Atrium Medical Center
Premier Health Partners

One Medical Center Dr.
Middletown, Ohio 45005
(513) 424-2111

AtriumMedCenter.org

For Adult Volunteer Applicants

Thank you for your interest in the volunteer program at Atrium Medical Center. We have a variety of openings that appeal to most people and our volunteers find that their time here provides them with activities they enjoy while giving them the chance to help others.

Please print:

- The Application
- Physician Form
- Medical Information/Patient Access HIPAA privacy Form (fill in the highlighted areas)
- Three requests for reference, which should be completed by non-family members.

Please take the completed HIPAA Privacy Form to your doctor along with the Physician Form. Your doctor can either mail the physician form or fax it to us at the number at the top of the form.

You may bring your application to the Volunteer Office on the main level of the hospital. If you stop at the Information Desk, the staff will give you directions to our office. Or you may mail the materials to us.

And please ask your references to mail the completed reference forms to:

Volunteer Services Supervisor
Atrium Medical Center
One Medical Center Drive
Middletown, OH 45005

Once we have received all of your paperwork, we will call to schedule an interview. At that time, we will discuss openings that might be of interest to you, as well as the orientation and training process.

If you need any additional information, please call the Volunteer Office at (513) 420-5201 or email KAAWatson@AtriumMedCenter.org.

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Please have your personal physician complete this form and mail or fax it to Volunteer Services:
Phone: (513) 420-5201, Fax: (513) 705-4504

Dear Physician:

The individual listed below has applied to become a volunteer at Atrium Medical Center. He or she has signed below, granting permission for you to release medical information to the volunteer office.

Many of our volunteers work in direct contact with our patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard the patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering, but not physically or mentally able to perform the required tasks.

You may indicate blanket approval for any type of service, or you may impose some restrictions such as: no lifting; no pushing wheelchairs or heavy carts; or no patient contact because of a physical or emotional problem. Please use the section below to list restrictions and for any comments.

We appreciate your prompt response in order to help us place this volunteer.

Yours truly,

Kathy Watson

Kathy Watson
Supervisor, Volunteer Services
(513) 420-5201

I give permission for my physician to release relevant medical information to the Volunteer Office.

Signature of Volunteer Applicant _____

Please print the following information:

_____
Volunteer name (first) (last) (other last name(s), previously used)

_____
Address City Zip

Physician comments; please list any restrictions or recommendations: _____

_____

Date of rubella shot/test showing immunity, if available: _____

(if information is not available, we will provide a rubella screen at no charge to the volunteer)

Physician Signature _____

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Reference for Volunteer Applicant

Your name has been given as a reference by _____, who has submitted an application to the Volunteer Services Office at Atrium Medical Center. We would appreciate your completing this form and returning it in the enclosed envelope so that we may make a decision on the applicant's ability to fulfill the responsibilities involved in our volunteer program. All information you supply will be kept confidential. If you have any questions, please contact the Volunteer Services office at (513) 420-5201.

Thank you,

Kathy Watson

Kathy Watson
Supervisor, Volunteer Services

Date: _____How long have you known the applicant? _____

In what capacity have you known the applicant? _____

_____

Describe the applicant's reliability and willingness to make a commitment such as this:

_____

_____

Are you aware if the applicant has any physical or emotional limitations?

_____

Would you recommend the applicant for placement in a setting such as ours?

_____

Or do you think he or she may be better suited to another type of agency?

_____

Additional comments: _____

_____

Signature _____ Date _____

Please print the following information

Name _____ Phone _____

Address _____

Atrium Medical Center
Premier Health Partners

One Medical Center Drive, Middletown, OH 45005

Volunteer Services (513) 420-5201 AtriumMedCenter.org

Volunteer Application

For office use only
Dept (s)
Orientation date:
Other

Please **print** all information on application

Name: _____
(Last) (First) (Middle) (other last names used)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

CURRENT INFORMATION:

1. Present place of employment: _____

   Occupation: _____ Work hours/days: _____

2. Emergency Contact: _____ Relationship: _____

   Home phone: _____ Work Phone: _____

3. Please check all times you are available to volunteer:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

4. Physician's Name _____ Address: _____

   Limitations related to health: _____

EDUCATION: High School, College, Graduate School, Special Training (Please list last three schools)

Name & Location of School	Field of Study	Years Completed	Degree or Diploma

PREVIOUS EXPERIENCE

Work Experience | Volunteer Experience

_____

_____

_____

_____

Please give any other information you think is pertinent to your application, including your interests and types of activities you might enjoy (sitting, answering phones, moving about, paperwork, being with people, etc.):

_____

_____

OTHER INFORMATION:

Have you ever been convicted of a crime other than a minor traffic violation, or received drug treatment in lieu of conviction? Yes ☐ No ☐ If yes, please explain _____

_____

Have you been employed by Atrium Medical Center, Atrium Health System or Middletown Regional?
Yes ☐ No ☐
If yes, under what name: _____ Dates of employment from _____ to _____

_____

What position(s) held _____

Have you ever been a volunteer at Atrium, MRH or AHS? Yes ☐ No ☐

If yes, under what name: _____ Dates of service from _____ to _____

CERTIFICATION

The statements made above are true and accurate to the best of my knowledge. I will inform the Volunteer Services Office of any changes in this information, including any convictions during my term as a volunteer. I consent to the release to Atrium Medical Center any hospital, physician or mental health records. I also consent to the release of any educational, work or police records. Atrium Medical Center or Atrium Health System are not obligated to provide a place, nor am I obligated to accept the position(s) offered. Volunteering is a privilege. All persons involved with patient care must maintain the highest standards of behavior. I understand and agree that as a Volunteer at Atrium Medical Center, I must hold in strictest confidence any observations I may make or hear regarding patients, patients' families or staff.

Signature _____ Date _____

ATRIUM USE ONLY: This Section completed by Atrium personnel.
☐ Request Approved
☐ Request Denied (Complete Patient Access Denial Form)
☐ NA (Information released to persons other than the patient)
Date: Initials:

Atrium Medical Center
Premier Health Partners

Authorization For Release of Medical Information/Patient Access Form

Patient's Name: _____ Unit #: not applicable Acct #: not applicable

Birth Date: _____ Social Security Number: _____

Service Date/Type(s): not applicable
(Please specify whether inpatient, Clinic, Emergency Room, etc.)

I, the undersigned, hereby authorize (*insert name of physician/practice*)_____ to release any information contained in the above named patient's medical records, with no limitations, including any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above service dates to the individual(s) or organization(s) listed below.

INFORMATION REQUESTED

☐ Face Sheet ☐ Progress Notes ☐ X-ray Reports ☐ Pathology Reports / materials
☐ History / Physical ☐ Physician Orders ☐ Consultation(s) ☐ Operative Reports
☐ Discharge Summary ☐ EKG Interpretations ☐ Laboratory Reports ☐ Copy of Entire Record
☒ Other - Please Specify: ***Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely***

Unless otherwise revoked this authorization will expire on the following date, event or condition, i.e. end of research: ***60 days from date of signature below***. If the expiration date, event, or condition is not specified, this authorization will only include the service dates as listed above. It is the responsibility of the recipient of this information to notify our facility when additional information is needed as defined within the scope of this authorization

Information to be released to: Volunteer Services Supervisor

Address: Atrium Medical Center , One Medical Center Drive
Middletown, OH 45042

This information is to be released for the purpose of: ☐ At the request of the patient **OR** ☒ Other (Please specify below):
To meet hospital Infection Control Guidelines (immunity to rubella) and any limitations for the safety of the volunteer, patients and visitors

I understand that I may revoke this authorization in writing at any time, except if Atrium Medical Center has already released the information based on this authorization. I can revoke this authorization by sending a written request attention to the Medical Record Department.

I understand that I am not required to sign this authorization form and that Atrium Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except that Atrium Medical Center may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Atrium Medical Center may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

Signature of patient or representative: _____ Date: _____
If you are the representative of the patient*, describe the scope of your authority to act on the patient's behalf. Please check one below:*
☐ Guardian ☐ Parent of Minor ☐ Power of Attorney Over Healthcare

*This authorization will be accepted up to **60 days** from date of signature.*

Signature of witness: _____

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations

A photocopy of this authorization is to be accepted the same as the original.