Premier Health
Atrium Medical Center

One Medical Center Dr.
Middletown, Ohio 45005
atriummedcenter.org

**Dear Adult Volunteer Applicant:**

Thank you for your interest in becoming a volunteer at Atrium Medical Center. Our Adult and Junior volunteers perform a valuable service to our hospital as well as our patients and families. We are so grateful you have decided to join us.

***The process of becoming a Volunteer begins with our application packet:***

- A **personal application**
- The **Physician Form** is for your doctor to complete. Your doctor's office can return it to you, they can mail it to us or even fax it to us.
- The **Authorization to Release Medical Information Form** needs to be completed by you and returned with your application. (Your doctor may ask for a copy as well.)
- **Reference forms (3)** should be complete (by non-family) and returned in the pre-addressed envelopes enclosed.

If any of the forms are missing from this packet, you may download them at **www.atriummedcenter.org**. *See Volunteer Services at bottom of page.*

A parent or guardian **must** sign all forms enclosed.

Once **all forms** have been returned to our office, we will contact you via telephone or email to schedule an interview/orientation with you to discuss volunteer openings, safety guidelines within the hospital, days/times you would like to volunteer, etc.

If you need more information or if we can answer any questions, please contact our office.

Volunteer Services
*513.974.5201*

Premier Health
Atrium Medical Center

One Medical Center Drive
Middletown, OH 45005
Website: atriummedcenter.org
Volunteer Services: 513.974.5201

# VOLUNTEER APPLICATION: Adult

Name: _____
*First* *Last* *Middle Initial*

Address: _____
*Street* *City* *State* *Zip*

***Please include area codes:***

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

How did you hear about our volunteer program:

_____

CURRENT INFORMATION:

1. Present place of employment: _____

   Occupation: _____ Work hours/days: _____

2. Emergency Contact: _____ Relationship: _____

   Home phone: _____ Work Phone: _____

3. Physician's Name _____ Address: _____

   Limitations related to health: _____

PREVIOUS EXPERIENCE

Work Experience Volunteer Experience

_____

_____

_____

***Please see back for page 2…***

Please give any other information you think is pertinent to your application, including your interests and types of activities you might enjoy (sitting, answering phones, moving about, paperwork, being with people, etc.):

_____

_____

OTHER INFORMATION:

Have you ever been convicted of a crime other than a minor traffic violation, or received drug treatment in lieu of conviction? Yes ☐ No ☐ If yes, please explain _____

_____

Have you ever been employed by Atrium Medical Center, Middletown Regional Hospital or Premier Health?

If yes, under what name: _____

Dates of employment from _____ to _____

What position(s) held _____

Have you ever been a volunteer at AMC, MRH or for Premier Health? Yes ☐ No ☐

If yes, under what name: _____

Dates of service from _____ to _____

CERTIFICATION

*The statements made above are true and accurate to the best of my knowledge. I will inform the Volunteer Services Office of any changes in this information, including any convictions during my term as a volunteer. I consent to the release to Atrium Medical Center any hospital, physician or mental health records. I also consent to the release of any educational, work or police records. Atrium Medical Center nor Premier Health System are not obligated to provide a place, nor am I obligated to accept the position(s) offered. Volunteering is a privilege. All persons involved with patient care must maintain the highest standards of behavior. I understand and agree that as a Volunteer at Atrium Medical Center, I must hold in strictest confidence any observations I may make or hear regarding patients, patients' families or staff*.

Volunteer Signature _____ Date _____

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Atrium Medical Center

**PHYSICIAN FORM:**

Please have your physician complete this form and mail or fax to Volunteer Services:

Phone: 513.974.5201 or FAX: 513.974.4504
One Medical Center Drive, Middletown, OH 45005

## Dear Physician:

The individual listed below has applied to become a volunteer at Atrium Medical Center. The volunteer (or his/her parent/guardian) has signed below, granting permission for you to release medical information to the volunteer office.

Many of our volunteers work in direct contact with our patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard the patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering, but may not be able to physically or mentally perform the required tasks.

You may indicate blanket approval for any type of service, or you may impose some restrictions such as: no lifting; no pushing wheelchairs or heavy carts; or no patient contact because of a physical or emotional problem. ***Please use the section below to list restrictions and for any comments.***

We appreciate your prompt response in order to help us place this volunteer in the appropriate position within the hospital.

Volunteer Services

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**I give permission to my physician to release relevant medical information to The Atrium Medical Center Volunteer Services**

Volunteer's Name: _____

If volunteer under age 18, Parent's Name: _____

Parent's Signature: _____

Dates of first & second rubella shot or test showing immunity: _____

*(Or attach shot record documentation)*

Physician comments, please list any restrictions or recommendations:

_____

Physician's Name/Office: _____ Date: _____

Physician's Signature: _____

| AMC USE ONLY: This Section completed by AMC personnel. | |
|---|---|
| ☐ Request Approved | |
| ☐ Request Denied (Complete Patient Access Denial Form) | |
| ☐ NA (Information released to persons other than the patient) | |
| **Date:** | **Initials:** |

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/PATIENT ACCESS FORM

Patient's Name: _____ Unit #: not applicable Acct #: not applicable

Birth Date: _____ Social Security Number: _____

Service Date/Type(s): not applicable
(Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize (*insert name of physician/practice*)_____ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

**INFORMATION REQUESTED**

| | | | |
|---|---|---|---|
| ☐ Face Sheet | ☐ Progress Notes | ☐ X-ray Reports | ☐ Pathology Reports / materials |
| ☐ History / Physical | ☐ Physician Orders | ☐ Consultation(s) | ☐ Operative Reports |
| ☐ Discharge Summary | ☐ EKG Interpretations | ☐ Laboratory Reports | ☐ Copy of Entire Record |

☒ Other - Please Specify: ***Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely***

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: ***60 days from date of signature below***. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

Information to be released to: Volunteer Services Supervisor

Address: Atrium Medical Center , P.O Box 8810

Middletown, OH 45042

This information is to be released for the purpose of: ☐ At the request of the patient **OR** ☒ Other (Please specify below):
**To meet hospital Infection Control Guidelines (immunity to rubella) and any limitations for the safety of the volunteer, patients and visitors**

I understand that I may revoke this authorization in writing at any time, except if Atrium Medical Center has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Atrium Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except that Atrium Medical Center may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Atrium Medical Center may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

**Signature of patient or representative:** _____ **Date:** _____

***If you are the representative of the patient**, describe the scope of your authority to act on the patient's behalf. Please check one below:*

☐ Guardian ☐ Parent of Minor ☐ Power of Attorney Over Healthcare

*This authorization will be accepted up to **60 days** from date of signature.*

**Signature of witness:** _____

**ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED**. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations

**A photocopy of this authorization is to be accepted the same as the original**.

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**Reference for Volunteer Applicant, Adult**

Your name has been given as a reference by _____ who has submitted an application to the Volunteer Services Office at Atrium Medical Center. We would appreciate your completing this form and returning it in the **enclosed envelope** so that we may make a decision on the applicant's ability to fulfill the responsibilities involved in our volunteer program. All information you supply will be kept confidential. If you have any questions, please contact the Volunteer Services office at (513) 974-5201.

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How long have you known the applicant? _____

In what capacity have you known the applicant? _____

_____

Describe the applicant's reliability and willingness to make a commitment such as this:

_____

_____

Are you aware if the applicant has any physical or emotional limitations?

_____

Would you recommend the applicant for placement in a setting such as ours?

_____

Additional comments: _____

_____

Signature _____ Date _____

**Please print the following information:**

Name _____ Phone _____

Address _____