would prefer a placement which allows me to interact with others (greeter, transporter, etc.).

☐ would prefer a placement with minimal interaction with others (department assistant, mail sorter, etc.).

☐ I'm flexible and do not have a preference.

Acknowledgement

Submitting an application to ALH Volunteer Services does not obligate Athens-Limestone Hospital to provide a volunteer placement, nor are volunteers obligated to accept the position offered. Placements are created and filled based on current needs of the hospital. Volunteer preference is taken into account but cannot be guaranteed.

Applicant Signature	Date

Non-Employee ID #: _____

Athens-Limestone Hospital

NON EMPLOYEE DATA SHEET

Please Print Clearly: Incomplete forms WILL NOT be processed.

NAME:_____ Social Security# _____ Date of Birth: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE #:_____ COMPANY/SCHOOL:_____

ALH DEPARTMENT:_____

BADGE TYPE:_____ CONTRACTOR **_____ PHYSICIAN**

_☐_ STUDENT **_____ ADVANCED LEVEL PRACTITIONER**

_____ SECURITY **☐ VOLUNTEER**

_____ HOSPITAL BOARD **_____ FOUNDATION BOARD**

There will be an initial $10.00 charge for all students to have an ALH badge. The badge will be active up until the graduation date that the student supplies. There is a $10.00 fee to reprint lost or damaged badges.

Contractor badges will be free of charge for the first badge. If the badge is lost or damaged there will be a $10.00 fee to reprint the badge. All contractor badges will have a termination date of one year from the print date. If the contractor is still actively working at ALH the supervisor of the host department will need to contact security to reactivate the badge.

By signing below, I understand I am required to provide documentation regarding my COVID Vaccine status prior to receiving a non-employee badge at Athens-Limestone Hospital per the Mandatory COVID-19 Vaccination Policy.

Signature:_____ Date:_____
(Signature verifies that you have read and understand the statement above)

Badges can be printed in the Human Resources office upon receipt of form. The Human Resources office is located on 721 West Market St Suite C. Badges can be generated Monday through Thursday 8:30am – 4:30 pm.

To Be Completed by Human Resources:

COVID Vaccine Documentation Attached *(Required)*: HR Initials: _____ Date Obtained: _____

Flu Vaccine Documentation Attached: HR Initials: _____ Date Obtained: _____

QUALITY COUNTS, INC.

APPLICANT CONSENT FORM FOR PRE-EMPLOYMENT INVESTIGATION & SPECIFIC RELEASE
ATHENS LIMESTONE HOSPITAL

I certify and declare under penalty of perjury under relevant state and federal law that the information contained in my employment application is complete, true and accurate. I acknowledge that falsification or omission of information may result in immediate dismissal or retraction of any offer of employment.

In consideration of Volunteer Service's review of my application for employment, (herein referred to as ATHENS LIMESTONE HOSPITAL), I hereby voluntarily consent to and authorize ATHENS LIMESTONE HOSPITAL, or its authorized agents bearing this release or copy thereof, to obtain a consumer report for employment purposes. I agree that this consumer report may include verification of any of the following:

Employment, Education, Credentials, Personal Identity, Past Employment, Reference Checks, Criminal Records, Arrests, Civil Cases, Motor Vehicle Records, Credit Report

I authorize all persons and organizations that may have information relevant to this research to disclose such information to ATHENS LIMESTONE HOSPITAL or its authorized agents. I hereby release ATHENS LIMESTONE HOSPITAL, its authorized agents, and all persons and organizations providing information from all claims and liabilities of any nature in connection with this research. I hereby further authorize that a photocopy of this authorization may be considered as valid as the original.

I understand that I have specific prescribed rights as a consumer under the Federal Fair Credit Reporting Act ('FCRA'), and may have additional rights under relevant state law; I hereby certify that I have been informed of my rights.

_____ _____
SIGNATURE of Applicant Date

_____ _____
PRINTED Name of Applicant Maiden Name(s)

_____ _____
Date of Birth Social Security Number

Driver License Number & State of Issue: _____

Current Address: _____

Previous Address (es): _____

EMPLOYER TO CHECK SERVICES TO BE COMPLETED:

___ ALABAMA STATEWIDE CRIMINAL & ARRESTS
___STATEWIDE CRIMINAL & ARRESTS
___COUNTY CRIMINAL & ARRESTS
___SOCIAL SECURITY TRACE
___MOTOR VEHICLE REPORT
___SEXUAL OFFENDER REGISTRY
___PEER CREDIT REPORT
___PREVIOUS EMPLOYMENT VERIFICATION
___REFERENCE VERIFICATION
___WORKER'S COMPENSATION
___EDUCATION VERIFICATION
___OIG EXCLUSIONS

STATES(S): _____ **COUNTY:** _____

*** NOTE ***

FOR EDUCATION & EMPLOYMENT VERIFICATION PLEASE SUPPLY ADDITIONAL INFORMATION (RESUME OR APPLICATION)
INFORMATION IS BEING VERIFIED BY QUALITY COUNTS, INC. ANY INFORMATION OR QUESTIONS SHOULD BE DIRECTED TO THE FOLLOWING:

QUALITY COUNTS, INC.
16096 HIGHWAY 216
BROOKWOOD, ALABAMA 35444
PHONE: (205) 561-2340 FAX: (205)561-2344

HH Health System Employment Application Addendum

Have you EVER been arrested for any crime, and/or do you have any pending charges? If you have been arrested for any crimes, you must so indicate on this form, as we will conduct a thorough background check. Criminal offenses include bad check writing, DUI, theft, domestic violence, drugs, etc. Although disclosing this information on your application may not disqualify you from employment with HH Health System, NOT disclosing the information WILL disqualify you for job opportunities with our organization. This form will be added to your application.

Yes ☐ No ☐

If yes, please provide a list of all arrests and/or pending charges, including dates and disposition:

_____

_____

_____

_____

_____

_____

I certify that the information given on this application addendum and in any other supporting documentation is true and correct. I understand that any false information given; willful or negligent misrepresentation made; or failure to disclose any requested information during the course of application for employment with HH Health System may result in termination and ineligibility for future employment with HH Health System.

_____

Applicant's Printed Name

_____

Applicant's Signature

_____

Date

Athens-Limestone Hospital

Affirmation Statement
on Security and Privacy of Information

My signature below verifies that I have read and commit to the Athens-Limestone Hospital requirements for confidentiality of protected health information (PHI). Additionally, I am aware of and will follow Hospital policies regarding the Privacy and Security of PHI including the use, disclosure, storage and destruction of PHI. I will only access patient information that I need to do my job at the I will not access (using CPSI, E-powerdoc, EMD, GE or any other hospital information system) patient information of family members , co-workers or other people that is not required to perform my job.

Confidential Information includes PHI as well as information concerning quality assurance functions, contracts, business arrangements, employee information and propriety information relating to the hospital's finances, operations or future plans as described in Administrative Policy "Confidentiality."

As part of the terms and conditions of my employment or association, I hereby agree and accept that I will not , during my employment (or affiliation) or after it ends, access PHI, or disclose confidential information except as required for my job duties and in accordance with a policies and laws governing disclosure or Release of Information.

I agree that user identification codes and passwords will not be shared. Neither will I make an attempt learn or use another employee's or associate's passwords. I am responsible for use and protection of my unique computer log-ins (passwords).

If I am an instructor, I understand that I assume responsibility for the actions of the students under my supervision to comply with the Security and Privacy of Information Policy.

If I am a physician, I understand that I assume responsibility for the actions of my employees or office staff to comply with the Security and Privacy of Information Policy.

Training: Members of the Hospital workforce receive training on security and privacy during new Employee Orientation and during annual required training. Any updates or changes to policies will be communicated via staff meetings, intranet and/or mandatory requirements tests. Annual Renewal: I acknowledge that I know where to find policies for Privacy, Confidentiality and Compliance.

Corporate Compliance: It is my responsibility to follow policies and regulations as well as State and Federal laws. I understand that I am responsible for knowing the rules and policies that apply to my job. The hospital has a Corporate Compliance program to assist my knowledge of the rules. The Hospital also monitors compliance with Federal and State laws and regulations, which includes my use of hospital equipment and information systems. I am not aware of any violations of policies, laws or regulations and agree to report any violations to the Corporate Compliance Officer. Questions about whether actions taken by the Hospital are legal should be referred immediately to the appropriate supervisor, or to the Corporate Compliance Officer.

Computer Applications: I further understand that I may be provided access to certain hardware and software applications, some of which may be proprietary to their respective vendors. I agree to keep the hardware and software applications confidential, to not disclose to third parties, and to use such hardware and software applications only for the benefit of Athens-Limestone Hospital.

Exclusion List or Status: I confirm that I have not been excluded by the U.S. Government from participating in any governmental program nor, to the best of my knowledge am I under investigation. I agree to notify the Corporate Compliance Officer immediately upon my receiving written or verbal notification that I am proposed for exclusion from any governmental health program.

I understand that a violation of this affirmation statement could result in disciplinary action up to and including termination of employment/contract/ association/appointment and a report to my professional regulatory body. Additionally, federal law provides for the imposition of fines and imprisonment pursuant to HIPAA violations.

PRINT NAME: _____ ID # _____

AFFILIATION: ❑ Employee ☐ Volunteer ❑ Physician ❑ Contractor ☐ Instructor/Student ❑ Other _____

SIGNATURE: X_____DATE: _____

WITNESS SIGNATURE: X_____DATE:_____

COVID-19 VACCINE Documentation

Athens-Limestone Hospital

Athens-Limestone Hospital offers all Health Care Workers (HCWs) i.e. employees, volunteers, medical staff, and licensed independent practitioners the COVID-19 vaccine, free of charge. It is required for our organization to capture documentation related to COVID-19 vaccination status.

1. **NAME:**

_____

First *Last*

2. **EMAIL:**

_____

3. **POSITION:**

☐ Employee ☐ Medical Staff
☐ Volunteer ☐ Other _____

4. **ALH BADGE ID#** ***(or date of birth for new hires)***

_____

5. **For COVID19 vaccination, I have**:

☐ **Had a primary series C19 Vaccination or any Boosters** **Date ____/ _____/ ____**
(*Please submit your vaccination card*.)

☐ **Have NOT been vaccinated for C19**
(I understand that I am not required to be vaccinated, nor am I required to request an accommodation in order to work.)

6. **If requesting a medical accommodation from the vaccine, I acknowledge the following facts:**
(all must be initialed)

INITIAL	FACTS:
_____	Those infected with the COVID-19 virus have no symptoms but may still transmit the virus to others.
_____	I acknowledge that COVID-19 vaccine is recommended for all healthcare workers to prevent infection from and transmission of the virus.
_____	I understand I may contact Employee Health to be vaccinated free of charge at any time.

7. **ACCOMODATION REQUEST**
If you are requesting a medical accommodation from getting the COVID-19 vaccine, please check which of the following applies to you:

☐ Past anaphylactic reaction to a vaccine with difficulty breathing, hives and/or fast heart rate and required emergency treatment.

☐ My physician states the vaccine is not recommended for me.

COVID-19 VACCINE Documentation

Athens-Limestone Hospital

8. EXPECTATIONS

I acknowledge and will abide by recognized and approved standards to include:

INITIAL

_____ **I will abide by the masking and attendance policy in the Employee Handbook and in my department.**

_____ **If I have been granted a temporary medical exemption, I will visit Employee Health to follow up, before the expiration of my exemption.**

9. SIGNATURE

In regards of exhibiting signs of illness: if I have a fever of ±100°F, have a positive COVID-19 test, have an upper-respiratory infection, exhibit diarrhea or vomiting; I will not clock in. I will report to Employee Health for testing and guidance, or consult my personal physician.

My signature indicates adherence to these standards and permission to release my vaccination status for reporting purposes.

My signature also verifies that the above information is complete and accurate to the best of my knowledge.

_____

Athens-Limestone Hospital

SEASONAL INFLUENZA (FLU) VACCINE DECLINATION

In compliance with Joint Commission's Infection Control Standard (4.15), Athens-Limestone Hospital must offer all Health Care Workers (HCWs) i.e. employees, volunteers, medical staff, and licensed independent practitioners the influenza (flu) vaccines free of charge. In addition, we are mandated to track reasons for declining the influenza vaccine and report vaccination/declination rates. If declining the influenza vaccine, please complete this form.

1. **NAME:_____ Emp ID#_____ Date: _____**

2. **POSITION ☐ Employee ☐ Medical Staff ☐ Student (school):_____ ☐ Volunteer ☐ Other _____**

3. **In declining the vaccine, I acknowledge the following facts:** *(all must be initialed)*
   _____By declining the vaccination, I continue to pose a risk to patients that may be at high-risk for complications.
   _____I have received the most current Flu Vaccine Information Sheet (VIS)
   _____The influenza virus may be spread to patient, co-workers, family members and other contacts up to 24 hours before symptoms of the illness develop.
   _____Up to 30% of people infected with the influenza virus have no symptoms but may still transmit the virus to others.
   _____The influenza vaccine is inactive or attenuated and cannot give me the flu.
   _____I acknowledge that flu vaccine is recommended for all healthcare workers to prevent infection from and transmission of flu and its complications.
   _____I am aware the choosing to decline for personal reasons may cause ineligibility for any variable pay plans & merit raises during the fiscal year.
   _____Should I change my mind during flu season, I understand I may contact Employee Health to be vaccinated free of charge.

4. **DECLINATION REASON**
   Indicate your primary reason for declining the flu vaccine:
   ☐ **Medical Reason** ☐ **Religious or Moral Conscious Objection**

   A. **For MEDICAL DECLINATION REASON**
      If you chose Medical Reason, which of the following applies to you:
      (Documentation required from your personal physician, for any medical declination).
      ☐ History of Guillain Barré or other neurological condition.
      ☐ Past anaphylactic reaction to a vaccine with difficulty breathing, hives and/or fast heart rate and required emergency treatment.
      ☐ My physician states the vaccine is not recommended for me.

   B. **For RELIGIOUS or MORAL CONSCIOUS OBJECTION** ***(Please initial)***
      _____ I understand my employer may ask for additional information and/or documentation about my religious belief(s) or practice(s).
      _____ I understand my employer may need to contact my religion's spiritual leader, or scholar regarding the request for exception

      **** REQUIRED DOCUMENTATION ****
      Attach documentation from Personal Physician if requesting a medical exception.
      Attach religious belief documentation if requesting religious exception.

5. **SIGNATURE**
   My signature indicates permission to release declination status for reporting purposes. My signature also verifies that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

_____

Name **Date**

Athens-Limestone Hospital

Volunteer Agreement

Attestation

I, _____, attest that I have read and understand the Volunteer Handbook. I agree to adhere to these standards and understand that I may be dismissed from the program for repeated violations of the standards listed above. Further, I agree to uphold all expectations to the best of my ability which include but are not limited to: being prompt, adhering to confidentiality standards, upholding communication expectations and being constantly mindful of improving the patient experience.

I understand that the purpose of the Volunteer Program is to improve the patient experience, provide the community with service opportunities and allow local teens an opportunity to explore a career in healthcare through hands-on experience. I understand that if I am found to be in violation of any of the Volunteer Program guidelines, or if it is determined that I am not a good fit for the program, I will be dismissed and will not be able to reapply in the future.

_____ _____

Signature Date

Athens-Limestone Hospital
#bethedifference

Affirmation Statement on Use of the Slack Application

The Slack Application is a communication tool that is only to be utilized by employees of Athens Limestone Hospital for a specific project and purpose. Setting up an account with an ALH email requires prior approval from the Director of Information Technology. Invitations to join an ALH Slack account are not to be shared with vendors or other persons not employed by Athens Limestone Hospital or part of the formal ALH Volunteer Program. **Protected health information (PHI) is *NOT* to be uploaded, shared, used, disclosed or stored in Slack. Additionally, passwords are *NOT* to be uploaded, shared, used, disclosed or stored in Slack.**

I acknowledge that I have received and completed training via tutorial videos and/or in-person training on the use of the Slack application.

My signature below verifies that I understand and commit to the Athens Limestone Hospital requirements for using the Slack app as well as the confidentiality of protected health information (PHI) and I will not share PHI or passwords in the Slack Application.

_____ _____

Print Name **Employee ID# / Volunteer**

_____ _____

Signature of Employee **Date**

Athens-Limestone Hospital

Phone Use & Behavioral Standards Acknowledgement

For ALH Ambassador Program Volunteers Only

While volunteering at Athens-Limestone Hospital, in association with the ALH Ambassador Program, it is expected that program participants adhere to the following set of guidelines regarding **cell phone use**:

(It is understood that Ambassadors must use their phone to communicate with one another, with hospital staff and program administrators - this type of correspondence is permitted and encouraged. It is also understood that personal emergencies may arise while volunteering - Ambassadors will not be penalized for taking these types of texts or calls.)

- Ambassadors will not be permitted to play games, scroll social media, make personal phone calls & send text messages, etc. during their volunteer hours.

- If volunteering at a greeting placement in which there is no specific task assigned, Ambassadors may bring books, homework, etc. to keep busy. Ambassadors are expected to prioritize their placement while working their shift.

While volunteering at Athens-Limestone Hospital, in association with the ALH Ambassador Program, it is expected that program participants adhere to the following set of guidelines regarding **behavior**:

- Ambassadors will not be permitted to sleep or rest during placements.

- Ambassadors are expected to interact with patients and visitors in a professional manner, including in appearance and language.

- Ambassadors may not bring meals to eat during their shift. Lidded beverages, water bottles are allowed. Small, pre-packaged snacks are permitted in **non-clinical areas.**

Attestation

I, _____, attest that I have read and understand the guidelines listed above. I agree to adhere to these standards and understand that I may be dismissed from the program for repeated violations of the standards listed above.

_____ _____

Signature Date

Athens-Limestone Hospital

Name: _____

Sports & Extracurricular Activities Information

Please attach schedules for each sport/extracurricular activity, if you have them. If not, list schedule details in the fields provided below.

☐ Football
Season (Month-Month):
_____

☐ Basketball
Season (Month-Month):
_____

☐ Baseball
Season (Month-Month):
_____

☐ Softball
Season (Month-Month):
_____

☐ Tennis
Season (Month-Month):
_____

☐ Volleyball
Season (Month-Month):
_____

☐ Cross Country
Season (Month-Month):
_____

☐ Track & Field
Season (Month-Month):
_____

☐ Soccer
Season (Month-Month):
_____

☐ Other: _____
_____
Season (Month-Month):
_____

Practice Schedule Details (please include schedule information for each sport):

_____
_____
_____
_____
_____
_____

Game Schedule Details (please include schedule information for each sport):

_____
_____
_____
_____
_____
_____

Other Extracurricular Activities (work schedules, Scholars Bowl, Mayor's Youth Commission, Limestone LEAD, Health Sciences Program, Tech School student, dance, travel sports, etc.):

_____
_____
_____
_____
_____