NEMOURS CHILDREN'S HEALTH

Volunteer Program

Required Forms

The following five forms should be completed and scanned back to us as one document labeled: *Your last name, Your first name –Basic*.
(Example: Doe, John – Basic)

1. Adult Abuse Authorization Form
2. Child Abuse Authorization Form
3. Volunteer Confidentiality Agreement
4. Authorization to Release Photo/Video/Audio Form
5. Code of Conduct, Commitment & Quality (2 pages)

Also, please complete the Immunization record following the instructions on the form. Scan the completed form back to us labeled: *Your last name, Your first name – Medical.*
(Example: Doe, Jane – Medical)

1. Immunization Record

Please do not fax to the State! Needs to be returned to the Volunteer Services Office.

DELAWARE HEALTH & SOCIAL SERVICES
Division of Long Term Care Residents Protection
Adult Abuse Registry
3 Mill Road, Suite 308
Wilmington, DE 19806-2164

AUTHORIZATION TO DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF LONG TERM CARE RESIDENTS PROTECTION FOR THE RELEASE OF ADULT ABUSE REGISTRY INFORMATION

Employer: **Nemours Children's Health**

Address: **1600 Rockland Road**
Wilmington, DE 19803

I hereby authorize the indicated employer to obtain from the Division of Long Term Care Residents Protection any information concerning me which may be on the Adult Abuse Registry pursuant to 11 Del. C., § 8564.

APPLICANT **(Black or Blue Ink Only)**

_____ _____
PRINT NAME SOCIAL SECURITY NUMBER

_____ _____
SIGNATURE DATE

8/2021

DSCYF
Department of Services for Children, Youth & Their Families

DELAWARE CHILD PROTECTION REGISTRY CONSENT FORM

Web Portal

Request must be within 90 days of signature date in order to be processed

PART I - APPLICANT INFORMATION

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

Other Name(s) used/Alias: _____

Social Security #: _____

Date of Birth (mm/dd/yyyy)*: _____

Gender*: _____

Race: _____

Ethnicity: (Hispanic/Non-Hispanic) _____

Address (Street, City, State, Zip): _____

Are you on the Delaware Child Protection Registry for any substantiated cases of child abuse/neglect? Yes ☐ No ☐

If yes, explain:

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named requester(s) with all substantiated cases of child abuse or neglect concerning me that are active on the Delaware Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: _____

Date: _____

Parent/Guardian Signature (If applicant is under the age of 18):

PART II - REQUESTER INFORMATION

Check one option below and complete required information*:

1. ■ Agency Request – Agency Name*: **Nemours Children's Health, Delaware Valley - Volunteer Services**

2. ☐ Individual Request – Self

3. ☐ Individual Request – Share Results with Requesting Agency

   Requesting Agency 1 – Agency Name*:

   Requesting Agency 2 – Agency Name*:

   Requesting Agency 3 – Agency Name*:

   Requesting Agency 4 – Agency Name*:

   Requesting Agency 5 – Agency Name*:

* Mandatory (Agency Name is Mandatory.)

NEMOURS VOLUNTEER SERVICES CODE OF CONDUCT, COMMITMENT & QUALITY

DEPENDABILITY AND QUALITY OF WORK

- I will be punctual and conscientious about coming to volunteer and carrying out assignments.
- I will complete the minimum hour's requirement set by Volunteer Services.
- I will notify my supervisor and Volunteer Services about my anticipated absence.
- I will record my service hours accurately. I may request a print out of hours after the minimum time commitment is met.

SERVICE EXCELLENCE

- I will exhibit a pleasant attitude and utilize **AIDET** principles for Service Excellence.
- I will utilize the 4 service standards: Listen, Empathize, Apologize, Problem-solve.
- I will attempt to make every interaction with patients and families a "WOW" moment.

WORKING WELL WITH STAFF

- I will smile and greet the staff when I arrive to volunteer.
- I will keep my supervisor informed about my progress and any needs that I have to insure the successful completion of tasks.

LIMITS AND BOUNDARIES

- If I am physically, educationally, or emotionally unprepared to do a task, I will politely decline the task and request another task that I can safely perform.
- If I am asked to perform tasks that I have not been properly trained to perform, I will request and receive additional training before attempting the task.
- I understand that new tasks or duties that are not listed on my Position Description must be approved in advance by Volunteer Services.

CONFIDENTIALITY, CORPORATE COMPLIANCE AND BUSINESS PRACTICES

- I will respect and protect confidential information by abiding by all the confidentiality policies of the hospital and the federal regulations of the **H**ealth **I**nsurance **P**ortability & **A**ccountability **A**ct.
- I will not discuss any information I hear or read concerning patients, staff or hospital business.
- I will not make comments or ask question of patients/families about diagnosis, prognosis, or treatment.
- I will share patient concerns/questions directly to appropriate staff members.
- I will abide by Nemours Corporate Compliance, Ethics, and Business Practice Standards and policies.
- I will safeguard Nemours assets, property, and information.
- I will help maintain a safe, healthy environment as safety is everyone's responsibility.

VOLUNTEER VALUE AND STATUS, APPEARANCE, IDENTIFICATION, AND UNIFORM

- As a valued team member, I will suggest improvement ideas such as ways to offer better programs, contain costs, increase service excellence, and insure safety and security.
- I will communicate any concerns or needs to my supervisor and/or the Volunteer Services Director.
- As a volunteer, I agree to work without expectation of compensation now or in the future.
- I will be well-groomed, neat, and clean in person and in dress. I will wear the correct Nemours volunteer uniform and ID badge at all times while I am on duty and conform to the appearance guideline.

TERMINATION POLICIES

- I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of failure to abide with hospital policies, rules, and regulations; absences without prior notification to both the Volunteer Department and to my supervisor; unsatisfactory attitude, work performance, or appearance and any other circumstances which, in the judgment of the Director of Volunteer Services, would make my continued service as a volunteer contrary to the best interests of the hospital and/or those we serve.
- Upon termination of my service to the hospital, I understand that it is my obligation to return my identification badge and my volunteer uniform.

I have read, understand, and will comply with the Nemours Volunteer Services Code of Conduct, Commitment, and Quality statements and the Nemours Children's Health's policies and procedures. Failure to comply may result in dismissal from the program.

Print Name: _____Signature: _____Date: _____

NEMOURS CHILDREN'S HEALTH

NEMOURS VOLUNTEER SERVICES
CODE OF CONDUCT, COMMITMENT & QUALITY

SERVICE EXCELLENCE

- I will exhibit a pleasant attitude and utilize **AIDET** principles for Service Excellence.

A	**ACKNOWLEDGE** Goal: Establish trust by demonstrating empathy. • I will make eye contact, smile, and give a cheerful comment/greeting to everyone I meet. To be courteous, I will stop what I am doing so others will know that they are important. • I will conduct myself appropriately with dignity and courtesy. • I will work, walk, and talk quietly so I will not disturb others.
I	**INTRODUCE** Goal: Reduce anxiety by sharing with the patients the skill set and experience of those that will be caring for them. • I will extend a welcome and introduce myself: "Hello, I am _____. I have been a volunteer here at Nemours for ___days/months/years. • I will promote a philosophy of respect, use good manners, and be gracious. • I will use appropriate language and gestures. I will be friendly, but never familiar — interested, but not inquisitive. I will refrain from asking medical questions of patients. • I will respect the cultural diversity and personal belief systems of others. • I will respect other's personal belongings. • I will "manage up" other associates and departments to acknowledge excellence.
D	**DURATION** Goal: Reduce anxiety by establishing time expectations. • I will do whatever it takes to make every contact a uniquely satisfying experience. • I will check with staff on the anticipated wait time to keep the patients informed so they do not feel forgotten. I will notice when others need special attention or help.
E	**EXPLANATION** Goal: Enlist the patient in the care plan. • I will explain the procedure or process that I will use to provide service to others. • I will offer to answer any questions, respond to concerns, or resolve any complaints.
T	**THANK YOU!** Goal: Thank the patient and family for trusting us and letting us care for them and provide a final opportunity for the patient to share any concerns or questions. • I will show appreciation for the trust the family has given Nemours: "Thank you for choosing and trusting Nemours to care your child. I have really enjoyed getting to know you all today. Is there anything more I can do for you?"

VOLUNTEER CONFIDENTIALITY AGREEMENT

I understand that I may be exposed to information regarding Nemours' Associates, visitors, patients, business practices, or other information of Nemours (collectively, the "Confidential Information") when I am present at a Nemours site or when performing volunteer services at any Nemours or outside location on behalf of Nemours. I agree to keep all Confidential Information strictly confidential and agree not to disclose to anyone or use for any purpose any Confidential Information without specific authorization in advance in writing by the Nemours site Administrator. The term Confidential Information does not include information regarding Nemours which is already in the public domain through the marketing efforts of Nemours or as reported in the media.

I also understand that protected health information (PHI) regarding patients of Nemours is protected from unauthorized disclosure by state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). I have been provided training regarding protected health information, HIPAA and other confidentiality laws and agree to keep strictly confidential any information regarding the identity, diagnosis, treatment, and financial, family or social situation of any Nemours patient.

I understand that Nemours has many policies and procedures regarding its business and patient operations which may be relevant to my service as a Nemours Volunteer. I have received information and training on these policies and procedures and agree to comply with those policies and procedures that are applicable to the services I provide on behalf of Nemours as a Nemours Volunteer. I also understand that if I need additional information or have questions regarding any policy or procedure, I should ask Volunteer Services or the site Administrator at the Nemours location where I provide services, as appropriate.

I understand that my failure to comply with Nemours policies and procedures, or to adhere to the confidentiality requirements of this Agreement, may result in my dismissal as a Nemours Volunteer and could subject me to legal action. I also understand that I am still obligated to comply with my confidentiality obligations under this Agreement even after I am no longer serving as a Nemours Volunteer.

Finally, I understand that my signing this agreement does not transform my status at Nemours from that of a volunteer into an employee or provide me with any other contractual rights. I agree to the obligations and responsibilities stated above.

_____ _____

Print Name of Volunteer Signature of Volunteer

_____

Today's Date

NEMOURS CHILDREN'S HEALTH

Authorization to Release Photo/Video/Audio for Publication

Adult, Non-Associate

1. I, (print name)_____, authorize Nemours Children's Health to USE AND/OR DISCLOSE the above-named person's information and story with media outlets, social media channels and networks, advertising, websites, public marketing, promotional materials, training and/or presentation and other similar venues.

2. The following people and/or media organizations will have access:
   Nemours Social Media Outlets and Volunteer Recognition Wall

3. This authorization will expire:
   - ☐ On a specific date (if checked, enter the date) _____
   - ☐ After the completion of the following event/service/project _____
   - ☑ 10 years from date this form is signed

I understand that:

- I can change my mind and revoke this authorization, in writing, at any time, by sending a written revocation to the Nemours Children's Privacy Officer at 10140 Centurion Parkway North, Jacksonville, Florida 32256 or call 800.472.6610.
- Information used or disclosed may be redistributed by the recipient and may no longer be protected by Federal or state confidentiality law.
  – It is common that disclosures for broadcast or publication will include posting the materials onto web, social media or similar sites. Once this occurs your information will be publicly available and freely distributed.
- I will receive a copy of this Authorization.

Signature _____ Date _____

Printed Name _____

Email Address _____ Home Phone # _____ Cell Phone # _____

To be completed by associate:

Purpose of photo/video: Promote Volunteer Services

Situation in photo/video: Varies

Patient's gender ☐ Male ☐ Female ☐ Nonbinary ☐ Prefer not to answer

Adult's description in photo/video (hair color, clothing):_____

Name of staff person: Judy Lieberman

Department: Volunteer Services

Location: Delaware Valley

Specific location in hospital or clinic in photo/video: _____

Date photo/video taken: _____

Nemours Children's includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware, Nemours Children's Hospital, Florida, Nemours Children's Hospital, Surgery Center, Bryn Mawr and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.

NEMOURS CHILDREN'S HEALTH

Immunization Record
Volunteers

Please provide a copy of your immunization record by either method below:

- **Have a Licensed Provider complete *and* sign this form *OR***
- **Attach a copy of your immunization record to this form in lieu of a Licensed Provider's Signature**

Name: _____ Date of Birth: _____

Dates of Mandatory Immunizations

MMR (measles, mumps, rubella): 1) _____ 2) _____
Titer Date: _____ Immune: ☐ *OR* Not Immune: ☐

Varicella (Chicken Pox) Vaccine: 1) _____ 2) _____
Titer Date: _____ Immune: ☐ *OR* Not Immune: ☐

Flu Shot Date: (Applies during Flu Season only, November- April): _____

COVID Vaccine: A copy of your vaccination card is required. Please send a copy to Volunteer Services

Recommended But Not Required Immunization

TdaP (Tetanus, Diphtheria and Acellular Pertussis) vaccine: Date: _____

Tuberculosis Testing:

Two Step TB skin test is required. Specifically, a TB skin test recorded within the preceding year can be used for the "first step"; another recorded within the last 6 weeks can be used for the "second step."

TB Skin Test #1 (must be within the past year): Date Read: _____ Results: _____mm

TB Skin Test #2 (must be within the last 6 weeks): Date Read: _____ Results: _____mm

OR

Negative Quantiferon Gold test result or equivalent (Must be within the last 6 weeks): Date: _____

Provider's Printed Name: _____ Address: _____

Licensed Provider's Signature: _____ Date:_____

This form and any attachments may be emailed to volunteers@nemours.org *OR* hand-delivered to the Volunteer Services office.