Lovelace
Health System

Volunteer Application – Lovelace Health System

Name: _____Date: _____

Volunteering is a privilege and commitment. We have many applicants, but not all applicants will be interviewed or selected. Selection of Volunteers will be on an equal opportunity basis regardless of race, creed, color, national origin, sex, age or physical challenge. Volunteers are selected in accordance to the best fit for the position and our organization. All volunteers 18 years of age and older will be required to submit to a background check and tb test.

Please complete this packet and return to the Volunteer Department at the location you wish to serve.

Please circle the facility where you wish to volunteer:

Lynn Holloway, Interim Dir. Chaplaincy & Volunteer Services
Ph. 505-727-2700 FAX: 505-727-9708 email: lynn.holloway@lovelace.com

Lovelace Medical Center, Downtown, Heart Hospital, Rehabilitation Hospital
601 Martin Luther King Jr. Ave NE 87102

Rebecca Poe, Volunteer Coordinator
Ph. 505-727-7895 email: rebecca.poe@lovelace.com

Lovelace Women's Hospital
4701 Montgomery Blvd. NE 87109

Lovelace Westside Hospital
10501 Golf Course Rd. NW 87114

FOR OFFICE USE ONLY

- ☐ _____ Background Check _____
- ☐ _____ Background Check _____
- ☐ _____ Background Check _____
- ☐ Personal Interview _____
- ☐ Orientation Scheduled/Date _____
- ☐ TB Test/Results _____
- ☐ Compliance/HIPAA/ Ethics Test/Incident Management/Confidentiality/ Results_____
- ☐ Service Description _____
- ☐ Annual Competency: Year_____Year_____Year_____Year_____Year_____Year_____Year_____Year_____

Volunteer Position Schedule

Day:_____

Time/Shift_____

Assignment:_____

Dept. Mgr_____

Lovelace Health System Volunteer Application

Name:_____Date: _____

Address: _____ Apt: _____

City:_____State:_____Zip:_____Phone(Home): _____

(Cell):_____ E-mail Address:_____

Name and phone number(s) and relationship of a local person to be contacted in case of an emergency or illness while on duty.

Name: _____Relationship:_____Phone #: _____

Name: _____Relationship:_____Phone #: _____

WORK HISTORY:

Business Name, City & State **Job Assignment** **Dates of Employment**

_____

_____

Previous Volunteer Experience:

Where? **Job Assignment** **Dates of Service**

_____

_____

Education, special training, languages spoken fluently, other than English:

_____

_____

Why are you interested in volunteering your services to Lovelace Health System?

_____

_____

Name, phone number and affiliation of two references that we are permitted to call.

_____

_____

What days are you available to volunteer?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

By my signature below, I certify that all of the information provided in this volunteer application is true and correct to the best of my knowledge. I authorize Lovelace Health Systems to conduct any and all inquiries necessary to determine my acceptability as a volunteer.

_____ _____

Signature **Date**

All information provided is held in strict confidence.

In addition to filling out this application you will need to:

- Pass a criminal background check.
- Complete an interview with the Volunteer Program Office.
- Attend a volunteer orientation.
- Complete a Department specific orientation.
- Be issued a security badge.

PLEASE BE SURE YOU HAVE COMPLETED THE APPLICATION IN ITS ENTIRETY.

Thank you!!

CONFIDENTIALITY AND INFORMATION ACCESS AGREEMENT

As a volunteer, with privileges at Lovelace Health System (LHS), you may have access to confidential information. This access to confidential information may be through a computer system or through other employment activities.

Confidential information is strictly protected by law and by Lovelace Health System policies. You are required to conduct yourself in conformance to applicable laws and LHS policies governing confidential information. This is to assure the confidentiality and privacy of such information. Failure to adhere to LHS policies regarding confidential information will subject you to disciplinary action, up to and including termination of volunteering and legal action.

As a volunteer, I understand that I will have access to confidential information that may include, but is not limited to, information relating to: patients, members, staff, physicians, LHS proprietary business information, or third parties (computer, client, or vendor information).

As a condition and in consideration of access to such Information, I agree to:

- Respect the privacy and rules governing use of any such information in any form.

- Not divulge, copy, release, sell, or use for personal benefit, loan, review, identify, remove, alter, or destroy any confidential information except as property authorized within the scope of professional activities affiliated with Lovelace Health System.

- Not divulge any information; disclose information only to those authorized to receive it; prevent unauthorized use of any such information (release of any information must follow the applicable Release of Information Policies and Procedures).

- Not knowingly include, or cause to be included in, any record or report a false, inaccurate, or misleading entry; and not remove or copy any record or information from the facility where it is kept except in performance of my duties.

With regard to passwords or other access authorizations provided, I agree to:

- Not release my password, authentication code, or device to anyone else, or allow anyone else to access or alter information under my identity.

- Not utilize anyone else's authentication code or device in order to access any LHS system.

- Accept responsibility for all activities undertaken using my access code or other authorization.

Confidentiality and information Access Agreement continued:

With regard to computer systems and software, I agree to:

- Respect the ownership of proprietary software, including not making unauthorized copies of such software for personal or other use or distribution.

- Respect the limited capacity of the system, to limit my use of the system so as not to interfere unreasonably with the activity of other users, log out of information systems, and not leave unattended a display device to which I have logged on.

- Not install, download, or operate any non-licensed or non-approved software on any computer provided by LHS, including, but not limited to, screen savers, games, or other executable codes.

Further, I understand that:

- All access to the system and activity will be monitored for audit trail purposes as required by law.

- My obligations under this Agreement will continue after I discontinue volunteering. I understand that these computer and information access privileges are subject to periodic review, revision, and renewal.

- Violations of this policy by any individual or entity should be reported to the manager in charge or to the System Security Administrator. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.

- Violations of the terms of this Agreement may result in legal penalties and/or disciplinary action, up to and including termination of volunteering – under policies of Lovelace Health Systems and under the laws of the State of New Mexico or the United States of America to the extent applicable.

By signing this, I agree that I have read, understand, and will comply with the Agreement.

Volunteer Signature **Date**

Print Name