



Sponsoring Norwood Crossing (formerly Norwood Park Home) and Norwood Seniors Network

VOLUNTEER APPLICATION

Date: _____

A. Personal Information *(Please PRINT all information)*

Name _____ E-Mail _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Name: _____ Relationship _____ Phone _____

How did you learn about our volunteer program or NPH: _____ Newspaper _____ Church _____ School
 _____ Family/Friend _____ NPH Resident/Former Resident _____ Other (please specify) _____

B. Employment Information

Former/Current Employer _____

Supervisor _____

Address _____ City _____ State _____ Zip _____

Position _____ Dates Employed _____

C. Volunteer Experience

Organization _____ Organization _____

Activities _____ Activities _____

Dates Active _____ Dates Active _____

Supervisor _____ Supervisor _____

D. Please mark your time(s) available for volunteer tasks?

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
<input type="radio"/> AM	<input type="radio"/> AM	<input type="radio"/> AM	<input type="radio"/> AM	<input type="radio"/> AM	<input type="radio"/> AM	<input type="radio"/> AM
<input type="radio"/> PM	<input type="radio"/> PM	<input type="radio"/> PM	<input type="radio"/> PM	<input type="radio"/> PM	<input type="radio"/> PM	<input type="radio"/> PM

Would you be available on holidays? YES NO

E. Volunteer Preferences *Please indicate volunteer task(s) in which you are interested:*

- | | | |
|---|--|---|
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Visiting & Reading | <input type="checkbox"/> Home Delivered Meals |
| <input type="checkbox"/> Thrift Shop | <input type="checkbox"/> Plants & Pets | <input type="checkbox"/> Transportation Driver |
| <input type="checkbox"/> Office Help | <input type="checkbox"/> In-Home Assistance | <input type="checkbox"/> Transportation Companion |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Saturday Happy Hour | <input type="checkbox"/> Yard & Maintenance Help |
| <input type="checkbox"/> Chapel | <input type="checkbox"/> Special Events | |
| <input type="checkbox"/> Sunday Family Festival | | |

(Please complete reverse side)

F. Volunteer Category ___ Retired ___ Adult ___ High School ___ Pre-Teen

Purpose of Volunteer Service Hours: ___ School ___ Confirmation ___ Community Service ___ Other

Name of School/Organization: _____ Counselor: _____

Number of Volunteers Hours Needed: _____

G. Special Skills and Interests _____

Are there any specific medical or physical difficulties/limitations that you would NOT be comfortable working with? ___ NO ___ YES (Please Explain) _____

Do you speak a language besides English? ___ NO ___ YES If yes, what? _____

H. Do you drive? ___ YES ___ NO **Do you have a car?** ___ YES ___ NO

(Please complete the driving information only if you will be driving for Norwood Park Seniors Network.)

NOTE: Drivers are solely responsible for any damage to property (including their own automobile) that results from any accidents that occur while driving for the Norwood Park Seniors Network programs. NPSN liability insurance is secondary to driver's personal automobile insurance. Please provide proof of the following:

Illinois Driver's License# _____ Expiration Date _____

Insurance Carrier _____ Expiration Date _____

Please provide two (2) personal references (not related)

1. Name _____ Phone _____

Relationship _____ # of Years Known _____

2. Name _____ Phone _____

Relationship _____ # of Years Known _____

Please provide the following information

Date of Birth _____

Have you ever been denied permission to participate as a volunteer in an organization? ___ YES ___ NO

Have you ever been convicted of a felony? ___ YES ___ NO

Are you a member of a particular church/congregation? If yes, please provide the following information:

Church/Congregation _____ Pastor _____

Address _____ Phone _____

I expressly authorize Norwood Life Care Foundation and its representatives to contact all references, contacts or employer and to seek verification of any and all information provided in this application. Also, by signing, I agree that the information I have provided is true and correct to the best of my ability and knowledge. *For drivers*, I also authorize to obtain from the Illinois Secretary of State a Motor Vehicle Record, which reports my driving record for the past year. I certify that all the information submitted by me on this application is true and complete. I agree to keep confidential any private information obtained from my volunteer service. If a photograph is taken during my volunteer service, I give permission for Norwood Life Care Foundation to use the photographs. I also agree that, as a volunteer, I may be dismissed for any reason upon discretion of Norwood Life Care Foundation Volunteer Program Staff.

Signature _____ Date _____



HIPAA VOLUNTEER CONFIDENTIALITY AGREEMENT

I acknowledge that during the course of performing my assigned duties at Norwood Crossing/Foundation/Seniors Network I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a trustworthy and confidential manner at all times during and after my employment and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties;

B. I will request, obtain or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties;

C. If applicable, I will take reasonable care to properly secure confidential health information stored electronically and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off properly in order to prevent access by unauthorized users;

D. I will not disclose my personal password(s) to anyone without the express written permission of my department head or record or post it in an accessible location and will refrain from performing any tasks using another's password.

I understand that as a volunteer of Norwood Crossing/Foundation/Seniors Network, a health care provider, the use and disclosure of patient and employee information is governed by the rules and regulations established under HIPAA, the Health Insurance Portability and Accountability Act of 1996, and related policies and procedures of this organization. Therefore, with regard to such information, I commit to the following additional obligations:

A. I will use and disclose confidential health information solely in accordance with the federal and organizational policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner;

B. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to my supervisor or other Department Head / Administrator.

I also understand and agree that my failure to comply with any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to disciplinary action, up to and including, termination.

PRINTED NAME

DATE

SIGNATURE