

Baptist Health Louisville Volunteer Handbook Acknowledgement

This acknowledgement is to indicate that you are aware and understand all the topics outlined below. Key points are listed below:

Baptist Health Commitment to Service Excellence and Standards of Conduct

Mission: Baptist Health demonstrates the love of Christ by providing and coordinating care and improving health in our communities.

Vision: Baptist Health will lead the transformation to healthier communities.

Faith-Based Values: Integrity, Respect, Excellence, Collaboration & Joy

Baptist Health Louisville Commitment to Volunteers, Patients, Community, Safety & Promoting a Just Culture and Stewardship

Philosophy of Baptist Health Louisville Volunteer Service

Baptist Health Louisville Statement of Purpose

What is Required As A BHLou Volunteer

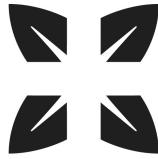
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| <ul style="list-style-type: none"> ○ Attendance ○ Benefits of Volunteering ○ Changes in Personal Information ○ Communication ○ Confidentiality and Patient Privacy ○ How to Handle Conflicts ○ Using the Volgistics Database OR Recording Service Hours ○ Health and Training Requirements | <ul style="list-style-type: none"> ○ If an Injury Occurs ○ Meals and Breaks ○ Annual Training and other Requirements ○ Where to Park ○ Resignations – Voluntary or Involuntary ○ Schedule and/or Placement Changes ○ Smoking Policy ○ Solicitations and Gratuities ○ Uniform and Appearance |
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Steps to Success

- Review and Complete Volunteer Orientation Program.
- Be Dependable: You are part of the hospital healthcare team. Be Consistent in Attendance
- Remember to Smile ☺
- Wear your Namebadge at all times. This is a hospital policy.
- Sign In Before Ever Shift To Make Sure We Track Your Hours
- Be Considerate; Most Patients and their families are not happy to be in the Hospital.
- Lock Up Valuables; a locked cabinet is available in the Volunteer Office, just request the key
- Be Respectful of Patient's Privacy; Keep patients medical conditions or things you may see private
- Ask Questions; If you don't know the answer, don't be afraid to ask questions.
- Support the Hospital AND HAVE FUN (:)

I have reviewed all the information contained in the Baptist Health Volunteer Handbook and understand who to contact with questions and the need to comply with the guidelines. By signing this Acknowledgement, I do hereby agree that I have read and understand the information contained in this Handbook and will follow the guidelines to the best of my ability.

Signature: _____ **Date:** _____



BAPTIST HEALTH

VOLUNTEER CONSENT FOR BACKGROUND CHECK

You have applied for a volunteer position with a health care facility operated by Baptist Health, or one of its affiliates (“Baptist”). For purposes of considering your volunteer application or continued volunteer position, Baptist requests your authorization to obtain a consumer report (or an investigative consumer report containing information as to your character, general reputation, personal characteristics, and mode of living) for purposes related to your volunteering with Baptist as part of its normal screening process and/or for other related purposes at any time while you maintain a volunteer position at Baptist. Should an investigative consumer report be requested, you may request a complete and accurate disclosure of the nature and scope of the report.

By signing below, you hereby authorize Baptist to obtain a consumer report (or an investigative consumer report) in order to consider your volunteer position at Baptist. If you become a volunteer at Baptist, this form will remain on file and shall serve as an ongoing authorization for Baptist to obtain a consumer report (or an investigative consumer report) at any time while you are a volunteer at Baptist, unless such consent is subsequently withdrawn in writing.

Acknowledged and Agreed:

_____	Soc. Sec. No.: _____
<i>Signature</i>	
_____	Date of Birth: _____
<i>Name Printed</i>	
Dated: _____	



BAPTIST HEALTH

CONFIDENTIALITY AGREEMENT FOR BAPTIST HEALTH LOUISVILLE VOLUNTEERS

THIS CONFIDENTIALITY AGREEMENT is between **BAPTIST HEALTHCARE SYSTEM, INC. d/b/a BAPTIST HEALTH LOUISVILLE** and _____, **VOLUNTEER.**

In consideration of Baptist Health Louisville's relationship with Volunteer 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 Louisville 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 Louisville 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 Louisville 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 Louisville 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 username/password in order to access from authorized terminals a variety of confidential information and that such username/password must be maintained by the Volunteer as confidential information.
- 2. STATUS OF VOLUNTEER.** Volunteer has an at will relationship with Baptist Health Louisville and the execution of this Agreement does not change that status or create any contractual relationship or employment agreement between Volunteer and Baptist Health Louisville. 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 Louisville.
- 3. SCOPE OF AGREEMENT.** Volunteer agrees to follow all policies and procedures, rules and regulations of Baptist Health Louisville 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 username/password he or she may be given by Baptist Health Louisville for access to computer information to anyone, including any other employee or volunteer of Baptist Health Louisville.
 - d. Volunteer agrees not to use any username/password of any other person.
 - e. Volunteer agrees not to write down passwords or usernames that would make them accessible to other individuals.
 - f. Volunteer will report breaches of this Confidentiality Agreement by others to the Director 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 username/password he or she may be given by Baptist Health Louisville 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 Louisville, in addition to any other rights and remedies available at law, which Baptist Health Louisville 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 Jefferson County in the Commonwealth of Kentucky in connection with the performance and enforcement of this Agreement and further agrees that the provisions of the 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 HEALTH Volunteer Health Requirements



Services provided through the Employee Health Program are documented within the secure, portal called "ReadySet".

Immunizations and test results given within this program for volunteer purposes are housed here, but also accessible on MyChart. During your volunteer onboarding to Baptist Health Louisville, you will be enrolled into ReadySet by a member of the Volunteer Services Team, which is used for the following:

TB Testing- You will be required to complete the 'TB Program Symptom and Exposure Questionnaire' prior to your blood draw. Volunteers will be provided a form to take to the Outpatient Lab to receive this service. Results are available in ReadySet and you will be notified if results require follow-up.

In addition, all volunteers will complete a TB Risk Assessment form during onboarding and continue annually during their birth month to determine if they need further testing. Volunteers in the Child Development are required to be tested annually for exposure to tuberculosis.

Flu Shots- The flu vaccine is required annually by ALL Volunteers. Volunteers are offered the regular dose Flu Vaccination at no charge by Employee Health. Volunteers may have their vaccination done at their doctor or local pharmacy, but **MUST** provide proof to Volunteer Services that they have received the vaccination. Requiring: Name, DOB, Date administered and the Product name/Type. Employee Health does not offer the HIGH Dose vaccine.

If you choose to decline the flu vaccine, a deferral form will be provided to you. This must be signed by a physician along with documentation of the reasoning, then approved.

COVID-19 Vaccine- To support our mission to serve others — Baptist Health mandates all Volunteers should be fully vaccinated by receiving both doses of the Pfizer or Moderna COVID-19 vaccines or one dose of the Johnson & Johnson vaccine. Exemption forms are available upon request.

Hepatitis B Vaccination/HBsAb Titer- For areas determined by Infection Control to have potential of exposure to blood and/or potentially infectious body fluid(s) Baptist Health offers the Hepatitis B Vaccine Series. You will be informed if this is offered for your position, and a form will be required for vaccine/titer request or declination.

Other Requirements- If you work in an area that deals directly with infants you will be required to provide proof of Tdap, be assessed for baseline immunities of Rubeola/Mumps/Rubella or provide proof of MMR vaccination. More details will be provided during interview.



HEALTH SCREENING RECORD

NAME _____ DATE OF BIRTH _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

VOLUNTEER ASSIGNMENT _____

In compliance with policy all volunteers must complete the Health Screening Record form. Those who cuddle babies must have Proof of Immunities to items listed below and volunteers that have a risk of exposure to blood and/or bodily fluids require the Hepatitis B series or deferral. *Staff will detail specifications in correlation to your assignment.*

MEDICAL HISTORY

CHILDHOOD DISEASES

Mumps: Yes No

Measles (Rubeola): Yes No

Rubella: Yes No

Chicken Pox (Varicella): Yes No

Other: _____

Have you had the Chicken Pox vaccine? Yes No 1 or 2 doses

Have you had a blood test for chicken pox immunity?

If so, the date of the test _____ / test results: **immune or non-immune**

Have you had Shingles? Yes No

IMMUNIZATIONS (please indicate date received if known)

Measles/ Mumps/ Rubella _____

Hepatitis B _____

Tetanus or Tdap _____

Shingles (1 or 2 vaccines) _____

Influenza/Flu _____ (date received)

Covid vaccine (1, 2 or 3 doses)

I verify that the above information is correct, that I have the ability to and will provide proof of any one of these measures upon request.

Signature

Date

Volunteer Tuberculosis (TB) Risk Assessment

Volunteer Name: _____ DOB: _____

Best contact number: (____) _____ - _____ Volunteer Work Area: _____

County of Residence: _____ Work Affiliation: Volunteer

Instructions: Please complete the following sections, **sign and date, and forward** this completed form along with any supporting TB documentation to your managing Employee Health office. If none apply, please check "None Apply".

Section 1: TB History

- I have never experienced a positive TB test
- I have a history of a positive TB skin test, blood test, or have experienced active TB disease
- I have taken treatment for latent TB infection
 - I completed the treatment
 - I was unable to complete the treatment

Section 2: Screen for ACTIVE TB Symptoms

(check or circle all that apply)

I currently have the following symptoms:

- Cough for longer than 3 weeks Productive?
 - Yes or No
- Coughing up blood
- Unexplained fever of 100°F (or 38°C) for over 2 weeks
- Unexplained weight loss > 10 lbs.
- Poor appetite
- Unusual** or heavy unexplained sweating at night
- Unusual, unexplained** weakness or extreme fatigue
- None Apply**

Comments (Explain any checks):

**Notify the Employee Health office immediately of any unexplained symptoms.*

Section 3: Screen for Risk of Developing TB Disease
(check all that apply)

- HIV positive
- Risk for HIV infection
- Inject drugs that are not prescribed by doctor
- A history of TB, without finishing treatment
- 10% below ideal body weight
- Currently taking immunosuppressive medications such as: Methotrexate, Remicade, Humira, etc.
- Current use of alcohol and/or tobacco
- Have or have had any of the following medical conditions (circle all that apply):

Diabetes	Kidney Disease
HIV infection	Colitis
Cancer	Stomach or intestine surgery
Rheumatoid Arthritis	
- None Apply**

Section 4: Screen for TB Infection Risk (check all that apply)

Since my last TB evaluation:

- I currently live with or have close contact with someone who has active TB
- I have lived in a country outside the U.S. for 3 months or more in the past 5 years (High risk: Mexico, Philippines, Vietnam, India, China, Haiti, and Guatemala).
Name of country(s): _____
- I inject drugs not prescribed by my doctor
- I currently live, work, or volunteer in a homeless shelter, jail, prison, or long term care facility, or work with patients in a home care setting
- I currently work or volunteer in a clinic that serves patients with poor access to healthcare that have a higher risk for TB
- I have been exposed to an individual in the community or workplace setting with confirmed active TB in the past year
- Since my previous TB evaluation, I have collected or processed sputum or tissue specimens **for TB testing**
- I perform bronchoscopy, endotracheal intubation, or autopsy
- I provide **hands on patient care** in an emergent setting (ED, EMS) before a diagnosis is made or isolation initiated
- None Apply**

Volunteer Signature (required)

I hereby certify that the information is true and complete, to the best of my knowledge. I understand that this information will remain a part of my employee health record and will not be released without my knowledge and written consent except for new findings which are required to be reported to the local health department having jurisdiction.

_____/____/____
Volunteer Signature **Date**

OFFICE USE ONLY:

- No risk factors for TB infection (no further action)
- Complete TB test
- Refer for medical evaluation

Staff Signature: _____ Date: ___/___/___

Date of Health Dept. notification: ___/___/___