SMP Health – St. Raphael

Volunteer Services Application Packet

SMP Health – St. Raphael
979 Central Ave N
Valley City, ND, 58072

P: (701)845-8222

https://smphealth.org/straphael

Volunteer Services Program

Thank you for your interest in volunteering at SMP Health – St. Raphael! We are seeking volunteers who will carry out our facility's vision and mission. Please note we are required by law to complete a screening process and run a background check on all volunteers.

WHAT IS A VOLUNTEER?

A SMP Health – St. Raphael volunteer is a member of a team of individuals who serve without salary under staff supervision and direction. Volunteers are placed in nonprofessional areas and are essential in helping us deliver compassionate care to our residents.

VOLUNTEER EXPECTATIONS

All volunteers attend a special orientation session and receive personal training within the department to which they are assigned. In addition, each volunteer receives an identification badge to wear while volunteering.

GOALS FOR EACH VOLUNTEER

- Assist staff members with non-professional aspects of their work.
- Enhance the resident care experience by providing a personal touch in a highly technical environment.

VOLUNTEER TERMINATION

All volunteers deemed unsuitable for continued volunteer service will be terminated and prohibited from further volunteer activity at the facility. Volunteers may be terminated for but not limited to the following:

- Breach of Confidentiality
- Disregard for facility and Volunteer Program policies.
- Inability to work well with others.
- Any concern the facility may have for the safety and comfort of our residents and their families.

In addition to the application and forms provided, SMP Health – St. Raphael requires vaccination records for all caregivers and volunteers. If you have received T-dap, MMR, varicella (chicken Pox), Hepatitis B and/or a current season flu (influenza) vaccination, please submit these records with your application. Please call (701)845-8222 if you have any questions.

We will contact you for an interview and run a background check. When volunteer criteria has been met, we will schedule you for Volunteer Orientation. Please bring your photo ID to your appointments. If you have any questions, please call the facility at (701)845-8222

Volunteer Services Program Packet

The following Steps must be completed for every new volunteer:

Required:	✓
STEP ONE: Complete Volunteer Application Form	☐
• **Signed Confidentiality Statement/Mission Statement**	☐
• **Volunteer Availability Statement**	☐
STEP TWO: Volunteer interview Process	☐
STEP THREE: Background Check Process	☐
• **Three Reference Checks**	☐
STEP FOUR: Volunteer Orientation	☐
• **Attend Volunteer orientation session**	☐
• **Volunteer Orientation Checklist**	☐
• **Copy of Vaccination Records (T-dap, MMR, Varicella, Tuberculosis screening, annual flu [influenza] shot, Hepatitis B)**	☐
• **Copy of Driver's License and Auto Insurance (only if Administrator authorized driver)**	☐
• **Identification Badge/ Parking**	☐
• **Facility Tour and Department Orientation**	☐
• **Other:**	☐

VOLUNTEER SERVICES PROGRAM APPLICATION

PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle)

Street Address: _____

_____
(City) (State) (Zip Code)

Home Phone: ( )_____ ☐ OK to contact?

Cell Phone: ( ) _____ ☐ OK to contact?

Date of Birth: _____ Email Address: _____

Do you have a family member employed at SMP Health – St. Raphael? ☐ Yes ☐ No

If you answered yes, please list name of family member: _____

Have you ever volunteered or been employed with any SMP Health Facility or any other contracted agency affiliated with SMP Health? ☐ Yes ☐ No

Present Occupation/Employer: _____

Position/Years of Service: _____

Special Training/ Certification: _____

_____

Previous volunteer experience with any other organizations? ☐ Yes ☐ No

If yes, where? _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency whom should we notify?

Name: _____

Relationship: _____ Phone: _____

VOLUNTEER STATEMENT OF CONFIDENTIALITY

Confidentiality is defined as safeguarding the content of information including written, video, audio, or other computer stored information from unauthorized disclosure without consent of the resident and/or the resident's representative.

During the course of my work as a volunteer, I may develop, use, maintain, or have incidental contact with or access to information related to residents, caregivers, employees, providers, financial data, and/or any other information pertaining to *SMP Health – St. Raphael business or operations, including trade secrets, that is confidential.*

I understand and agree that in performance of my duties as a volunteer of this facility:

- Confidential information in any form (including paper records, oral communication, email, audio recordings, and electronic displays) is the property of *SMP Health – St. Raphael and is to be considered strictly confidential unless specified otherwise*.

- I will hold medical information regarding any past, present or future resident, and company information in the strictest confidence.

- I further understand all information concerning written procedures, plans, computer hardware, programs and software, and manuals including this and all other policy manuals, are the confidential property of this facility and must not be disclosed to individuals or entities outside the company either during or after my volunteer service has ended.

- The confidentiality obligation set forth in this agreement as well as applicable policies continue beyond the end of my relationship with *SMP Health – St. Raphael.*

- This agreement is valid for all individuals with access to confidential information, regardless of employment status.

- I understand the resident has a right to personal privacy and confidentiality of his or her personal and medical records to include accommodations, medical treatment, written and telephone communications, personal care and meetings with family.

- I further understand that voluntary or involuntary, willful or unwilful violation of this confidentiality will result in my volunteer services being terminated and may result in legal action to include possible defamation lawsuit, privacy or human rights complaints, copyright, patent or trademark infringement claims, criminal charges with respect to obscene or hate materials, damage to the company's reputation and business interests. The legal responsibility for damages from an inappropriate disclosure could potentially rest with the individual volunteer.

I understand that violations of *SMP Health – St. Raphael policies and procedures include, but not limited to:*

- Accessing, using, or disclosing confidential information that is not within the scope of my authority, job, or responsibilities to *SMP Health – St. Raphael,* or otherwise not permitted by written policy.

- Leaving confidential information in any form in an unsecured location or environment.

- Failure to properly secure a computer workstation when leaving the immediate work area.

- Disclosing my computer system user ID and password combination to another person for any reason or using another person's computer system user ID and password combination.

- Discussing confidential information in a public place or with persons not authorized to receive such information.

I hereby agree to abide by the volunteer policies and facility rules and regulations and uphold resident confidentiality as I fulfill my role as volunteer. I understand and agree that I am solely responsible for knowing, understanding, adhering to, and complying with the terms of the above agreement as well as *SMP Health – St. Raphael policies, policy compliance rules, and procedures regarding the confidentiality, privacy, and security of confidential information, and the Notice of Privacy Practices adopted by SMP Health – St. Raphael*

Signature below indicates an acknowledgement of notification of the above notices.

_____

Volunteer's Name: First MI Last (please print)

_____ _____

Volunteer's Signature Date

VOLUNTEER SHIFT AVAILABILITY & ASSIGNMENT PREFERENCE

Please tell us which days and times you are available to provide assistance.

First Choice

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐

Second Choice

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐

Third Choice

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐

Please list any current scheduling obligations: _____

How many Hours would you like to serve? _____ per _____

HEALTH CONSIDERATIONS

Are there any known health concerns, allergies, physical limitations that need to be accommodated to help you volunteer?

HOBBIES, TALENTS, OR SKILLS

Tell us a little about yourself. What hobbies, talents, or skills do you have that will assist you in a volunteering position?

Art ☐ Music☐ Reading ☐ Nutrition/Cooking ☐ Ceramics ☐ Gardening ☐

Nature☐ Knitting/Crochet ☐ Quilting ☐ Aerobics ☐ Religious Services Support ☐

Foreign Languages spoken: _____

Other ☐ _____

AREAS OF INTEREST FOR VOLUNTEERING

Please tell us which areas you are interested in volunteering:

☐ Assisting with nursing staff as a unit helper.

☐ Helping transport residents to and from the facility to the community.

☐ Engaging our residents in conversation by leading discussion groups.

☐ Providing entertainment to our residents by assisting our Activities Department.

☐ Arts and Crafts

☐ Music

☐ Spending the day with a resident and simply keeping them company.

☐ Assisting with rehabilitation services.

☐ Religious services support and pastoral visits.

☐ Clerical support such as answering telephones, data entry, filing and taking messages.

☐ Gardening/Grounds Care/Picking Up Litter

☐ Library services.

☐ Other _____

PERSONAL OR PROFESSIONAL REFERENCES

Please provide names and email addresses of three people who are not family members or significant others. References can be personal or professional in nature.
I authorize my reference to release any information they may have concerning my volunteering.

1. Name _____ Phone: _____

   Home Address: _____

   Email Address _____ Relationship _____

2. Name _____ Phone: _____

   Home Address: _____

   Email Address _____ Relationship _____

3. Name _____ Phone: _____

   Home Address: _____

   Email Address _____ Relationship _____

VOLUNTEER HEALTH REQUIREMENTS

SMP Health – St. Raphael requires all volunteers to have proof of immunity to the following:

- Varicella (Chicken Pox): Varicella vaccine is given to those that have been identified as non-immune to chickenpox.
- MMR (Measles, Mumps, and Rubella): MMR vaccine is given to those identified as non-immune to measles, mumps and rubella.
- T-dap (Tetanus, Diphtheria and Pertussis Whooping Cough: T-dap vaccine is available for those who aren't current.
- Tuberculosis Testing: Monitoring for risk and symptoms required.
- Annual flu(influenza) vaccination: Volunteers may refuse the flu vaccination yearly.
- COVID-19 vaccination: Up to date vaccination suggested for all volunteers.

Adult TB Risk Assessment and Screening Form

Name:_____ **DOB:**_____ **Date:**_____

TB Risk Assessment	**Yes**	**No**
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the middle East? In what country were you born?		
2) In the past 5 years, have you lived in or traveled to Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?		
3) In the last 2 years, have you lived in or traveled to Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?		
4) Do you have (or have you had) any of these medical conditions? Diabetes — Kidney disease HIV infection — Colitis Cancer — Stomach or intestine surgery Rheumatoid arthritis — Solid organ transplant		
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?		
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?		

Symptom Screening – At this time, do you have any of these symptoms?	**Yes**	**No**
1) Coughing for more than 2-3 weeks?		
2) Coughing up blood?		
3) Weight loss of more than 10 pounds for no known reason?		
4) Fever of 100 degrees F (or 38 degrees C) for over 2 weeks?		
5) Unusual or heavy sweating at night?		
6) Unusual weakness or extreme fatigue?		
7) Eye pain or Blurry Vision?		
8) Headache, decreased level of consciousness or neck stiffness?		
9) Swelling/pain of lymph nodes, joints or vertebra?		

Employee Signature: _____

SMP Health
St. Raphael

Mission

SMP Health - St. Raphael, inspired by the Sisters of Mary of the Presentation, serves those in our care with respect and compassion as we strive to fulfill the healing mission of Jesus.

Values

Relationships are purposely developed and nurtured among residents, families, staff, and community. Consistent relationships between residents and staff build trust and enhance continuity of care.

Environment is homelike, offering Christ-like hospitality to enhance socialization, independence, and dignity.

Stewardship is using responsibly all of our God-given gifts.

People Directed Care honors residents' choices, encourages them to maintain control of their lives and preserves their human dignity.

Ethical Care is guided by the Ethical & Religious Directives for Catholic Healthcare Services in all our decision-making. We act on behalf of justice for all, especially for the poor and the most vulnerable in society.

Compassion calls us to love and respect those in our care as Jesus would, recognizing the individuality of each person and responding to their physical, emotional, spiritual, and social needs.

Teamwork commits us to the common good by serving with Spirit-filled joy and integrity. All team members are individually responsible for promoting an atmosphere of service and open communication among residents, family, and staff.

By signing this document, I hereby state that I have read, understand, and will commit myself to put into action SMP Health - St. Raphael's Mission and RESPECT Philosophy. I will hold any information regarding residents and SMP Health - St. Raphael in confidence. Further, I understand that intentional or involuntary violation of my employer's or SMP Health - St. Raphael' resident's confidentiality may result in disciplinary action, including possible dismissal.

Printed Name: _____

Signature_____ Date_____