



This is care.

VolunTeen Form 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) Commonwealth of Kentucky – CAN Central Registry Check Form

- All students are required to complete this form.
- Please fill in Name, Sex, Race, Date of Birth, Social Security Number, Present and Previous addresses on page 1.
- Sign/date page 2.
- NOTE: No money is required. Central Baptist will pay the \$10.00 processing fee.

4) Youth Leader Request Form

- All students are required to complete information which includes Social Security Number, DLN (Driver's License Number), Name, Date of Birth, Street Address etc.

5) Medical Awareness Form

- Please complete this form accordingly. It's for your safety in the event of an emergency and will be kept confidential.

6) Consent to Treatment of Minor

- All students under the age of 18 must have a parent complete and sign this form.

7) Confidential High School Recommendation

- All students must obtain a parent's signature first on this form.
- After parent has signed this form, all students must give it to a high school counselor/teacher for their recommendation and signature.
- The counselor/teacher mails or faxes the completed form to Central Baptist Hospital.

8) TB Results and Immunization Schedule

- All students must get a TB test done in 2012.
- All students must bring a copy of their 2012 TB results at the time of their interview.
- All students must bring a copy of their immunization schedule to their interview. (You can request a copy from your pediatrician.)

All forms must be completed and returned to us when you come in for your interview. Thank you!

CENTRAL BAPTIST HOSPITAL VOLUNTEER CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is between **BAPTIST HEALTHCARE SYSTEM, INC.** d/b/a/ **CENTRAL BAPTIST HOSPITAL** (“Central Baptist Hospital”) and _____, Volunteer Services (“Volunteer”).

In consideration of Central Baptist Hospital’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.** Central Baptist Hospital 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 Central Baptist Hospital 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 Central Baptist Hospital 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 Central Baptist Hospital 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 Central Baptist Hospital and the execution of this Agreement does not change that status or create any contractual relationship or employment agreement between Volunteer and Central Baptist Hospital. 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 Central Baptist Hospital.
3. **SCOPE OF AGREEMENT.** Volunteer agrees to follow all policies and procedures, rules and regulations of Central Baptist Hospital 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 Central Baptist Hospital for access to computer information to anyone, including any other employee or volunteer of Central Baptist Hospital.
 - 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 Central Baptist Hospital 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 Central Baptist Hospital, in addition to any other rights and remedies available at law, which Central Baptist Hospital 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: _____

CENTRAL BAPTIST HOSPITAL

VOLUNTEER SERVICES:

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.

Volunteer Signature: _____

Date: _____

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Protection and Permanency

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATIONS REQUIRE A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT. KENTUCKY ADMINISTRATIVE REGULATIONS MAY BE FOUND ON THE INTERNET AT <http://www.lrc.ky.gov/kar/titles.htm>. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

Day Care Related Categories

- Day Care Center Employee or Volunteer (Required by 922 KAR 2:090)
- Applicant for Day Care Center Licensure (Required by 922 KAR 2:090)
- Registered Child Care Provider Applicant (Required by 922 KAR 2:180)

Other Categories

- Foster/Adoption/Independent Living Agency Employee (Required by 922 KAR 1:310)
- Residential Child-Caring Facility Employee (Required by 922 KAR 1:300)
(Institution/Group Home/Emergency/Wilderness)
- IMPACT-PLUS Subcontractor (Required by 907 KAR 3:030)
- Supports for Community Living (SCL) Employee (Required by 907 KAR 1:145)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: _____
(first) (middle) (maiden/nickname) (last)

Sex: ___ **Race:** _____ **Date of Birth:** _____ **Social Security #:** _____

Date of Initial Hire: _____

Present Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.



CENTRAL REGISTRY CHECK

A check or money order made payable to the "Kentucky State Treasurer" in the amount of ten dollars (\$10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will **NOT** be processed without payment. Mail check or money order to:

**The Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 East Main St., 3E-G
Frankfort, Kentucky 40621**

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and provide the results of the check to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

Witness Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet to disclose additional information regarding a substantiated finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

NAME OF EMPLOYER/AGENCY: Central Baptist Hospital Child Development Center
ADDRESS: 110 Southland Drive **CITY:** Lexington
STATE: Kentucky **ZIP:** 40503 **PHONE:** 859-260-5187

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]

- No reportable incident found in accordance with 922 KAR 1:470.
- Substantiated child abuse found on the registry Date of substantiated finding: _____
- Substantiated child neglect found on the registry Date of substantiated finding: _____

CHECK CONDUCTED ON _____ **BY** _____



YOUTH LEADER REQUEST

MAIL REQUESTS TO:
ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
100 MILLCREEK PARK
FRANKFORT, KENTUCKY 40601
502- 573-1682 or 800-928-6381

The process to obtain the information contained in CourtNet is as follows:

Individuals serving as Youth Leaders

FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUAL'S INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS / P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

I understand that failure to accurately provide the information requested may result in my prosecution under KRS 523.100. I have provided the basic information necessary to qualify for record processing.
*** ALL INFORMATION BELOW IS REQUIRED.**

Requestor/Contact Person	Date
Agency	Phone Number
Address	E-mail Address
City, State, Zip	

MEDICAL AWARENESS LIST

This form is for your safety in the event of an emergency and is Confidential.
Please complete and return this form with your other orientation materials.

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** _____



CONSENT TO TREATMENT OF MINOR

I, the undersigned, being the parent or legal guardian having care and custody of _____ a minor and a VolunTeen at Central Baptist Hospital, in order to induce Central Baptist Hospital 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 Central Baptist hospital as to the results that may be obtained by the procedures and treatment hereby authorized.

Parent or Guardian Signature _____ Date _____

Address _____

Home Phone () _____ Work Phone () _____

If covered by Health or Accident Insurance

Company _____

Policy No. _____

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

_____ Phone () _____

_____ Phone () _____

CENTRAL BAPTIST HOSPITAL

This is care.

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 Central Baptist Hospital.

Parent/Guardian Signature: _____

Dear Counselor or Teacher:

High School Students who apply for volunteer service must 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 Central Baptist Hospital. The information you provide will be kept confidential. Please return the completed form to:

Central Baptist Hospital
Attn: Volunteer Services Department
1740 Nicholasville Road
Lexington, KY 40503
OR Fax to 859-260-4418

Please evaluate the student identified above of 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:** _____