

grand river Health

Volunteer Services



Young Adult Volunteer Program

How to get started:

1. Fill out enclosed application. Fax, e-mail, hand deliver or mail application back to the address listed below.
2. Get two letters of reference from your school, church, or youth organization (not family members).
3. We will call you to set up an appointment for Medical Screens and a Drug Screen (parent or guardian must be present during the drug screening if under 18). Grand River Health pays for all this. If you are well hydrated this will take about an hour, however it can take up to three hours.
4. Sign an Oath of Confidentiality, Media/Photo Release. Have your picture taken for a name badge.
5. Commitment of a minimum of 48 hours volunteering at Grand River Health
6. A flu shot is required between Nov. 1-April 1 (This is provided free of charge to our volunteers)

You are cleared to volunteer when the test results come in and all the above is complete!

I look forward to working with each of you. If you or your parents have any questions please feel free to call or e-mail.

Kaaren Peck

Volunteer Services/Grand River Meals on Wheels
kpeck@grhd.org
970.625.6423 | 970.625.7366 fax 501 Airport Road |
P.O. Box 912 | Rifle, CO 81650

Dee Warwick

Volunteer Services Assistant
dwarwick@grhd.org
970.625.6215 | 970.625.7366 fax
501 Airport Road | P.O. Box 912 | Rifle, CO 81650



YOUNG ADULT VOLUNTEER APPLICATION

Date of Application _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Date of Birth _____ Age _____

School/Organization: _____ Program of Study: _____ Grade Level _____

Career Aspirations: _____

School Program IB Career Shadow Other
Location

- Grand River Hospital and Medical Center
- Grand River Care Center
- Clinic West

Availability (Check all that apply) A.M. P.M.

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

How did you learn about the Young Adult Volunteer Program

Do you know anyone employed at Grand River Health?

Have you ever been employed by or volunteered for GRH before? YES NO

If yes, when and which site?

References

Please List two references and provide two letters of reference

1. _____
Name Phone

2. _____
Name Phone

Please be prepared with letters of reference for meeting with Volunteer Services Representative.

Emergency Contact Information:

Name/Relationship Address Phone

By signing this application, I am acknowledging that I understand the guidelines of the Young Adult Volunteer Program and agree to the following:

- I will provide two letters of reference.
- I agree to volunteer a minimum of 48 hours.
- I agree to complete yearly TB paperwork and flu shot paperwork.
- I will take the drug screen and medical screens (parent must be present if under 18).
- I have read, understand and will abide by the Oath of Confidentiality.

VOLUNTEER APPLICANT _____ *(print)*

Signature Date

Parental Permission (if under 18)

I give _____ Permission to volunteer for Grand River Health.
Teen's Name

PARENT / GUARDIAN _____ *(print)*

Parent Guardian / Signature Date

TB Test Permission (if under 18)

I give _____ Permission to receive a TB test Grand River Health.
Teen's Name

PARENT / GUARDIAN _____ *(print)*

Parent Guardian / Signature Date



YOUNG ADULT ORIENTATION GRAND RIVER HEALTH POLICIES AT A GLANCE

Appearance: professional (and conservative)

You may just have a 5-minute encounter with a patient and you are to shine and put forth a professional, respectful, caring image.

- Wear your name badge and volunteer vest at all times (it is important that you are not mistaken for an employee!)
- No open toed shoes when in patient care areas.
- No denim, not even skirts, shirts or jumpers.
- Nails and makeup – conservative. No intense perfumes (may trigger asthma).
- Hair: neat, clean and away from your face. If you are in the kitchen, you will need a hairnet (provided) or a hat.
- No t-shirts, sweatshirts, spaghetti strap, backless shirts or dresses. No slogans or printed messages on shirts (logos are fine). Scrubs are great and easy to clean. No holes, tears, too tight or showing of skin.
- No shorts; capris and longer skirts or dresses or skorts are fine.(all of which need to be only 5 inches above knee).
- No lip / mouth / nose piercings (ears are fine).
- No unfriendly tattoos

Cell Phones / Electronics:

No cell phone use while on duty (no texting or talking); leave it at home, in the car, etc. You may use your phone/I-pods, etc. in the cafeteria or outside during breaks and meals.

Customer Service & Confidentiality:

You are here to make someone's day:

- Smile – it goes along way
- Greet / welcome, ask, "How may I help you?"
- Frequent thank you's. Politeness is key; remember, you represent Grand River Health!
- Remember and keep your oath of confidentiality when you leave GRH.
- You are invited to attend the periodic Customer Service Training – see your supervisors for dates.

Sign – In Procedure:

Please sign in and out for every shift in the Volunteer / binder found at the Customer Service front desk (ask Customer Service Representative for help if need be).

Punctuality and Absences:

Please be punctual to your shifts. Call if an unexpected absence (Dee 625-6215) is necessary. We rely on you! You are important and your presence and work will be missed! Planned vacations are expected. Please let me know your schedule changes.

Parking:

Please park in the South Employee parking lot. It is important that we save the closer parking spaces near the entrances for our patients. If you are volunteering at the Grand River Office Plaza, you may park in that parking lot.

Perks:

For every 4-hour shift, you are entitled to a meal in our great cafeteria. You should be wearing your name badge and volunteer vest and you can pick up your meal ticket at the customer service desk. The meal will be charged to the Volunteer program.

I have read and understand Grand River Health's Volunteer Policies and agree to comply. Any volunteer who does not meet the standards of these policies will be required to take corrective action, which may include leaving the premises. Continued refusal to comply with these policies will result in further disciplinary action and may subject the volunteer to suspension and possible dismissal.

Printed Name

Signature

Volunteer Service's Signature

Date



HOSPITAL SERVICES | FAMILY MEDICINE | WOMEN'S HEALTH | INTERNAL MEDICINE | SPECIALTY SERVICES
MENTAL HEALTH SERVICES | LONG TERM CARE | OCCUPATIONAL HEALTH SERVICES | SCHOOL BASED HEALTH

PHOTO RELEASE FORM

I hereby grant the Grand River Hospital District permission to use my likeness in a photograph or video in any and all of its publications, including website entries, without payment or any other consideration.

I understand and agree that these materials will become the property of the Grand River Hospital District and will not be returned.

I hereby irrevocably authorize the Grand River Hospital District to edit, alter, copy, exhibit, publish or distribute this photo or video for purposes of publicizing and advertising Grand River Hospital District programs and services or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph or video.

I hereby hold harmless and release and forever discharge the Grand River Hospital District from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

Signature

Date

Printed Name

If the person signing is under age 18, there must be a consent by parent or guardian, as follows,

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent or Guardian's Signature

Date

Parent or Guardian's Printed Name



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OATH OF CONFIDENTIALITY

Confidentiality is a patient/resident right. Breach of confidentiality is unacceptable and will not be tolerated. Any employee of GRH that divulges or inappropriately looks up Health Information on a patient is subject to immediate suspension and possible termination pending investigation results.

Information may be given to another employee or member of the medical staff when it is necessary to do so in the performance of job duties.

I, _____ agree not to divulge, publish or otherwise make known to unauthorized persons or the public any information obtained in the course of my work at Grand River Health.

Confidential information shall include, but is not limited to the following:

- Any medical information concerning the patient's history of illness, condition, diagnosis, treatment, prognosis, and/or visit history etc.
- Any insurance or financial information regarding the patient or patient representatives.
- Any information acquired about a patient or patient's family due to the employee's association with Grand River Health.
- Any Grand River Health information about departmental operations, projects, studies or research.

The Colorado Computer Crime Statute, CRS SS 18-5.5-1011, et seq., is designed to punish and deter computer crime. In compliance with the law, the district prohibits unauthorized access to its computer system, either directly or by network or telephone. An individual who does not have a legitimate password will be held to know that access is unauthorized. The sharing of computer passwords is strictly prohibited. The District prohibits the destruction or corruption of electronically stored or processed data. Persons who violate these rules will be prosecuted to the full extent of the law.

This oath applies if you are on duty, off duty, or on your free time and after you have left the employment of Grand River Health.

If you have questions regarding what is considered confidential information, please ask your supervisor, Health Information Management/Privacy Officer, Information Technology/Security Officer.

I have read the above information and understand its contents and agree to abide by the rules of confidentiality. I understand that failure to maintain confidentiality will result in disciplinary actions that may include immediate termination. I also understand that if I discuss confidential information inappropriately, that I could be held civilly liable and personally liable for any damaged persons.

Employee Signature

Date



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SUPPLEMENTAL COVID-19 ACKNOWLEDGEMENT FORM VOLUNTEERS/SHADOWS-OBSERVERS

I, _____, wish to volunteer my time and services for Grand River Health ("GRH"). I acknowledge that I am volunteering my services at GRH and that my participation is completely voluntary and is being undertaken with no promise or expectation of compensation.

I am aware that on January 27, 2020, the U.S. Department of Health and Human Services issued a Public Health Emergency as a result of the pandemic conditions associated with COVID-19, and on March 10, 2020, Governor Polis issued his Executive Order to declare a State of Emergency concerning the COVID-19 virus as it impacts the State of Colorado.

Due to the nature of some volunteer activities that I may perform, I acknowledge that despite safety precautions taken by GRH, my volunteer participation could involve exposure to COVID-19 and could involve risks associated with such exposure. With full knowledge and understanding, I accept any and all risks of injury, illness, or death and I release and discharge BCH, its officers, directors, and employees, from any claims for damages or injury and all liability arising out of my participation as a volunteer.

I understand that GRH is providing no direct medical health coverage during my time as a volunteer, and that GRH is not responsible for any potential exposure to COVID-19 that I may experience while acting in my role as a volunteer at GRH.

I agree to adhere to all GRH policies, procedures and guidelines, including all requirements related maintaining a safe environment during the COVID-19 pandemic. This includes:

- temperature check and symptom and exposure questions at the beginning of every shift
- not coming in if ill

By signing below, I acknowledge that I have read and understood the entirety of this document; and consent and agree to be legally bound by the terms thereof.

Print Name

Signature

Parent/Guardian Print Name

Parent/Guardian Signature

Date

Effective: 7/1/2020



Written Authorization to Request a CAPS Check

A check of the Colorado Adult Protective Services (APS) data system (CAPS) is required for you (individual) because you are:

- A potential employee/contractor who will provide direct care to at-risk adults, or
- A person who may be appointed as a conservator or guardian of an at-risk adult.

An employer may also request a CAPS check for you if you provide direct care to an at-risk adult and you:

- Were hired/contracted prior to the CAPS check requirement (1/1/2019), or
- Are a volunteer, or
- Will provide services to a CDASS recipient

The CAPS check will alert the employer or court (agency) whether you have or have not been substantiated in an APS case of mistreating an at-risk adult, to include physical abuse, sexual abuse, caretaker neglect, exploitation, and/or harmful act.

More information on the CAPS check requirement can be found in Colorado Revised Statute (26-3.1-111, C.R.S.) and in the Colorado code of Regulations (12 CCR 2518-01).

Written authorization is required from the individual being checked, using this form. Please complete this form in its entirety. Knowingly providing inaccurate information on a CAPS check request is a class 1 misdemeanor pursuant to 18-1.3-501, C.R.S.

■ AGENCY INFORMATION (To be completed by the agency.)

Agency Name: Grand River Hospital District

Agency Address: 501 Airport Road Rifle, CO 81650

■ INDIVIDUAL'S INFORMATION (To be completed by the individual being checked.)

First Name: _____ Middle Name: _____ Last Name: _____

Maiden Name/Previous Name(s)/Alias: _____

Date of Birth: _____ SSN (Last 4 digits): _____ DORA License #: _____
(required for all licensed professionals)

Provide the Name(s) of Your Previous Employer(s) Over the Past Five (5) Years: _____

You must provide at least one (1) personal phone number and one (1) email address.

Personal Email Address: _____

Work Email Address: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone Extension: _____

All individuals are required to provide five (5) years of residential history, regardless of whether in the U.S. or abroad. If you lived outside the US in the past five (5) years, provide the international address(es), including the name of the city and country. If you have lived at your current address less than 5 years, please list your previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Current Address Start Date (DD/MM/YYYY): _____

Current Street and Number (No PO boxes): _____

Current Address City: _____ Current State: _____ Current Zip/Postal Code: _____

Previous Address Start Date (DD/MM/YYYY): _____ Previous Address End Date (DD/MM/YYYY): _____

Previous Street and Number (No PO boxes): _____

Previous City (City & country for international addresses): _____

Previous State (Not required for international addresses): _____ Previous Zip Code (Use "00000" for international addresses): _____

Previous Address Start Date (DD/MM/YYYY): _____ Previous Address End Date (DD/MM/YYYY): _____

Previous Street and Number (No PO boxes): _____

Previous City (City & country for international addresses): _____

Previous State (Not required for international addresses): _____ Previous Zip Code (Use "00000" for international addresses): _____

Previous Address Start Date (DD/MM/YYYY): _____ Previous Address End Date (DD/MM/YYYY): _____

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Previous Address Start Date (DD/MM/YYYY): _____ Previous Address End Date (DD/MM/YYYY): _____

Previous Street and Number (No PO boxes): _____

Previous City (City & country for international addresses): _____

Previous State (Not required for international addresses): _____ Previous Zip Code (Use "00000" for international addresses): _____

I, _____, by my signature below, authorize the agency referenced above to request a CAPS check to determine if I have a substantiated finding as a perpetrator of mistreatment of an at-risk adult. I acknowledge that a substantiated finding resulting from such a check, unless the finding was expunged through a successful appeal, shall be provided to the person directly involved in the employer's hiring process or the court's hearing process and may be used to inform their decision. I acknowledge notification may occur through CAPS to this agency, for the duration of my employment, volunteer assignment, or authority as an appointed or potential conservator or guardian with them, of any future substantiated findings against me. I understand that willfully providing false information on this form is a misdemeanor 1 penalty, punishable as outlined in §18-1.3-501, C.R.S. I declare under penalty of perjury under Colorado Law that this CAPS Check Request Form, including supporting documents, has been examined by me and is true, correct, and complete.

Signature: _____

Date: _____

CLEAR FORM

PRINT



COLORADO
Adult Protective Services
CAPS Check Unit