

VOLUNTEER APPLICATION

Patient and Family Advisor or Advisor Council Member

Application includes:

- Request for Reference Contact Information
- Volunteer Agreement
- Confidentiality Agreement
- Volunteer Information and Release Authorization

Submit completed application to **koerner@[davishealthsystem.org](mailto:koerner@davishealthsystem.org)** or mail to:

**Davis Medical Center
ATTN: Arvela Koerner, BSN, RN, ACM
812 Gorman Ave
Elkins, WV 26241**

Background Check: Each applicant will be subject to a background check. Permission to run this background verification is provided within application.

Reference: The contact information for one reference must be submitted with the application. The individual identified as the applicant's reference will be contacted via phone, e-mail or mail by a Davis Medical Center employee.

Orientation: If accepted, you will be scheduled for a mandatory orientation. Our orientation covers the policies and procedures of Davis Medical Center.

Please contact **koerner@[davishealthsystem.org](mailto:koerner@davishealthsystem.org)** with any questions. Thank you!

Personal Information:

Name: _____ Nickname: _____
Street Address _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____
Work #: _____
Email: _____
What is the best way to contact you? _____
Date of Birth: _____ Sex: Male Female
*Must be 18 years or older

Emergency Contact Information:

Name: _____
Relationship: _____ Home: _____
Work: _____ Cell: _____
Email: _____

Personal Reference:

All applicants must submit at least one reference. Please provide complete information for a personal reference (no relatives) that has known you for a minimum of two years.
Mr./Mrs./Miss: _____
Street: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Email address: _____
Relationship to applicant: _____

Employment History (if applicable):

Most Current Employer: _____
Position _____ Telephone: _____
Contact Name: _____ Telephone: _____
Title: _____



Please answer the following:

Have you worked in any Health Care settings?	Yes ____ No ____
Where? _____	When? _____
Have you volunteered at any Health Care facilities?	Yes ____ No ____
If yes Where? _____	When? _____
Are you related to anyone employed by Davis Medical Center? _____	
If yes, please offer full name and his/her employment location: _____	

Commitment Terms:

The time commitment required is a two hour monthly meeting, however, additional time might be required depending on the specific committee or project to which you are assigned. If selected, we will work with you individually to involve you in an area or team based on your availability and interest. Completion of application does not guarantee assignment.

Volunteer Agreement:

As a Patient and Family Advisor, I agree:

I hereby certify that the answers on this application and any resulting from interviews are true and correct and that any misrepresentations or omissions of facts, or misleading or false information on my part will be grounds for dismissal as a volunteer. Acceptance as a Patient and Family Advisor is contingent upon satisfactory references, verification of information submitted on the applications, and satisfactory completion of mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions related to my application.

I understand that submitting my application does not guarantee assignment.

My services are donated to Davis Medical Center without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

I authorize Davis Medical Center to administer emergency medical treatment to me while volunteering. I understand that Davis Medical Center is not responsible for volunteers before or after their assigned shifts.

Applicant's Signature: _____ Date: _____

Have you, or do you know of anyone who has, been involved in a quality of care issue? If so, please explain. _____



Davis Medical Center obtains arrest and conviction records on all potential volunteers. An arrest or conviction will not automatically eliminate you from consideration for volunteering. However, failure to list all pending charges and/or convictions may lead to your disqualification or termination of volunteering at Davis Medical Center. Examples include, but are not limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud and embezzlement.

Have you ever been convicted of any criminal violation of law, or are you now subject to a pending investigation of charges for violation of criminal law? If yes, please explain:

Please Note:

Your signature indicates your approval for us to check references and run a background check. Completing an application does not assure placement as a Patient and Family Advisor or council member since the number of applicants may exceed available openings. Submitting an application also does not obligate you to accept the assignment offered.

The first 90 days of the volunteer experience are mutually probationary. Opportunities for Patient and Family Advisors are provided without regard to religion, disability, race, national origin, age or sex.

Please tell us about yourself:

Why would you like to be a Patient and Family Advisor?

What past experience, interests or skills do you have that you could bring to this role? Please include personal/family, hospital/medical experiences and description.

Is there anything we have not asked you that you want to tell us?



Issues of special interest to you; check all that apply:

- Reviewing patient and family satisfaction tools.
- Developing/reviewing educational materials.
- Planning for the hospitalization (inpatient) care experience.
- Planning for the surgical experience.
- Planning for the clinic (outpatient or ambulatory) care experience.
- Planning for the emergency care experience.
- Ensuring patient safety and the prevention of medical errors.
- Educating medical students and residents, new employees, and other staff about the experience of care and effective communication and support.
- Participating in facility design planning.
- Improving the coordination of care and the transition to home and community care.
- Developing uses for information technology, including electronic medical records, patient portals, and electronic personal health records.
- Serving as an e-Advisor, responding by email to questionnaires and surveys seeking your opinions.
- Long-term advisory council membership to have impact and influence on policies and practices that affect the care and service patients receive.

Do you know other individuals and/or families who have experienced care at Davis Medical Center who might be interested in serving as advisors? Please call them for us or list their name(s) and email address(es) here:

Please return this form to:

Davis Medical Center

ATTN: Arvela Koerner, BSN, RN, ACM

812 Gorman Ave

Elkins, WV 26241

Phone: 304-637-3773

Email: koenera@davishealthsystem.org



Confidentiality Agreement:

Davis Medical Center has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment(s) at Davis Medical Center, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services. I understand that such information must be maintained in the strictest confidence. I understand that I can only use patient information for proper purposes under this Agreement, and that I cannot use it at all after my assignment ends.

As a condition of my assignment, I also agree that I will not, at any time during or after my assignment, disclose any patient information to anyone outside of Davis Medical Center. When I need to discuss patient information with the health care practitioners in the course of my duties, I will use discretion to ensure that such conversations will not be held in a public place or with unauthorized individuals. I will participate in all required HIPAA and privacy training, and I will follow privacy and security policies and requirements. I will not take any patient information with me off-site, and I will put patient information only in an approved shred bin. I will not use any personal devices to take any pictures of patients or providers, record conversations with patients or providers, or take pictures of any patient or other information that is proprietary to Davis Medical Center.

I understand that if I am currently, or have been in the past, a patient of Davis Medical Center, any disclosure of my own information is voluntary and my choice. This includes any conversations I may have with other patients where I share my story, or any comments I make in council or other meetings. I understand that Davis Medical Center is not responsible for what other patients or family members do with that information when I share it. If I would like for Davis Medical Center to disclose information from when I was a patient, I understand that I will need to sign an Authorization.

I understand that violation of this agreement may result in termination of my assignment at Davis Medical Center.

Printed Full Name of Applicant

Date

Signature of Applicant



VOLUNTEER INFORMATION AND RELEASE AUTHORIZATION

TERMS OF VOLUNTEER SERVICE

Because volunteer service as a Patient and Family Advisor is based on mutual consent, both Davis Medical Center and you may terminate your volunteer service at any time, for any reason, with or without cause, and without prior notice. All Davis Medical Center decisions with regard to termination of volunteer service are based on Davis Medical Center policies and procedures. Davis Medical Center values integrity in the workplace. Any false or misleading representations or omissions contained in your Patient and Family Advisor application may disqualify you from further consideration for volunteer services and may result in discharge even if discovered at a later date. The System may contact any persons and organizations named in your volunteer application to confirm or explain the information provided.

BACKGROUND VERIFICATION DISCLOSURE

As part of the volunteer services process, Davis Medical Center may obtain a Consumer Report and/or an Investigative Consumer Report. The Fair Credit Reporting Act as amended by the Consumer Reporting Reform Act of 1996, requires that we advise you that for purposes of volunteer services, a Consumer Report may be made which may include information about your criminal record, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided in the event the report contains information regarding your character, general reputation, personal characteristics, or mode of living. Examples may include, but should not be limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud, embezzlement, etc.

AUTHORIZATION, ACKNOWLEDGEMENT, AND RELEASE

During the application process and at any time during my affiliation with Davis Medical Center, I hereby authorize BIB – Background Investigation Bureau, on behalf of Davis Medical Center to procure a Consumer Report which I understand may include information as described above. This report may be compiled with information from credit bureaus, courts record repositories, departments of motor vehicles, past or present employers and education institutions, governmental occupational licensing, or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification, to the extent such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living.

I understand that I must report, in writing, any offense to the Patient Experience Coordinator by the next assignment. I further acknowledge that failure to report an offense will be grounds for immediate termination of my participation in the program. I understand that I must report, in writing, any conviction or sanction to the Patient Experience Coordinator within five days of the occurrence. I further acknowledge that failure to report a conviction or sanction will be grounds for immediate termination of my participation in the Patient and Family Advisor program. I authorize the ongoing procurement of the above-mentioned reports at any time during my volunteer experience. My signature releases any liability against Background Investigation Bureau, Inc. or its acting agents. A photo or fax copy of this release form will be valid as an original thereof, even though said copy does not contain an original writing of my signature.

Name (Last, First, Middle): _____
Please print

Maiden or Other Name Used: _____

Social Security Number: _____ Date of Birth: _____

Current Address: _____

How long have you lived at this residence? _____
(If less than 7 years, please indicate all previous addresses during this period below. Please attach an additional sheet if needed.)

Address: _____

Address: _____

Signature

Date



**REFERENCE FORM FOR PATIENTS
AND FAMILY ADVISORS APPLICANTS**

Name of Applicant _____

How long have you known the applicant? _____

In what capacity have you known the applicant? Personal and/or professional?

(We cannot accept references from family members. Thank you for understanding.)

What strengths do you think the applicant will bring to Davis Medical Center as a volunteer?

On a scale of 1 to 5, 1 being poor and 5 being excellent, rate the applicant on the following:

- | | |
|---|---|
| <input type="checkbox"/> Interaction with other people | <input type="checkbox"/> Verbal communication skills |
| <input type="checkbox"/> Likelihood to follow through on commitment | <input type="checkbox"/> Written communication skills |
| <input type="checkbox"/> Ability to take direction | <input type="checkbox"/> Overall attitude |
| <input type="checkbox"/> Capability to uphold privacy and confidentiality | |

Do you have any reservations about recommending the applicant to serve as a Patient and Family Advisor at Davis Medical Center? No Yes If yes, please explain

We have strict policies on confidentiality for our volunteers. Do you think the applicant will be able to understand and follow these policies? ___ No ___ Yes If no, please explain

Additional Comments:

___ I am unable to provide a reference.

Please Print Full Name: _____

Signature: _____ **Phone:** _____

Submit completed application to koerner@DavisHealthSystem.org

Or mail to: **Patient Experience Division**
Attn: Patient and Family Advisors
812 Gorman Ave
Elkins, WV 26241

