



Mailing Address

P.O. Box 8810
Middletown, Ohio 45042-9813

Driving/Shipping Address

One Medical Center Dr.
Franklin, Ohio 45005-1066
(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 Manager
Atrium Medical Center
P.O. Box 8810
Middletown, OH 45042

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 PPLane@AtriumMedCenter.org.

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, Middletown Regional Hospital or Middletown Regional Health System? 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 MRHS? 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 Middletown Regional 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 _____



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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,

Priscilla Lane
Manager, 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 _____

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:** _____



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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Pathology Reports / materials |
| <input type="checkbox"/> History / Physical | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Consultation(s) | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG Interpretations | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Copy of Entire Record |
| <input checked="" type="checkbox"/> Other - Please Specify: <u>Immunization dates (MMR only) and restrictions that would affect the individual's ability to volunteer safely</u> | | | |

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 Manager

Address: Atrium Medical Center, P.O Box 8810
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.

<p>Signature of patient or representative: _____ <i>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:</i> <input type="checkbox"/> Guardian <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Power of Attorney Over Healthcare</p>	<p>Date: _____ <i>This authorization will be accepted up to 60 days from date of signature.</i></p>
<p>Signature of witness: _____</p>	

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.



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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,

Priscilla Lane
Manager, 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 _____