One

APPLICATION

Patient and Family Advisor or Advisor Council Member

Application includes:

- Request for Reference Contact Information
- Volunteer Agreement
- Confidentiality Agreement
- Volunteer Information and Release Authorization

Submit completed application to p-fadvisors@carolinashealthcare.org
or mail to: **Patient Experience Division**
Attn: Patient and Family Advisors
P.O. Box 32861
Charlotte, NC 28232

Background Check: Each applicant will be subject to a background check. Permission to run this background verification is provided within 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, e-mail or mail by a Carolinas HealthCare System employee.

Orientation: If accepted, you will be scheduled for a mandatory orientation. Our orientation covers the policies and procedures of Carolinas HealthCare System.

Please contact p-fadvisors@carolinashealthcare.org with any questions.
Thank you!

Carolinas HealthCare System

Personal Information

Name:____ Nickname:_______________

Street Address:____

City:______________________________ State:________________ Zip:__________

Home #:___________________________ Cell #:___________________________

Work #:___________________________

Email:____________________________

What is the best way to contact you? _______________________________________

Date of Birth*:____ Sex: Male Female

*Must be 18 years or older

Emergency Contact Information

Name:____

Relationship:___________________________ Home:________________________

Work:________________________________ Cell:__________________________

E-mail:____

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.

Mr./Mrs./Miss:____

Street:____

City:________________________________ State:__________ Zip:____________

Telephone:____

Email address:____

Relationship to applicant:______________________________________

Employment History (if applicable)

Most Current Employer:____

Position:________________________ Phone #:_____________________

Contact Name:____________________ Telephone:_________________

Title:____

Please select your preference

Setting *(check areas of interest)*

Skilled Nursing Facility   Hospice   Home Health   Inpatient (Hospitals/Acute Rehab)
Outpatient (i.e. Physician Office)   Behavioral Health

Location *(example: CMC-Pineville)*: ______________________________

Have you worked at any of the above mentioned facilities?   Yes   No

Where? ______________________________ When? ______________________

Have you volunteered at any of the above mentioned facilities?   Yes   No

Where? ______________________________ When? ______________________

Are you related to anyone employed by Carolinas HealthCare System?   Yes   No

If yes, please offer full name and his/her employment location:

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Commitment Terms

The time commitment required is dependent on the specific committee or project to which you are assigned. If selected, we will work with you individually to involve you in an area or team based on your availability and interest. Completion of application does not guarantee assignment.

Volunteer Agreement:

As a Patient and Family Advisor, I Agree

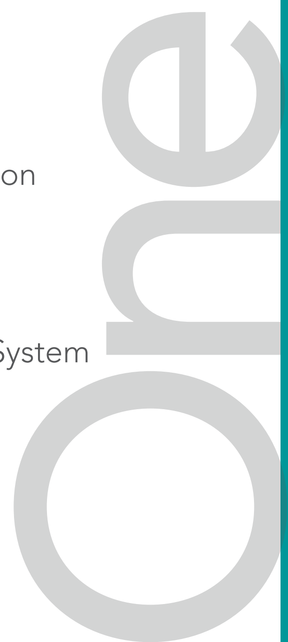
I hereby certify that the answers on this application and any resulting from interviews are true and correct and that any misrepresentations or omissions of facts, misleading, or false information on my part will be grounds for dismissal as a volunteer. Acceptance as a Patient and Family Advisor is contingent upon satisfactory references, verification of information submitted on the applications and satisfactory completion of mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions related to my application.

I understand that submitting my application does not guarantee assignment.

My services are donated to Carolinas Healthcare System without contemplation of compensation or future employment and given with humanitarian or charitable reasons.

I authorize Carolinas HealthCare System to administer emergency medical treatment to me while volunteering. I understand that Carolinas HealthCare System is not responsible for volunteers before or after their assigned shifts.

Applicant's Signature: ______________________ Date: ______________



Carolinas Healthcare System obtains arrest and conviction records on all potential volunteers.

An arrest or conviction will not automatically eliminate you from consideration for volunteering. However, failure to list all pending charges and/or convictions may lead to you disqualification or termination of volunteering at Carolinas Healthcare System. Examples include, but are not limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud and embezzlement.

Have you ever been convicted of any criminal violation of law, or are you now subject to a pending investigation of charges for violation of criminal law? If yes, please explain:

Please note

Your signature indicates your approval for us to check references and run a background check. Completing an application does not assure placement as a Patient and Family Advisor or council member since the number of applicants may exceed available openings. Submitting an application also does not obligate you to accept the assignment offered.

The first 90 days of the volunteer experience are mutually probationary. Opportunities for patient and family advisors are provided without regard to religion, disability, race, national origin, age or sex.

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?

Are there any areas of special interest to you?

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

Confidentiality Agreement

Carolinas HealthCare System has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment(s) at Carolinas HealthCare System, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services. I understand that such information must be maintained in the strictest confidence. I understand that I can only use patient information for proper purposes under this Agreement, and that I cannot use it at all after my assignment ends.

As a condition of my assignment, I also agree that I will not, at any time during or after my assignment, disclose any patient information to anyone outside of Carolinas HealthCare System. When I need to discuss patient information with the health care practitioners in the course of my duties, I will use discretion to ensure that such conversations will not be held in a public place or with unauthorized individuals. I will participate in all required HIPAA and privacy training, and I will follow privacy and security policies and requirements. I will not take any patient information with me off-site, and I will put patient information only in an approved shred bin. I will not use any personal devices to take any pictures of patients or providers, record conversations with patients or providers, or take pictures of any patient or other information that is proprietary to Carolinas HealthCare System.

I understand that if I am currently, or have been in the past, a patient of Carolinas HealthCare System, any disclosure of my own information is voluntary and my choice. This includes any conversations I may have with other patients where I share my story, or any comments I make in council or other meetings. I understand that Carolinas HealthCare System is not responsible for what other patients or family members do with that information when I share it. If I would like for Carolinas HealthCare System to disclose information from when I was a patient, I understand that I will need to sign an Authorization.

I understand that violation of this agreement may result in termination of my assignment at Carolinas HealthCare System.

_______________________________________ ____________

Printed Full Name of Applicant Date

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Signature of Applicant

Volunteer Information and Release Authorization

Terms of Volunteer Service

Because volunteer service as a Patient and Family Advisor is based on mutual consent, both Carolinas HealthCare System and you may terminate your volunteer service at any time, for any reason, with or without cause, and without prior notice. All Carolinas Healthcare System decisions with regard to termination of volunteer service are based on Carolinas HealthCare System policies and procedures. Carolinas HealthCare System values integrity in the workplace. Any false or misleading representations or omissions contained in your Patient and Family Advisor application may disqualify you from further consideration for volunteer services and may result in discharge even if discovered at a later date. The System may contact any persons and organizations named in your volunteer application to confirm or explain the information provided.

Background Verification Disclosure

As part of the volunteer services process, Carolinas HealthCare System may obtain a Consumer Report and/or an Investigative Consumer Report. The Fair Credit Reporting Act as amended by the Consumer Reporting Reform Act of 1996, requires that we advise you that for purposes of volunteer services, a Consumer Report may be made which may include information about your criminal record, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided in the event the report contains information regarding your character, general reputation, personal characteristics, or mode of living. Examples may include, but should not be limited to: driving while impaired, worthless checks, assault, driving while license is suspended, disorderly conduct, credit card fraud, embezzlement, etc.

Authorization, Acknowledgement and Release

During the application process and at any time during my affiliation with Carolinas HealthCare System, I hereby authorize BIB – Background Investigation Bureau, on behalf of Carolinas HealthCare System to procure a Consumer Report which I understand may include information as described above. This report may be compiled with information from credit bureaus, courts record repositories, departments of motor vehicles, past or present employers and education institutions, governmental occupational licensing, or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification, to the extent such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living.

I understand that I must report, in writing, any offense to the Patient Experience Division by the next assignment. I further acknowledge that failure to report an offense will be grounds for immediate termination of my participation in the program. I understand that I must report, in writing, any conviction or sanction to the Patient Experience Division within five days of the occurrence. I further acknowledge that failure to report a conviction or sanction will be grounds for immediate termination of my participation in the Patient and Family Advisor program. I authorize the ongoing procurement of the above-mentioned reports at any time during my volunteer experience. My signature releases any liability against Background Investigation Bureau, Inc. or its acting agents. A photo or fax copy of this release form will be valid as an original thereof, even though said copy does not contain an original writing of my signature.

Name *(Last, First, Middle)*:____

Please print

Maiden or Other Name Used:______________________________________

Social Security Number:____________________ Date of Birth:______________

Current Address:____

How long have you lived at this residence?____________________________

(If less than 7 years, please indicate all previous addresses during this period below. Please attach an additional sheet if needed.)

Address:____

Address:____

____ ______________

Signature Date