CENTRAL MAINE HEALTHCARE (CMH) & BATES COLLEGE

VOLUNTEER COVID VACCINE CLINIC APPLICATION

FOR BATES COLLEGE STUDENTS

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Fill out all forms completely.

Scan and e-mail completed forms to: Treasurer@bates.edu

Paper applications may be dropped off at Lane 216 or Commons 117

Employer: ___BATES COLLEGE____

APPLICATION FOR COMMUNITY VACCINE CLINIC VOLUNTEERS

NAME (First, Last, Middle Initial): ____

Mailing Address: ____

City/Town: ______________________________ Zip Code: __________________________

Home/work Phone: ______________________ Cell Phone: _________________________

E-mail Address: ______________________________________ Date of Birth: __________

In Case of Emergency, Contact:

Name: ____________________________ Relationship to You: ______________________

Primary Contact Number: _________________ Secondary Contact Number: ___________

Indicate the Community clinic sites that you are willing to work. Check all that apply.

__X__CMMC/Lewiston/Auburn ____Bridgton ____Rumford ____Others

Please check off any volunteer role(s) you are willing to work. Check all that apply:

____Patient Arrival Coordinator ____Check in Assistant ____Line Manager

____Vaccinator Registrar ____Post Vaccine Observer ____Cleaning and Supply

____Transport Assistant

**CMH will do our best to accommodate your preferences but you may be asked to take on a different role based on needs on the day of the clinic*

Clinics are Tuesday, Wednesday, Friday, and Saturday. Shifts are 7:15am-1:30pm, and

1pm - 7pm. Once a volunteer is approved by CMH, Bates will coordinate shift sign-ups.

Photo & Publicity: Central Maine Healthcare (CMH) has permission to use my name and image for marketing and public relations purposes, including but not limited to, print, and digital advertising, social media, press releases, video, photographs, website, internal communications and additional internal and external marketing materials, as needed. I give permission for CMH to submit my name for awards and recognitions where my name and image may appear on various media as mentioned above.

____I DO give my permission to use my name and image for marketing and PR purposes.

____I DO NOT give my permission to use my name and image for marketing and PR purposes.

Consent for Criminal Background Check: A criminal background check is required before an applicant may be considered for a volunteer position at a Central Maine Healthcare entity. Background checks are administered by Data Facts and are done at no charge to the volunteer applicant. Failure to disclose infractions that may appear on an applicant's background check in advance will disqualify the applicant from consideration in the program.

I hereby acknowledge that the following convictions may appear on my criminal background check:

____

____

- ☐ I authorize Central Maine Healthcare to administer a criminal background check on my behalf.
- ☐ I am under the age of 18.

If under the age of 18, Parent Name (Print): ____

If under the age of 18, Parent Signature: ____

The information provided by me on this application is correct and complete to the best of my knowledge and belief. I understand that any false or misleading statements made on this application may result in refusal of my volunteer service.

Volunteer Applicant Signature: ____

Date: _______________

Bates College Volunteer Applications:
E-mail to treasurer@bates.edu
Paper applications may be dropped off at: Lane 216 or Commons 117

CENTRAL MAINE HEALTHCARE COVID VACCINE CLINIC
VOLUNTEER TRAINING CHECKLIST

ORIENTATION TASK	**DATE COMPLETED**	**VOLUNTEER INITIALS**
PPE Video **(ALL VOLUNTEERS)** https://vimeo.com/478697971/54a1db842f		

Instructions:

1. **All volunteers** must watch the first training video on proper PPE use, and donning and doffing.
2. Initial and mark date of completion for each training.

SIGNATURE: ____

NAME (PRINT): ____________________________________ DATE: _______________________

CENTRAL MAINE HEALTHCARE

Confidentiality Agreement for Volunteers

It is the responsibility of all CHMC Healthcare volunteers to preserve and protect confidential patient, employee and business information. *Confidential Patient Care Information* includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patient's and/or their family member's records, test results, conversations and financial information. Examples include, but are not limited to:

- Physical medical and psychiatric records including: paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department based computerized patient data;
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient.

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home and/or cell phone number(s) and address;
- Spouse or other relative names and/or contact information;
- Social Security number of income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from CMHC's records which if disclosed would constitute an unwarranted invasion of privacy; or
- Disclosure of confidential business information that would cause harm to CMHC.

I understand that I require information to perform my duties at and entity within Central Maine Healthcare Corporation (CMHC) for which I am volunteering. This information may include, but is not limited to, information on patients, employees, plan members, students, other workforce members, donors, research, and financial and business operations (collectively referred to as "Confidential Information"). Some of this information is made confidential by law (such as "protected health information" or "PHI" under the federal Health Insurance Portability and Accountability Act) or by CMHC policies. Confidential Information may be in any form, e.g., written, electronic, oral, overheard or observed. I also understand that access to all Confidential Information is granted on a need-to-know basis. A need-to-know is defined as information access that is required in order to perform my work or volunteer duties. If my duties change, my need-to-know also may change.

By signing below, I agree to the following:

I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with the individual patient care, risk management and/or peer review activities. I will access, use and disclose Confidential Information in keeping with CMHC's policies and only on a need-to-know basis.

It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information related to CMHC and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.

I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with the officially adopted policies of CMHC, or where no official policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it to conduct CMHC affairs.

I understand that CMHC performs audits and reviews patient records and logs in order to identify inappropriate access.

My user ID is recorded when I access electronic records and I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of a request.

I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing distance of other people who do not have a need to know about the information.

I will contact my supervisor or manager (if applicable) in order to obtain proper permission before I make any other use or disclosure of Confidential Information. If my immediate supervisor or the manager is not available, I will contact the CMHC Director of Volunteer Services to assure that the use or disclosure is within the law and CMHC's policies.

I will not disclose Confidential Information to other patients, other plan members, friends, relatives, co-workers or anyone else except as permitted by CMHC policies and applicable law and as required to perform my work or volunteer duties.

I will not post or discuss Confidential Information, including pictures and/or videos on my personal social media sites (e.g. Facebook, Twitter, etc.). Likewise, I will not post or discuss Confidential Information on CMHC-sponsored social media sites without the appropriate approval in accordance with established CMHC policies and procedures.

I will not access, maintain or transmit Confidential Information on any unencrypted portable electronic devices (e.g. Blackberries, Androids, iPhones, iPads, etc.) and agree to use such devices in accordance with CMHC policies only.

I will protect the confidentiality of all Confidential Information, including PHI, while at CMHC and after I leave CMHC.

All Confidential Information remains the property of CMHC and may not be removed or kept by me when I leave CMHC except as permitted by CMHC policies or specific agreements or arrangements applicable to my situation.

If I violate this agreement, as a volunteer, I may be subject to termination of my right to volunteer, under applicable program policies. In addition, under applicable law, I may be subject to criminal or civil penalties.

I have read and understand the above and agree to be bound by it. I understand that signing this agreement and complying with its terms is a requirement for me to volunteer at CMHC.

Name: ___________________________________ Daytime Phone: _______________________

Signature: ________________________________ Date: ________________________________

If under 18, Parent Name: ___________________________________ Daytime Phone: _______________________

If under 18, Parent Signature: ________________________________ Date: ________________________________

CMHC Entity and Location: ____

I, as the supervisor/manager of this CMHC location will assign a schedule, arrange for adequate training and provide adequate supervision and support for the volunteer. I also agree to assume full responsibility to ensure that the volunteer is in compliance and meets the institutional guidelines and adheres to the policies and procedures of CMHC.

Signature of Volunteer's Supervisor/Manager: ____

Signature of the Director of Volunteer Services: ____

Use of Confidential Information at Central Maine Healthcare:

It is important that the entire Central Maine Healthcare System community share a culture of respect for Confidential Information. To that end, if you observe access to or sharing of Confidential Information that is or appears to be unauthorized or inappropriate, please try to make sure that this use or disclosure does not continue. This might include advising the person involved that they may want to check the appropriateness of the use or disclosure with the CMHC's Privacy Office. It may also involve letting your supervisor or manager (if applicable) or others in authority at CMHC know about the issue or possible issue. Use of the Compliance Hotline (telephone #: 207-795-2906) is available 24 hours a day, 7 days a week. The Hotline is not set up for caller ID and cannot trace calls. If you decide to identify yourself in order to provide information necessary in an investigation, the information will remain confidential to the extent possible.