



BAPTIST HEALTH

VOLUNTEER SERVICES

Lexington

VolunTeen Forms Packet Instructions

- 1) Volunteer Confidentiality Agreement
 - All students must complete this form.
 - Write your name in blank space at the top of page 1.
 - Sign, print name and date on page 2; lower left hand corner.
- 2) Baptist Healthcare System, Inc HIPAA Security Form
 - All students must complete this form.
 - Print your name in first blank and sign/date form.
- 3) Medical Awareness Form
 - Please complete this form accordingly. It's for your safety in the event of an emergency and will be kept confidential.
- 4) Consent to Treatment of Minor
 - All students under the age of 18 must have a parent complete and sign this form.
- 5) Confidential High School Recommendation
 - This form is required. All students should obtain a parent's signature first on this form.
 - After parent has signed, student will give it to a high school counselor/teacher for completion.
 - It is the student's responsibility to bring your Recommendation to the Information Session.
- 6) Immunization Schedule
 - All students must bring a copy of their immunization schedule to their interview. You can request a copy from your pediatrician.

*(Note: **Accepted** students will be required to bring their current year Negative TB results – One Step or Two Step are accepted.)*

MUST include COVID vaccination documentation.

**All forms must be completed and brought to your interview.
There will be no exceptions. Thank you.**

BAPTIST HEALTH LEXINGTON VOLUNTEER CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is between BAPTIST HEALTHCARE SYSTEM, INC. d/b/a/ BAPTIST HEALTH LEXINGTON (“Baptist Health Lexington”) and _____, Volunteer Services (“Volunteer”).

In consideration of Baptist Health Lexington’s relationship with Volunteer Services continuation of such relationship, as the case may be, and for other valuable consideration, the parties agree as follows:

1. **PURPOSE OF AGREEMENT.** Baptist Health Lexington recognizes the importance of protecting confidential information concerning parties, their families, medical staff members, employees, and volunteers in the operation of the hospital as well as the importance of protecting the proprietary information of the hospital. Each Volunteer, in the performance of his or her duties as a volunteer at Baptist Health Lexington may have access to confidential patient information, confidential medical staff information, confidential employee information or proprietary hospital information. The purpose of this agreement is to document the understanding and agreement of Baptist Health Lexington Volunteers to maintain the confidentiality of such information at all times, both at the hospital and outside the hospital. More specifically, patient information should only be relayed to those persons involved with the patient’s treatment; persons designated by Baptist Health Lexington who are responsible for quality improvement; or as requested by Risk Management, BHS Legal Department and/or the hospital’s defense firm as necessary for Risk and Claims Management activities. Furthermore, this Agreement is to obtain acknowledgement of the Volunteer that he or she may be given a security code in order to access from authorized terminals a variety of confidential information and that such security code must be maintained by the Volunteer as confidential information.
2. **STATUS OF VOLUNTEER.** Volunteer has an at will relationship with Baptist Health Lexington and the execution of this Agreement does not change that status or create any contractual relationship or employment agreement between Volunteer and Baptist Health Lexington. Volunteer acknowledges that he/she is executing this Agreement, not as an employment agreement, but as a condition of and in consideration of Volunteer’s relationship with Baptist Health Lexington.
3. **SCOPE OF AGREEMENT.** Volunteer agrees to follow all policies and procedures, rules and regulations of Baptist Health Lexington including, but not limited to the following:
 - a. Volunteer will protect the confidentiality of patient, medical staff, employee, volunteer and proprietary hospital information as well as any privileged or confidential information obtained during the course of investigation of a hospital incident, claim or lawsuit. The Volunteer will not release such confidential information to any unauthorized source.

- b. Volunteer understands and agrees not to access or attempt to access information unless Volunteer has authorized access and access to the information is needed to perform his or her volunteer duties.
- c. Volunteer agrees not to disclose any security code he or she may be given by Baptist Health Lexington for access to computer information to anyone, including any other employee or volunteer of Baptist Health Lexington.
- d. Volunteer agrees not to use any security code of any other person.
- e. Volunteer agrees not to write down passwords or security codes that would make them accessible to other individuals.
- f. Volunteer will report breaches of this Confidentiality Agreement by others to the Leader of Volunteer Services. Volunteer understands that failure to report breaches may subject Volunteer to a discontinuation of relationship with the hospital.
- g. Volunteer understands that any security codes he or she may be given by Baptist Health Lexington to obtain access to patient medical records is his or her electronic signature on such medical records.

4. BREACH OF AGREEMENT. Volunteer understands that breach of any provision of this Agreement may result in immediate termination of relationship, at the option of Baptist Health Lexington, in addition to any other rights and remedies available at law, which Baptist Health Lexington may pursue.

5. SEVERABILITY. If a court of competent jurisdiction holds any provision of this Agreement invalid such invalidity shall not affect the enforceability of any other provisions contained in the Agreement and the remaining portions of this Agreement shall continue in full force and effect. The obligations in Section 3 of this Agreement shall survive termination of relationship.

6. JURISDICTION. Volunteer agrees to be subject to the jurisdiction of the courts of Fayette County in the Commonwealth of Kentucky in connection with the performance and enforcement of this Agreement and further agrees that the provisions of this Agreement shall be governed by, interpreted and construed in accordance with the laws of the Commonwealth of Kentucky.

ACKNOWLEDGMENT

VOLUNTEER HAS READ AND AGREED TO ADHERE TO THE CONDITIONS OF THIS CONFIDENTIALITY AGREEMENT AND ACKNOWLEDGES THAT ANY VIOLATION OF THE AGREEMENT CAN RESULT IN IMMEDIATE TERMINATION OF RELATIONSHIP.

IN WITNESS WHEREOF, the parties have set their hands effective as of the day and year first set forth hereinabove.

VOLUNTEER Signature: _____

Name (PRINT): _____

Date: _____

BAPTIST HEALTHCARE SYSTEM, INC
HIPAA SECURITY

I, _____ (please print) acknowledge and agree to abide by the Baptist Healthcare System, Inc. HIPAA Security policies and procedures and the specifications within the above and attached documents whereas they pertain to HIPAA Security. I realize that there are civil and criminal penalties for the unauthorized use and disclosure of confidential medical information and electronic protected health information.

VolunTeen Signature: _____

Date: _____

MEDICAL AWARENESS LIST

This form is for your safety in the event of an emergency and is confidential.

Medical Condition	Medication if Needed	Dosage
<i>Asthma</i>		
<i>Blood Pressure</i>		
<i>Diabetes</i>		
<i>Epilepsy</i>		
<i>Headaches</i>		
<i>Respiratory</i>		
<i>Seizures</i>		
<i>Other:</i>		
Note:		

PLEASE LIST ANY KNOWN DRUG ALLERGIES

Printed Name _____

Signature _____ **Date** _____



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CONSENT TO TREATMENT OF MINOR

I, the undersigned, being the parent or legal guardian having care and custody of a minor and _____ a Volunteer at Baptist Health Lexington, in order to induce Baptist Health Lexington to provide said minor with medical or surgical procedures when necessary in case of illness, of or injury to, said minor do hereby authorize and consent to the performance of the staff of the hospital of the procedures and treatment deemed necessary, in its judgment, for the preservation and general welfare of said minor's life, health, and well-being.

No guarantee, promise or representation has been made by the Baptist Health Lexington as to the results that may be obtained by the procedures and treatment hereby authorized.

Parent or Guardian Signature _____ Date _____

Insurance Company _____

Policy No. _____

If parent cannot be reached, list other person (s) to notify in case of an emergency:

Name: _____

Phone: _____

Name: _____

Phone: _____



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Volunteer Services Department Confidential High School Recommendation

Student Name: _____ **Date:** _____

Parental Consent: I authorize the release of information from my son/daughter's school records to the Volunteer Services Department of Baptist Health Lexington.

Parent/Guardian Signature: _____

Dear Counselor or Teacher:

High School Students who apply for volunteer service should have a recommendation from their school.

We would appreciate your evaluation and comments to help us ensure that your students benefit from the VolunTeen Summer Program at Baptist Health Lexington. The information you provide will be kept confidential. Please return the completed form to the Student.

Please evaluate the student identified above of on attendance, courtesy, overall academic and professional dependability, overall social and academic initiative, and the perceived willingness to participate as a volunteer team member in a hospital setting.

	Excellent	Good	Average	Below Average
Attendance				
Courtesy				
Dependability				
Initiative				
Scholastic Record				
Teamwork				

Additional Comments: _____

Name (Print): _____ **Title:** _____

Signature: _____ **Date:** _____