WINGS TO SOAR
VOLUNTEER APPLICATION

All information is strictly confidential.

Volunteer Camp applications will be considered for appropriate positions, by Camp Administrator.

NAME: ____

STREET ADDRESS: ______________________________________

CITY: ______________________ STATE: _________ ZIP: __________

BIRTHDATE: ___________________ AGE: __________ GENDER: _______

SS# (required for background check): ___________________________

T-SHIRT SIZE: Small____ Medium ____ Large ____ XL ____ XXL ____

CONTACT INFORMATION:

HOME PHONE: _______________ WORK PHONE: _______________

CELL PHONE: _______________ EMAIL: ______________________

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: ___________________ RELATIONSHIP: ___________________

PHONE: (H) _____________ (W) _____________ (C) _____________

* For background check you will receive an email from "My Certiphi". Please respond in a timely manner.

EDUCATION (Highest grade completed): ___________________________

DRIVERS LICENSE #: ______________________________________

STATE: ___________________ ***EXPIRATION DATE***: _______________

CAR INSURANCE CO: __________________ POLICY #: _______________

As a camp volunteer you will be exposed to many different types of deaths, which may bring up multiple emotions that may need processing. Please free contact Shea at any time pre, during and post camp if needed.

Position approved ____

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Health History

All information provided is strictly confidential. So that this information is readily available at camp, all staff and volunteers must complete this form in its entirety.

HEALTH HISTORY (please check all that apply):

- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Hearing Impairment
- ☐ Physical Limitations
- ☐ Motion Sickness
- ☐ Wears Contacts/Glasses
- ☐ Heart Disease
- ☐ Special Dietary Needs
- ☐ Currently Taking Medication

Please explain any items that were checked or indicate any other useful information regarding your health:

____

____

Are you currently under a physician's care for a medical problem?	☐ Yes	☐ No
Do you carry and EpiPen?	☐ Yes	☐ No
Are you restricted from participating in any physical activity?	☐ Yes	☐ No

I know of no health reasons, other than information indicated on this form, why I should not participate in any of the Wings to Soar camp activities.

______________________________ ____________________

Signature Date

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Authorization for Emergency Medical Treatment

And Release of Liability Form

Should a medical emergency arise during my participation in Wings to Soar Camp and I am unable to speak for myself, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp Director, and
2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

______________________ ______________________ ______________

Name *(please print)* Signature Date

Health Insurance Information

Preferred Medical Doctor/Facility: ______________________________

Address: ______________________________

Phone #: ______________________________

Insurance Company: ______________________________

Policy Number: ______________________________

Policyholder's Name: ______________________________

General Release of Liability

I understand and agree that Hospice & Palliative Care of Cabarrus County, Board of Directors, Employees and Volunteers are released from any legal responsibility and/or liability for negligence arising out of any accidents or illnesses which occur at the Wings to Soar camp.

______________________ ______________________ ______________

Name *(please print)* Signature Date

WINGS TO SOAR

Atrium Health

WINGS TO SOAR
VOLUNTEER APPLICATION

EMPLOYMENT:

VOLUNTEER EXPERIENCE:

CLUBS/COMMUNITY ORGANIZATIONS/PROFESSIONAL AFFILIATIONS:

____

____

SPECIAL SKILLS AND TALENTS:

____

____

____

FIRST TIME APPLICANTS ONLY:

NAMES OF 3 PEOPLE WE MAY CONTACT FOR REFERENCE:

1. NAME: ______________________ PHONE: ______________________
   STREET ADDRESS: ____
   CITY: ______________________ STATE: __________ ZIP: __________
   RELATIONSHIP TO APPLICANT: ____
   OCCUPATION: ____
2. NAME: ______________________ PHONE: ______________________
   STREET ADDRESS: ____
   CITY: ______________________ STATE: __________ ZIP: __________
   RELATIONSHIP TO APPLICANT: ____
   OCCUPATION: ____
3. NAME: ______________________ PHONE: ______________________
   STREET ADDRESS: ____
   CITY: ______________________ STATE: __________ ZIP: __________
   RELATIONSHIP TO APPLICANT: ____
   OCCUPATION: ____

Office Use:
Background check sent ______________________ Background check completed______________

WINGS
TO SOAR

Atrium Health

WINGS TO SOAR
VOLUNTEER APPLICATION

Volunteer Statement of Confidentiality and Non-Disclosure

Campers and families have a legal right to expect that confidentiality of information will be preserved. Unlawful use or disclosure of information may expose an agency to civil and criminal liability. Any breach of confidentiality must result in the automatic dismissal of a volunteer.

1. Confidentiality means that all information about a camper and family is protected.

   Protected information includes all information about a camper and family, including name, cause of death, address, financial information, family relationships, and any information learned from the staff, camper, or family.

2. I *will not* disclose any information with anyone unauthorized to receive this information. I will handle all paperwork and forms with proper procedure of control so that no information is accidentally observed or released to any unauthorized persons. I also understand that the casual sharing of patient care information in public places or settings is inappropriate.

   Volunteers do not discuss the camper, emotional status, coping, or family information with anyone other than appropriate agency personnel. "What you hear and see here, stays here."

   Volunteers will discuss information only in private spaces and not in cafeterias, lobbies, waiting rooms, parking lots, or other public spaces in the agency, at the camp site or elsewhere.

   Volunteers must observe these cautions even if others occasionally forget them.

   Volunteers are not to initiate contact with or indicate that they know a camper or a camper's family in any place other than camp.

3. I *will* disclose such information only in the discharge of my assigned duties and responsibilities with Hospice or persons authorized to receive such information through the signed consent of patient, family member, or affected party.

   In your role as a camp volunteer, all matters should be kept confidential, except those matters related to instances of harm or threat of harm to any person, child abuse, or child neglect.

   No photographs or videotapes of any kind are permissible without a signed release form from the camper's parent or legal guardian. Volunteers must not allow anyone to photograph or videotape campers without staff permission and a signed photo consent form.

I understand that information regarding Hospice & Palliative Care of Cabarrus County patients, their families and/or significant others and any persons receiving bereavement support or services in any capacity is privileged information for use by and with authorized persons only. I further understand and agree that any violation of this policy is of such critical offense that it will justify my immediate discharge as a Wings to Soar camp volunteer.

Name *(please print)*	Signature	Date

Participating in Atrium Health Communications and Marketing

Atrium Health is committed to improving health, elevating hope, and advancing healing for everyone. Sharing your patient story can help us achieve that goal. Out of respect for your privacy and other rights, we would like your permission to use your health information and your images. Please review the below forms, and sign and date each of them as appropriate. If you have questions or concerns, please call our Corporate Communications, Marketing & Outreach department at 704-631-0930.

1. **For Patients Only:** If you are patient or the patient's parent/guardian/personal representative and you are giving us permission to use and disclose the patient's information, please sign and date the ***Authorization to Use and Disclose Information for Communication and Marketing***.

2. **For All Relevant Persons:** If you are giving us permission to use your image, likeness, and other forms that are unique to you in our marketing and communications materials (even if you are not a patient), please sign and date the ***Permission to Use Likeness*** form.

We appreciate your willingness to help us tell the story of Atrium Health and the work that we do every day to improve lives. Thank you!

Authorization to Use and Disclose Information for Communications and Marketing

This form authorizes us to use and disclose your patient/health information as described below.

Full Patient Name: ______________________________ **Date of Birth:** ______________	
Who can use and disclose patient information	Atrium Health (including its Corporate Communications, Marketing & Outreach department and contractors), and its associated foundations, entities, affiliates, and locations (collectively, "Atrium Health")
Types of patient information we can use and disclose	You give Atrium Health permission to use and disclose any health information in any form (print, photograph, audio/oral, interview, video, digital, televised, posted, streamed, and other electronic forms), that we think is relevant about you and your health care, including your name, age, city of residence, illness/injury, your story, how we cared for you, and your image, including any photographs, videos, or recordings in which you appear.
What we can do with your information (purpose)	Atrium Health can use and disclose your information to share your patient story internally and externally, to market Atrium Health and promote our services, to educate others about health issues and care, and to publish articles and give presentations. We may communicate your information in newspapers, magazines and other publications; radio, podcast, and television broadcasts; internet and intranet sites; marketing and public relations materials/publications; social media outlets; and in patient or public education materials and brochures.
With whom we can share your information	Atrium Health can disclose your information to: local, regional, or national media outlets, including on social media; the public; Atrium Health marketing and communication recipients; associated Atrium Health Foundations; and other third parties designated by Atrium Health.
How long this Authorization lasts	This Authorization will expire when Atrium Health no longer needs the information. Please note that uses and disclosures involving your information made or issued before the expiration date cannot be retracted, especially if they were already released publicly.

Please also understand that:

- Refusing to sign this form will not interfere with your ability to receive treatment, payment, enroll in our health plan, or be eligible for benefits from Atrium Health if available.
- You can cancel this Authorization at any time by sending written notice to Atrium Health Corporate Communications, Marketing, and Outreach, PO Box 32861, Charlotte, NC 28232-2861. Cancellations will apply only to information not yet used or disclosed by Atrium Health. Note that once Atrium Health uses and discloses your information, the person or entity receiving it may disclose or share that information with others and it may no longer be protected by federal and state privacy protections.
- Atrium Health will not share or use your health information without your authorization other than as required by law or in the ways listed in the Atrium Health Notice of Privacy Practices, available at www.carolinashealthcare.org.
- You have a right to receive a copy of this form upon request.

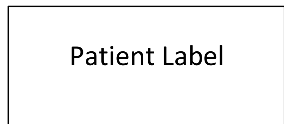
Signature: ____

Patient Name: ______________________________ Date: ____________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: ______________

Revision 04/18



Permission to Use Likeness

This form gives us permission to use your stories, image, voice, etc. under intellectual property laws. It is separate from the Authorization, which gives us permission to use and disclose your information under patient privacy laws.

I grant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health and its associated foundations, even if separately incorporated (collectively, "Atrium Health") a perpetual, world-wide, royalty free license and permission to record, use, disclose, portray, reproduce, broadcast, stream, post, print, and publish my (or the person on whose behalf I am serving as a personal representative, who will be included in the terms "my", "me", "mine", or "I") likeness, picture, video, information (including that released pursuant to an Authorization), story, quotes, and interview, whether in digital, electronic, paper, print, video, oral, or televised form ("Information") for Atrium Health's current or future internal and external marketing, fundraising, public relations, and educational purposes on behalf of Atrium Health (including on behalf of its hospitals, practices, programs, and associated foundations). I understand that such Information will be the exclusive property of Atrium Health, free and clear of any claim on my part and may be used in future video or print projects, in whole or in part.

I understand that I will not be compensated for the permissions, licenses, or use of the Information. I also understand that Atrium Health is only responsible for its own actions, and does not control third parties, including other media outlets. I understand that I can request that production of the recording be stopped at any time during production and I can revoke this Permission before the Information is used. On behalf of myself, my child, our heirs and representatives, I agree to release Atrium Health, their commissioners, directors, officers, and employees, from and against any liability related to their use of the Information.

Signature: ____

Patient Name: ________________________________ Date: ______________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: ______________

Patient Label