Thank you for your interest in joining the Junior Summer Volunteer Team at Pen Bay Medical Center & Waldo County General Hospital.

The summer program runs Monday - Friday for eight weeks from Monday, June 24 to Monday, August 10. You must be able to commit to at least seven of the eight weeks. Volunteers will be assigned to two departments on the same day of the week for the duration of the eight week program. Morning department assignment is 8:00 - 11:30 a.m., lunch is 11:30 a.m. to 12:00 p.m. and the afternoon department assignment is 12:00 p.m. to 3:30 p.m.

Department assignments may include radiology, in-patient medical surgical unit, intensive care unit (ICU), patient access reception and escort, volunteer department and gift shop. Space is limited and placement in a specific hospital department cannot be guaranteed.

Requirements:

- A sincere interest in health care and a desire to help others
- Between the ages of 15 and 19
- Available from 8:00 a.m. to 3:30 p.m. the same assigned day each week for at least seven of the eight weeks
- Have a positive and professional attitude, be respectful of everyone
- Be committed to confidentiality and patient safety
- If accepted, applicants must successfully complete all steps of the process detailed below and comply with all program guidelines

Benefits:

- Experience the healthcare environment amongst a group of committed and caring healthcare professionals
- Personal and professional development
- Learn new skills
- Help others and your community
- Build your college resume
- Career exploration
- Be recognized for your contributions

Jamie Geretz, Regional Director of Volunteer Services
Pen Bay Medical Center/Waldo County General Hospital, 6 Glen Cove Drive, Rockport
207-301-8552; jegeretz@pbmc.org
PBMC & WCGH VOLUNTEER APPLICATION

Date: ____________________________

1. CONTACT & DEMOGRAPHIC INFORMATION

Name: ______________________________________________________________

Address: ______________________________________________________________

Town, State and Zip Code: __________________________________________________

Phone Number(s): _________________________________________________________

Email: ______________________________________________________________

Best way to contact you: __________________________________________________

Birthday (day & month only, year optional): _________________________________

Are you under the age of 18?    ☐ Yes ☐ No
If yes, please note that your parent or legal guardian must sign ALL FORMS to authorize your participation in our volunteer program.

2. WORK EXPERIENCE

Current or most recent Employer

Name of Company: __________________________________________________________

Street Address: _____________________________________________________________

City, State, Zip: _____________________________________________________________

Contact Name & Phone Number: _____________________________________________

Your job duties and responsibilities: _______________________________________

May we contact this employer for a reference?    ☐ Yes ☐ No

Other work experience: _____________________________________________________
Have you ever been employed by, or volunteered at, any division of Pen Bay?
☐ Yes  ☐ No
If yes, state organization, position held and dates: ____________________________________________
__________________________________________________________________________

Have you ever, or do you currently volunteer, outside of Pen Bay?
☐ Yes  ☐ No
If yes, state organization, position held and dates: ____________________________________________

3. EDUCATION

High School: ______________________________________________________________
City, State, Zip Code: ________________________________________________________
Major: ______________________________________________________________
How many years did you complete? _____________________________________________
Did you graduate?  ☐ Yes  ☐ No

College: ______________________________________________________________
City, State, Zip Code: ________________________________________________________
Major: ______________________________________________________________
How many years did you complete? _____________________________________________
Did you graduate?  ☐ Yes  ☐ No
Year of Graduation: ____________________; Degree Type: _________________________

Other Education: ____________________________________________________________

4. EMERGENCY HEALTH & CONTACT INFORMATION

Do you have any health conditions that require restrictions or modifications of your function in the volunteer program, or that would require special treatment in a medical emergency?
☐ Yes  ☐ No
If yes, please explain: _________________________________________________________

Would you like us to provide you with a Maine Health Care Advance Directive Form?
☐ Yes  ☐ No

Person to notify in case of emergency:

NAME: ______________________________________________________________

RELATIONSHIP: _________________________________________________________

ADDRESS: ______________________________________________________________
__________________________________________________________________________

PHONE: ______________________________________________________________
5. SKILLS, INTERESTS, HOBBIES & SCHEDULE

What skills, interests and/or hobbies do you have that might apply to volunteer work?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Why do you want to volunteer?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

What type of volunteer assignments interest you?
(Feel free to think outside the box!)
_____________________________________________________________________________
_____________________________________________________________________________

What days and times are you available?
Monday ____________________ Friday __________________
Tuesday ____________________ Saturday __________________
Wednesday ____________________ Sunday __________________
Thursday ____________________

How often would you like to volunteer?
☐ Weekly ☐ Several times per week ☐ Special Events
☐ Other (please explain):

Please note that 4 hours per week, for a 6 month period, is the minimum requirement.

When are you available to start? _________________________________________________

Would you like us to contact you to let you know of special volunteer opportunities (i.e. blood drives, special projects, etc.) for which we need additional volunteers?
☐ Yes ☐ No

Do you have any relatives currently working in a division of Pen Bay?
If yes, give name and relationship:
_____________________________________________________________________________

6. REFERENCES. Please list 2 references that we may contact that are not related to you.

(Name) (Relationship) (Contact Number)

(Name) (Relationship) (Contact Number)
7. **OTHER REQUIRED INFORMATION**

**Have you ever been convicted or plead nolo contendere to a crime within the past ten years?**
- [ ] Yes
- [ ] No

If yes, please note that we will request more information and discuss the information with you when you are interviewed.

**If you are professionally licensed in the healthcare field, has any action ever been taken against your licensure?**
- [ ] Yes
- [ ] No

8. **AUTHORIZATION & CERTIFICATION**

**IF SELECTED FOR A VOLUNTEER POSITION AT PBMC or WCGH, I UNDERSTAND THAT:**

- I will be providing volunteer service with patients, visitors, staff and other volunteers with equal respect as to race, color, religion, ancestry or national origin, age, sex, physical or mental disabilities, or sexual orientation.
- I must abide by the hospital regulations and PBMC/WCGH policies and code of conduct.
- I am expected to maintain the confidentiality and dignity of patients, families, staff and other volunteers as we partner to provide excellent service to our community. Any breach of confidentiality is cause for dismissal.
- I am expected to adhere to the PBMC/WCGH standards of behavior as I perform my duties as a volunteer.

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING.**

I hereby certify that the facts set forth in the above volunteer application are true to the best of my knowledge. I understand that falsified statements or material omissions on this application may result in immediate dismissal. I understand that this application does not guarantee volunteer placement. I understand that if chosen as a volunteer, I will not have any contract and may be removed from the volunteer list at any time without advance notice at the will of PBMC/WCGH. I also understand that if offered a volunteer position at PBMC/WCGH, my volunteer service is conditional upon a medical examination and a medical release form from my personal physician. I agree to the disclosure to PBMC/WCGH and its divisions of the information and reports from the medical examination and release. In the event of an injury during volunteer service, the hospital has my consent for treatment as required. In the event that I am photographed during the course of my volunteer service, PBMC and WCGH and its divisions will have my permission to use any or all photos for various public relations purposes.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**APPLICANT’S AUTHORIZATION FOR REFERENCE VERIFICATION**

I hereby authorize the addressed individual, company, government agency or institution to furnish PBMC and WCGH with any information they may have concerning me which they have on record or otherwise, and hereby release the addressed individual, company, government agency, or institution and all individuals connected therewith, including PBMC and WCGH and its divisions and its employees from all liability for any damage whatsoever incurred in furnishing such information. I understand that reference verification may include, but is not limited to: verification of education, employment, professional licensure, personal references, motor vehicle check, criminal background check and sex offender registry check.

<table>
<thead>
<tr>
<th>(Applicant Signature)</th>
<th>(Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Signature of parent or legal guardian if applicant is under 18 years of age.)</td>
<td>(Date)</td>
</tr>
</tbody>
</table>
Concept for
Background Check
Sex Offender Registry Check

Please provide the following information. Please print clearly.

Full legal name (First, Middle, Last):
________________________________________________________________________

Other Names Used (maiden name, AKA names, etc.):
________________________________________________________________________

Current Residential Address:
________________________________________________________________________
________________________________________________________________________

Date of Birth: ____________________________________________________________

Social Security Number: ___________________________________________________

Department: Volunteer Services, Jamie Geretz

Your signature below authorizes Pen Bay Medical Center and Waldo County General Hospital to conduct a criminal background check and a sexual offender registry check:

_____________________________________________ ________________________
Signature Date

_____________________________________________ ________________________
Signature of parent or legal guardian  Date
If applicant is under 18 years of age

Internal use only: Date sent to HR for processing: _____________________

Shared/Application_Volunteer 2017/PBMC CBC_SOR Check
DISCLOSURE REGARDING BACKGROUND INVESTIGATION

MaineHealth System – Pen Bay Medical Center and Waldo County General Hospital ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature

Date

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by MaineHealth System - Maine Medical Center ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of
California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA’s file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver’s license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person’s presence.

Please check this box if you would like to receive a copy of an investigatory consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

______________________________
Signature

______________________________
Date

______________________________
Full Name (First/Middle/Last)

______________________________
Social Security Number (SSN)*

______________________________
Driver License State / Number

______________________________
Date of Birth*

______________________________
Current Address

______________________________
City, State and Zip Code

*SSN and DOB will be used for identification purposes and will not be used as selection criteria.

FOR EMPLOYMENT: 002996: 201501
# Request for Background Check

**Account #002998**

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Other Names Used**

<table>
<thead>
<tr>
<th>Current Residential Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

List each **CITY**, **STATE** and **ZIP CODE** (if known) where you have lived during the past seven years:

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>From Date</th>
<th>To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Driver's License Number</th>
<th>State of Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Junior Volunteer Applicant and Parent or Guardian if volunteer less than 18 years of age:

Participants in the PBMC and WCGH Junior Volunteer program must meet hospital health screening requirements. Please complete the authorization below and forward to your healthcare provider so they can complete the information on the attached sheet and return it to Jamie Geretz. Please call 301-8552 with any questions.

I authorize my healthcare provider, (fill in provider’s name here) __________________________________________________________________________ to complete and return the attached form to the Volunteer Services office in order to document my health screening requirements for participation in the Junior Volunteer program.

Patient’s Name: PLEASE PRINT

Patient’s Signature DATE

Signature of Parent or Guardian if patient less than 18 years of age DATE

Dear Healthcare Provider,

Your patient listed above has applied to PBMC and WCGH's 2019 Summer Junior Volunteer program and must meet hospital health screening requirements in order to participate.

The attached form lists the immunization requirements, verification needed and acceptable evidence of compliance. Please complete all highlighted sections. Please do NOT attach immunization records.

If no documentation for TB exists, please mark the “N/A” box and we will schedule TB screening through our Employee Health Office at no charge to the junior volunteer.

Please return the completed form to the Volunteer Services office, attn: Jamie Geretz by June 10 or sooner.

- Interoffice: Volunteer Services, Jamie Geretz
- Postal Mail: PBMC/WCGH Volunteer Services, attn: Jamie Geretz, 6 Glen Cove Drive, Rockport, ME 04856

Please let me know if you have any questions. Thank you so much for your help and for supporting participation in our Junior Volunteer Program!

Jamie Geretz, Regional Director of Volunteer Services, Pen Bay Medical Center and Waldo County General Hospital jegeretz@pbmc.org or 207-301-8552.
PBMC’s and WCGH’s policy requires all persons to be medically screened prior to gaining access to PBMC/WCGH facilities and patients. Individuals must meet the tuberculosis (TB) and immunization requirements for healthcare workers as set forth by CDC, Maine Law, and PBMC policy.

Compliance must be met for all the checked items under “Job-specific Requirements” on page 2. The table, below, indicates how those requirements can be met. If any requirements have not been met, they must be completed prior to onset of PBMC duties. PBMC/WCGH will issue an ID only after we have received a copy of the form on page 2, completed and signed by your medical provider. Please be aware that should PBMC/WCGH, or any regulatory agency, request specific documentation to verify requirements were met, you will have 24 hours to comply with the request.

Thank you for ensuring the safety of PBMC/WCGH’s patients by complying with these requirements.

<table>
<thead>
<tr>
<th>Acceptable Evidence of Compliance with TB &amp; Immunization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Varicella (chicken pox)</strong> Laboratory evidence of immunity</td>
</tr>
<tr>
<td><strong>Rubella (German measles)</strong> Laboratory evidence of immunity</td>
</tr>
<tr>
<td><strong>Rubeola (Measles)</strong> Laboratory evidence of immunity</td>
</tr>
<tr>
<td><strong>Mumps</strong> Laboratory evidence of immunity</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong> Laboratory evidence of immunity</td>
</tr>
<tr>
<td><strong>Tetanus</strong></td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
</tr>
<tr>
<td><strong>Tuberculosis</strong> Documentation of 2 negative TB tests within the last 12 months</td>
</tr>
</tbody>
</table>
To be completed by responsible director - Job-specific Requirements:

- Immunity to measles, mumps, rubella and varicella
- Current seasonal influenza vaccine
- TB screening
- Hepatitis B immunity or documented declination – required for all staff with reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an individual’s duties.
- Tetanus (Td or Tdap) – required for PBMCR I and WCGHR I staff; all other staff are to receive one dose of Tdap vaccine, and to have a Td booster every 10 years

To be completed by individual’s personal healthcare provider:

Verification of TB & Immunization requirements:

*My patient ____________________________, DOB ____________, meets the TB & immunization requirements as outlined on page one, and I have documentation to verify my patient’s status as follows:*

Immune status definitions:
- Immune – meets immunity criteria by vaccine or serology evidence as listed on page one
- In process – currently susceptible, but vaccine series is underway in accordance with CDC guidelines
- Susceptible – vaccine is medically contraindicated, or individual has declined vaccine for sincere philosophical or religious reasons, or is a Hepatitis B non-converter (negative HBsAb after 6 documented doses of Hepatitis B vaccine)

**Tuberculosis:**

- Documented negative TB status, or evaluation of positive TB screening, as listed on page 1

**Influenza (Nov – Apr)**

- Documented current seasonal influenza vaccine
- Declined vaccine

**Rubella** (German measles)

- Immune
- Susceptible
- Vaccine in process

**Rubeola** (measles)

- Immune
- Susceptible
- Vaccine in process

**Mumps**

- Immune
- Susceptible
- Vaccine in process

**Varicella** (chicken pox)

- Immune
- Susceptible
- Vaccine in process

**Hepatitis B**

- Immune
- Susceptible
- Vaccine in process
- Declined

**Tetanus**

- N/A
- Td within 10 years
- Tdap within 10 years

If “in process” or “susceptible” status for any of the above:

- My patient has been advised to refrain from close (in same room) contact with patients having suspected or known same disease

Sincerely,

Healthcare provider name: ____________________________

Contact number: ____________________________

Date: ____________________________
Volunteer Information

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td></td>
</tr>
<tr>
<td>City, state, zip code</td>
<td></td>
</tr>
<tr>
<td>Home telephone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Birth date</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Male □ Female □</td>
</tr>
<tr>
<td>Job title</td>
<td>Department</td>
</tr>
</tbody>
</table>

Emergency Notification Information

| Person to notify – last name, first name |                        |
| Street address                           |                        |
| City, state, zip code                    |                        |
| Telephone                               | Cell Phone             |
| Relationship to you                      |                        |

Languages

<table>
<thead>
<tr>
<th>Are you fluent in any language other than English? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If so, which language?</td>
</tr>
</tbody>
</table>

Optional Questions

<table>
<thead>
<tr>
<th>Why did you apply for employment with Pen Bay Healthcare? N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you feel you were treated courteously during the interview process and were adequately informed about the job, benefits, and salary? If no, would you please comment as to how we may improve our process in the future? N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
**ANNUAL TUBERCULOSIS (TB) QUESTIONNAIRE CONSENT AND TESTING FORM**

**Today's Date:** __________

**Full Name (print):** ____________________________________________  **Department:** ______________________

**Job Title or Position:** __________________________________________

**SSN#:** ___________________  **Date of Birth:** __________

If not employee:  
- [ ] Physician  
- [X] Allied Staff  
- [ ] Student  
- [ ] Volunteer  
- [ ] Other __________

### EMPLOYEES - Please complete this section only.

- [ ] No  
- [ ] Yes

**Have you ever had a positive TB test?**

**During the past year, have you had unprotected contact (not using a Respirator) with anyone who has active TB?**

**Have you ever had what you believe is an allergic reaction to a PPD test?**

**During the past year, have you had a cough lasting 3 or more weeks, bloody sputum, unexplained weight loss, night sweats or fever?**

**During the past year, have you had any health condition that affects your immune system?**

(Examples: cancer of the head or neck; gastric bypass; leukemia or lymphoma; chronic renal failure; HIV/AIDS; organ transplant; diabetes mellitus; pulmonary silicosis; asbestosis)

Please list any medications you are currently taking, including herbal and over-the-counter medications:

______________________________________________________________

**N/A**

**During the past 6 weeks, have you taken any medications that decrease your immune system (does not include inhalers)?**

(Examples: Prednisone, Methotrexate, Immuran, etc.)

**During the past 6 weeks, have you had a virus or viral infection such as influenza, shingles, chicken pox, measles or mumps?**

**During the past 6 weeks, have you had a live vaccine such as MMR (measles, mumps, rubella) or Varivax (chicken pox)?**

**During the past year, have you had any physical or medical problems using a respirator (PAPR or N95)?**

**During the past year, have you had a significant change in health status?**

**TST ID confirmed by:**

- [X] Employee ID  
- [ ] Drivers License  
- [ ] Other Photo ID

**Date:** __________  **AM** [ ] PM [ ]

**5 TU intradermally** [ ] R [ ] L forearm

**Sanofi/Parkdale Lot #** _______  **Exp Date:** _______

**Admin By:** ______________________________________

**Signature**

**Location test given, if not by EHS**

**READ ID confirmed by:**

- [X] Employee ID  
- [ ] Drivers License  
- [ ] Other Photo ID

**Date:** __________  **AM** [ ] PM [ ]

**Read as _____ mm transversely**

**Negative** [ ]  **Positive** [ ]  **Not Read** [ ]

**Read by:** ______________________________________

**Signature**

If not EHS staff, print name

**Action plan if +TST, see associated note in chart**

- [X] ALT  
- [ ] Chest x-ray, one view (PA)
- [ ] AST  
- [ ] Referral to TB clinic
- [ ] Client Accepted  
- [ ] Client Declined
- [ ] Referral letter to TB clinic/copy to PCP

**Signature** ______________________________________  **Date:** _______

**Copy of this complete form given to client by:**

- [ ] Hand delivery  
- [ ] Interoffice  
- [ ] Mailed

**Initials** ________

**Provider Comments:**

**I certify the above information is true to the best of my knowledge. I have read or had explained to me, information related to the TB skin test including indications, precautions, administration and results. I give consent to receive the TB skin test.**

**Signature** ______________________________________  **Date:** _______

**Signature of parent or guardian if applicant under 18 years of age:**

_________________________________________________________  **/Date:** __________

**OFFICE USE ONLY:**
MAINE HEALTHCARE CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement applies to the individuals (referred to as “Users”) at Maine Healthcare or any of its subsidiaries (referred to as “Organizations”) who may have direct access to patient, business, proprietary, trade secret, financial, employee or other confidential communications or data (referred to as “Confidential Information”) and information systems of Organizations to perform their work responsibilities and includes:

1. Employees;
2. Medical Staff;
3. Housestaff;
4. Clinical Affiliates;
5. Adjunct Professional Nurses appointed by the Department of Nursing;
6. Clinical Researchers;
7. Individuals authorized by the Chief Information Officer/SVP of Information Services or designee; and
8. Others with business or patient care responsibilities or contractual obligations.

I. General Confidentiality Principles.

User understands and agrees:

- Performance of his or her work responsibilities may require User to become aware of Confidential Information, which shall remain confidential consistent with the User’s work responsibilities, Organizations’ policies and procedures, and disclosures permitted by law.
- Approval to access Confidential Information is a privilege that may be granted to the User based only on his or her work responsibilities and which meets the Organizations’ need-to-know criteria for such access.
- To maintain the privacy, security and integrity of all Confidential Information and information systems of Organizations whether maintained in verbal, written, digital or electronic form.
- The duties relating to Confidential Information include:
  - Never discussing a patient’s case or presence outside of work, either with the patient, or with family or friends.
  - Never posting any patient information or images on social media unless specifically authorized by the Organization and have obtained the appropriate patient authorization in advance.
  - Never sharing password or system access codes;
  - Never disclosing, discussing, or enabling access to any Confidential Information or information systems of Organizations in any manner unless such action is consistent with the User’s work responsibilities, Organizations’ policies and procedures, the terms of this Agreement and permitted as a matter of law; and
  - Never discussing any Confidential Information outside of work and ensuring that the disposal of such Confidential Information always occurs through the Organizations’ confidential destruction system.

II. Information Systems Access

User understands and agrees:

- All network and software application passwords are confidential and shall not be shared with any third party including other authorized Users of Organizations’ information systems.
- Access to Organizations’ computer networks and certain system and software applications appropriate for the User’s work responsibilities within his or her Organization(s), shall be provided with uniquely assigned network and software application passwords.
- Access to Organizations’ computer networks and software applications may include, without limitation:
  1. On-site access at the Organizations’ locations;
  2. Remote access to defined systems or applications; or
  3. Access through dedicated communications lines.
- Network and software application passwords expire on a periodic basis and, if requested by Organizations’ Information Services Department, User shall provide new, confidential passwords for continued access to Organizations’ computer network and software applications. Such passwords shall meet standards as may be mandated by Organizations from time to time.
- In the event that User suspects or becomes aware of any unauthorized use or disclosure of User’s network and software application passwords or other confidential User identification, User immediately shall:
  1. Change such password or other User identification; and
2. Immediately report any unauthorized use or disclosure to his or her Organization’s Information Security Officer or designee, or the Maine Healthcare Audit and Compliance Department.

- Organizations have the right to suspend or revoke User’s network and software application passwords without notice if there is any breach or suspected breach of the confidentiality or security of information systems access.


User understands and agrees:

- To be accountable for all entries of patient information, orders and data entered by User into Organizations’ information systems linked to User’s network and software application password and electronic signature as applicable.

- To access patient information and/or records only for the following purposes in accordance with state and federal laws and regulations:
  1. Providing health care to the patient or coordinating such care with other health care providers;
  2. Billing and filing claims for reimbursement for care delivered to the patient;
  3. Conducting scientific or statistical research;
  4. Performing management or financial audits;
  5. Conducting quality assurance, utilization review or peer review activities;
  6. Providing technical support or remediation of network or software application functionality;
  7. Performing database administrators’ required functions involving verification and other operational purposes; and
  8. Sharing for legal or consultant purposes.

- To not disclose or re-disclose any patient information and/or records to any other entity or individual without the prior written authorization of the patient or the patient’s authorized representative, or in accordance with law, a statutorily authorized subpoena or a court order.

- To take appropriate security measures to prevent the unauthorized use of Organizations’ information systems, software applications, network and data to which User has access including:
  - Securing hard copy documentation;
  - Locking or logging out of any information system when not in use; and
  - Concealing screens in use by turning them away from unauthorized viewers or using privacy screens where available.

- To access User’s own electronic health records only through the Organizations’ patient portals (e.g., MyChart).

IV. Access to Electronic Mail System and the Internet

User understands and agrees:

- To access Organization’s e-mail system and/or Internet resources from Organization’s network only for permitted purposes in accordance with Organization’s policies and procedures for such use.

V. Audits of Information Systems, Software Applications, Network and Data

User understands and agrees:

- Organizations may audit User’s access to its Internet resources, information systems, software applications, network and data on a routine basis without notice. This is to monitor appropriate use of and compliance with the obligations stated in this Confidentiality Agreement.

- Any unauthorized disclosure of Confidential Information may result in User being subject to one or more of the following as applicable:
  1. Disciplinary action including termination of employment;
  2. Suspension or termination of clinical privileges;
  3. Termination of the business relationship with Organizations; and
  4. Legal action.

_______________________________________      ____________________________________________      __________________
Signature                 Printed Name               Date
Patient Centered
• Act with compassion and kindness.
• Listen actively and validate concerns; focus on the individual’s needs.
• Communicate effectively with patients, clients and families.
• Treat everyone with respect and courtesy; acknowledge cultural differences.
• Be empowered to advocate and speak up for patient and client safety.
• Partner with the people we care for, their families and care teams to develop a shared plan.

Respect
• Recognize all the people we care for, their family, visitors and co-workers as valued members of the healthcare team.
• Listen actively and respond thoughtfully.
• Treat others as you would want to be treated.
• Embrace diversity, acknowledging each person’s uniqueness.
• Be empathetic, compassionate and kind.
• Foster a professional and healing atmosphere.

Integrity
• Demonstrate professionalism at all times, regardless of the behavior of others.
• Maintain confidentiality and respect the privacy of all.
• Develop and maintain a culture of trust and accountability.
• Act with honesty and transparency at all levels of the organization.
• Model behavior that is consistently honest and ethical.
• Acknowledge mistakes as opportunities to learn and grow.

Excellence
• Consistently seek improvements in processes and performance.
• Set high standards.
• Strive to exceed expectations with every interaction.
• Lead by example.
• Work collaboratively as a team.
• Pursue opportunities to learn and grow personally and professionally.

Ownership
• Follow up and follow through.
• Look beyond our individual roles to do what is necessary to get the job done successfully.
• Take responsibility for our actions and our collective outcomes.
• Approach challenges with optimism.
• Represent our organization in a positive light.
• Promote an accountable, fair and supportive environment.

Innovation
• Welcome change with a positive attitude.
• Inspire others and foster creativity.
• Be courageous.
• Encourage diverse perspectives.
• Invest in people, technology and research.
• Commit to lifelong learning and educating.

Volunteer Signature Date

Parent or guardian if applicant is under 18 Date