CONTINGENT VOLUNTEER FORM

NAME: ____ PHONE: ______________________________
(PRINT)

ADDRESS: ____

In case of emergency, please notify:
Name: ___________________________________ Relationship: __________________________
Address: _________________________________
_________________________________ Phone: __________________________

Physician Name: __________________________ Phone: __________________________
(Optional)

Contingent Volunteer Guidelines

1. Contingent volunteers must be in a good state of health, with no signs of illness, on the day(s) of observation.
2. Contingent volunteers must dress professional; i.e. no jeans, shorts, open-toed shoes or leggings.
3. Contingent volunteers must come prepared to observe procedures rested, having eaten a healthy and fulfilling meal, well hydrated and with comfortable footwear. During your observation, if you should start to feel sick, please remove yourself from the observation area and sit down with your head in your hands. If you do not have time to remove yourself, sit down where you are and put your head in your hands. If you should faint, you must remove yourself from observations for the remainder of the day, seek medical attention in the Emergency Department (if warranted) and notify the Volunteer Resources office.
4. **ALL contingent volunteers** must submit proof of a **negative PPD** test from within the last year, proof of immunity to **measles, mumps, German measles, Chicken Pox** and a **transcript** from their school to prove enrollment.
5. Contingent volunteers **must** pick up their **temporary observer badge** prior to their observation in the Volunteer Resources office at the main hospital in Ridgewood. All badges must be picked up during normal business hours and signed in and when returned, signed out. All temporary badges must be returned. (This does not apply to EMT Student Observers).

_____________________________________ _____________________________
Volunteer Name (PRINT) Date of Scheduled Visit(s)

_____________________________________ _____________________________
Volunteer Signature Location of Visit

___________________ ___________________ _____________________________
Today's Date Projected Total Hours Reporting To

VALLEY HEALTH SYSTEM, INC. Ridgewood, N.J.

STATEMENT OF CONFIDENTIALITY For use by Employees, Physicians, Volunteers and Students

In connection with my relationship with Valley Health System, The Valley Hospital, Valley Home Care, or Valley Medical Group, as applicable (collectively, Valley Health System), I acknowledge and agree that I have a legal and ethical responsibility to safeguard the privacy of all confidential information of Valley Health System which I may receive, come into contact with, or use and disclose, including but not limited to patient clinical and financial information, business, operational and related confidential information of Valley Health System and its patients, employees, contractors and other affiliated individuals and entities.

I acknowledge and agree that I must maintain such information in the strictest confidence throughout the course of my relationship with Valley Health System and thereafter, in accordance with all applicable Health Insurance Portability and Accountability Act (HIPAA) and related Valley Health System policies. I acknowledge and agree that I may only access and use Valley Health System patient and other information where I have a need to know to provide care or perform my job responsibilities, and that I will further disseminate such information to only those other individuals who have a need to know, only as permitted by Valley Health System policies. When patient information must be discussed with any health care practitioners, patients or other individuals during the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care or who would otherwise not be authorized to have access to such information.

I acknowledge and agree that I am prohibited from accessing patient information for patients I am not working with and cannot access patient information related to family members, friends, colleagues or other individuals, regardless of whether they may give me permission to access such. If I am issued a username and password for access to Valley Health System computer systems, whether on-site or remote, I understand and agree that such credentials are for <u>my use only</u> and that I am responsible for all access and entries performed using such username and password. I agree to safeguard the confidentiality of such password, and will not post, share or otherwise distribute my password. I agree to contact the Information Systems Department immediately if I have reason to believe the confidentiality of my password or username has been compromised.

I acknowledge and agree that, in the event my relationship with Valley Health System has terminated, I will immediately discontinue any access to, use or disclosure of Valley Health System patient and other information. I will immediately return or present for inspection any badges, unique tokens, laptops or mobile devices which are the property of Valley Health System or which may contain Valley Health System information. I further acknowledge and agree that I may not keep copies of patient information after my relationship with Valley Health System has terminated, whether such copies may be paper or electronic, and will immediately return any such copies to Valley Health System.

By signing below, I acknowledge that I have read the above and accept the responsibility associated with these statements. I understand that violation of this agreement may be cause for disciplinary action or immediate termination of my relationship with Valley Health System.

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Name (print) Title/Affiliation

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Signature Date