Mon Health
Preston Memorial Hospital

Office Use ONLY
Name_____

Patient and Family Council

Application Includes:

1. Volunteer Information
2. Background Check
3. Media Release Authorization
4. Volunteer Agreement
5. Confidentiality Agreement

Submit completed application to Michelle Stanton, BSN, RN, Director of Quality, at mstanton@monhealthsys.org or mail to:

Mon Health Preston Memorial Hospital
ATTN: Michelle Stanton, BSN, RN
Director of Quality
150 Memorial Drive
Kingwood, WV 26537

- **Background Check:**
  - Each applicant will be subject to a background check. Permission to run this background verification is provided within the application.
- **Reference:**
  - The contact information for one reference must be submitted with the application. The individual identified as the applicant's reference will be contacted via phone, email, or mail by a Mon Health Preston Memorial Hospital employee. References may not be relatives of applicant.
- **Orientation:**
  - If accepted, you will be scheduled for a mandatory orientation. Our orientation covers the polices and procedures of Mon Health Preston Memorial Hospital.

Please contact Michelle Stanton at mstanton@monhealthsys.org with any questions.

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CONTACT INFORMATION

Name: _____
LAST *FIRST* *MIDDLE INITIAL*

Address: _____
STREET *CITY* *STATE* *ZIP*

Home Phone: _____ Cell: _____

E-mail: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Telephone: _____ Work/Cell: _____

Family Physician: _____ Telephone: _____

EMPLOYMENT HISTORY (if applicable)

Most Current Employer: _____

Position: _____ Telephone: _____

Contact Name: _____ Telephone: _____

Title: _____

PERSONAL REFERENCE

All applicants must submit at least one reference. Please provide complete information for a personal reference (no relatives) that has known you for a minimum of two years.

Name: _____

Address: _____
STREET *CITY* *STATE* *ZIP*

Telephone: _____ Email: _____

Relationship to applicant: _____

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PLEASE ANSWER THE FOLLOWING

Have you previously been employed by Mon Health Preston Memorial Hospital? □Yes □No

If yes, please give dates and titles _____

Are you related to any PMH employee? □Yes □No

Employee name: _____

Have you ever been discharged or forced to resign from employment? □Yes □No

If yes, please give details _____

Have you ever been convicted of a crime other than routine traffic violations? □Yes □No

If yes, please give details _____

COMMITMENT TERMS

The time commitment required is a two-hour monthly meeting, however, additional time may be required depending on the specific committee or project to which you are assigned.

I certify that all the information provided above is true, complete, and correct to the best of my knowledge. I voluntarily give Mon Health Preston Memorial Hospital permission to make a thorough investigation of my background, education, and criminal records.

Acceptance as a Patient and Family Advisor is contingent upon satisfactory completion of mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions relations to my application.

My services are donated to Mon Health Preston Memorial Hospital without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

Signature: _____ Date: _____

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PLEASE TELL US ABOUT YOURSELF:

Why would you like to be a Patient and Family Advisor?

What past experience, interests or skills do you have that you could bring to this role? Please include personal/family, hospital/medical experiences, and description.

Is there anything we have not asked you that you would like us to know?

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Areas of special interest to you: check all that apply:

_____ Arts and Aesthetics
_____ Communications/Development/Marketing
_____ Patient Experience
_____ Quality
_____ Revenue Cycle
_____ Safety

Do you know other individuals and/or families who have experienced care at Mon Health Preston Memorial Hospital who might be interested in serving as an advisor? Please fill out the following information.

Proposed Member Name: _____

Phone Number: _____

E-mail Address: _____

Mailing Address: _____

STREET *CITY* *STATE* *ZIP*

Medical Services Used by Member or Family Member:

_____

_____

_____

_____

_____

_____

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HIPAA Information

HIPAA stands for "Health Insurance Portability and Accountability Act" of 1996. It was created to protect individuals' medical records and other personal information at a national standard. With information broadly being held and transmitted electronically, the Privacy and Security Rules under HIPAA provide national standards regarding Protected Health Information (PHI).

HIPAA applies to any organization that routinely handles PHI in any capacity, such as a hospital, physician practice, lab, etc. This includes the entity where the volunteer/student will be spending time. The healthcare entities at PMH require staff, both clinical and non-clinical, volunteers, students, visitors, and observers to keep health information confidential.

Your educational endeavors at PMH may result in exposure to confidential information, including patient information. This information should:

- Only be accessed by employees or contracted personnel when the information is needed to perform health care options.
- Be protected to the extent possible.
- Remain confidential upon completing the educational/service experience.

Types of PHI:

A. Any health information that identifies an individual
B. Names
C. Dates relating to the individual
D. Telephone numbers
E. Fax numbers
F. Email addresses
G. Social Security numbers
H. Medical record numbers
I. Health plan beneficiary numbers
J. Account numbers
K. Certificate/license numbers
L. Vehicles identifiers
M. Device identifiers
N. Universal Resource Locators (URLs)
O. Internet Protocol (IP) addresses
P. Biometric identifiers - finger and voice prints
Q. Full face photographic images and comparable images
R. Testing results, research, and billing records that contain health information
S. Any other unique identifying number, characteristic or code

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Confidentiality & Behavior Statement

Access to the health care setting allows students or non-employees to use or to be exposed to information concerning employees, patients, their families, and hospital business, all of which may be confidential and/or proprietary. Confidential and/or proprietary information includes, but is not limited to, information pertaining to patient care, risk management, the medical staff, quality improvement, utilization review, budgets, revenues, debts, real estate developments, investments, financial statements, medical records, business plans, employee benefit programs, retirement plans, disciplinary actions, human resources issues, physician recruitment, business acquisitions, collaborative activities, mergers and joint ventures activities. This includes, but is not limited to, information that is verbal, written, computerized, faxed, emailed, audio or video taped, observed, or obtained through any other means.

For the purpose of this agreement, "confidential information" shall mean all such confidential and proprietary information that is not in the public domain to which the student or non-employee has access or exposure during their course of relationship with any entity of the Mon Health.

I agree that having been permitted to pursue my studies or to observe activities at Mon Health; I have a legal and moral responsibility to protect the confidentiality of privileged information to which I may be exposed during my educational activities or during my observation of patient care and daily facility operations. Accordingly, I agree during the course of my time at Mon Health and thereafter that I will not:

A. Use, disclose, or discuss any proprietary information or other confidential or patient-related information with any person or entity that does not need to know it.
B. In any way divulge, copy, release, sell, loan, alter, or destroy any confidential information except as properly authorized.
C. Discuss confidential information where others can overhear the conversation. It is not acceptable to discuss confidential information even if the patient's name is not used.
D. Attempt to access any computerized information to which I am not authorized
E. Encourage any past, present or future employee of Mon Health to violate the restrictions of this agreement.
F. Disclose my password(s) for gaining access to any Mon Health computer system; allow anyone to use the system under my sign on or use anyone else's passwords for access.
G. Make any unauthorized transmissions, inquiries, modifications, or purging of confidential information.
H. Access software systems to review patient records when I am not authorized. By accessing a patient's record, I am affirmatively representing to Mon Health that I have the patient's consent to do so, and Mon Health may rely on the representation in granting such access to me.
I. Take photographs in any areas of Mon Health entities. Texting, blogging, and posting comments regarding staff, MHS entities or patients on social networking sites are also prohibited.

Further, I will report activity that violates this agreement or any other incident that could pose a risk of non-compliance with Mon Health Corporate Compliance Standards. I will report possible violation or non-compliant activity to management or the Corporate Compliance Officer at 844-536-3273. I understand that Mon Health may take legal action against anyone who does not follow these established guidelines.

I understand that copies of the Bylaws, Policies and Procedures, and Rules and Regulations of Mon Health including those of its Medical Staff are always available in PolicyStat and the Quality Office and furthermore agree to abide by them. I always agree to comply with the standards of conduct of Mon Health and to conduct myself in a professional and positive interpersonal manner. I understand that Mon Health may prohibit me from continuing in my observation, shadowing, or educational-related experience if I do not follow these guidelines or if my personal behavior is disruptive or inappropriate.

Applicant Name (Please Print): _____

Applicant Signature:_____ **Date:** _____

Revised: 11/14/2021

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CRIMINAL BACKGROUND CHECK:

My last clear criminal background check was completed on: _____.

I certify that my criminal history has not changed since I last received this clear criminal background check.

I understand it is my responsibility to inform my supervisor and Community Programs of any changes in this status. I understand I will be relieved immediately of my service obligations for failing to notify them of such changes.

_____
Name

_____
Signature

_____
Date

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RELEASE

Please read this information carefully before signing below:

This release and waiver of liability is in favor of Preston Memorial Hospital (hereafter referred to as "Hospital") and their directors, officers, employees, representatives, agents, successors, assigns, and any and all persons or entities on Hospital's behalf who may be liable and, further, shall be binding upon the volunteer and his/her heirs, personal representatives, successors and assigns. The Volunteer/Student wishes to engage in activities related to being a Hospital volunteer/student, on hospital premises or elsewhere. The Volunteer/Student understands that engaging in these activities may expose him/her to dangers.

Release, Waiver, and Assumption of Risk:

Acknowledging that such risks exist, the Volunteer/Student does FULLY RELEASE the Hospital and its representatives from, and INDEMNIFY and HOLD HARMLESS Hospital against any and all claims, demands, actions, suits, and/or liability of any kind, for property damage and/or personal injury, including death, damages, expenses, costs, fees and/or liabilities related to engaging in these activities, including, but not limited to, property damage and/or personal injury, including death, caused in whole or in part by the negligence of Hospital or its representatives. The Volunteer/Student recognizes that if he/she is hurt and/or his/her property is damaged while engaged in these activities, he/she will have no right and waives the right, to make a claim or file a lawsuit against Hospital or any of its representatives, even if Hospital or its representatives caused the injury or damage. The Volunteer/Student understands that these activities may include work that may be hazardous. The Volunteer/Student assumes the risk of injury or harm, including death, and the risk of damage to personal property during these activities and releases Hospital and its representatives from any duty or obligation owed to the Volunteer/Student.

The Volunteer/Student releases and forever discharges Hospital and any of its representatives from any claim which may arise or result from any first-aid treatment or medical services rendered in connection with these activities.

In Witness where of Volunteer/Student, the undersigned, has signed this release on the date written above.

_____	_____
Applicant Signature	Applicant Printed Name
_____	_____
Witness Signature	Witness Printed Name

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Media Consent

Subject's Name (print) _____

Address, City, State, and Zip _____

Email and Phone Number _____

I hereby give consent to Mon Health Medical Center (MHMC), Preston Memorial Hospital (PMH), Stonewall Jackson Memorial Hospital (SJMH), Grafton City Hospital, The Village at Heritage Point, or Mon Health Equipment and Supplies to interview, film, photograph or create a video or audio recording of me. I authorize Mon Health to use and disclose the information about me for the purposes of creating press releases, news stories, photographs and/or video clips in which I or my likeness or voice may appear and/or be heard for use in publications, marketing, the Mon Health website (monhealth.com), Mon Health blog, Mon Health and its entities' social media including but not limited to: Facebook, Instagram, YouTube, and Twitter and/or disclosure to external news media.

The information disclosed may include, but is not limited to, my name, age, diagnoses, city and state of residence and photographs. The information may also be disclosed to external news media in the form of press releases, stories, photographs, video clips, audio recording or published on the Internet.

I understand the provision of healthcare treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization; however, the information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to re- disclosure.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released in a fashion described in this authorization at the time of the revocation. I can revoke this authorization by sending written, signed correspondence by U.S. Mail to Mon Health at the address listed above.

I hereby release, discharge, and agree to hold Mon Health harmless from all liability that may arise from the release of information authorized above.

This consent to photograph, film, interview or create a video or audio recording of me and authorization to release said media or to use or disclose the product of such film, interview, photograph or video/audio recording of me shall expire in ten (10) years from the date of the signature below.

Signature of Applicant: _____ **Date:** _____