



Process for Visiting Clergy to Receive Badges

Thank you for your interest in volunteering as a visiting clergy at Slidell Memorial Hospital. You will find this a very rewarding experience.

Attached is the application, background check consent form and confidentiality agreement. We will need these forms returned as well as **one of the following documents**:

- Certified copy of graduation diploma/certificate from an accredited theology school
- Certification of Affiliation with Church Denomination
- Letter Certification of Pastorship from Church
- Certification of State Licensure

Once these documents are received and the background check completed, we will contact you to schedule a day/time for you to be TB tested and to receive a flu shot.

Please feel free to call me at 985-280-8531 or email me at Laurie.Manley@SlidellMemorial.org with questions. I look forward to meeting you.

Sincerely,

A handwritten signature in blue ink that reads "Laurie".

Laurie Manley, CAVS
Volunteer Coordinator



CLERGY APPLICATION

DATE: _____

NAME: _____
Last First Middle

HOME ADDRESS: _____
Street City/State ZIP

PHONE: _____ (h) _____ (c)

CHURCH AFFILIATION: _____

DATE OF BIRTH: _____
Month Day Year

E-MAIL ADDRESS: _____

IN CASE OF EMERGENCY CONTACT:

Name Home Address Phone

RELATIONSHIP: _____

SIGNATURE OF APPLICANT _____

Date: _____

Department: Volunteer Services

PLEASE READ CAREFULLY

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

We truly welcome your application to volunteer with, **SLIDELL MEMORIAL HOSPITAL**, (hereinafter referred as "Company"). We're proud that our success is the result of the quality and caliber of our volunteers. You are applying for a position whose acceptance will place you in a category of recognized Professionals. In pursuit of that excellence we require, as a condition of placement, and/or continued placement, that all applicants consent to and authorize a pre-volunteer verification of the background information submitted on their application or resume.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of volunteering is true and complete to the best of my knowledge. I understand that if I am accepted as a volunteer any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this company may now, or at any time while you are a volunteer, administer a personality profile, conduct a verification of your education, previous employment/work history, credit history, contact personal references, require that you provide a urine specimen to be tested for the presence of drugs or alcohol, motor vehicle records, worker's compensation from the Department of Labor and/or the Worker's Compensation Commission, and to receive any criminal history record information pertaining to me which may be in the files of any Federal, State, or Local criminal justice agency in any State and/or other information as deemed necessary to fulfill the job requirements.

In conformance with the Americans Disabilities Act, I acknowledge by my **signature** _____ that I have been offered a volunteer position, contingent upon a satisfactory background investigation, and therefore, worker's compensation information obtained from the Department of Labor and/or the Worker's Compensation Commission is hereby authorized. If blank, the obtaining of worker's compensation information is not authorized. The results of this verification process will be used to determine eligibility under this Company's employment policies.

I authorize Employment Research Services, (hereinafter referred as "ERS"), and any of its agents/designated by Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of this Company.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide ERS and Slidell Memorial Hospital with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge the Company, our agent, ERS, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if volunteering was denied based on information obtained by SMH, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

Volunteer: Please Print

_____, SS#: _____
Last (Maiden) First M.I. U.S. Citizen: Yes _____ No _____

Address: _____
Date of Birth: _____

Telephone # Home _____ Cell _____ Alternate _____

Excluding current residence, list the last two City, State and ZIP codes that you have lived in:

Signature: _____ Date: _____

Client # : 402-H25



CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

IMPORTANT: Please read all information below. If you have any questions regarding this agreement, please ask them of the Volunteer Coordinator or the Director of Human Resources before signing. A copy of this agreement will be provided to you.

ACKNOWLEDGMENT

I recognize and acknowledge the following:

- The services Slidell Memorial Hospital ("SMH") performs for its patients/providers are confidential;
- To enable SMH to render those services, its providers/patients furnish to SMH confidential information concerning their affairs;
- The goodwill of SMH depends, among other things, upon keeping such services and information confidential;
- Because of my duties, I may come into possession of information concerning the services performed by SMH for its patients/providers even though I do not take any direct part in or furnish the services performed for those patients/providers;
- Disclosure of any such information by me may cause irreparable injury to SMH and the owner of the information; SMH or the owner of the information may seek legal remedies against me;
- Computer information belonging to SMH, its patients, providers or vendors is confidential; and disclosure of such information, revealing passwords, PIN numbers, etc., or granting access to such information by me, may cause irreparable injury to SMH or the owners of such information;
- Violations of my duty to maintain the confidentiality of all confidential information will subject me to appropriate disciplinary action according to SMH's progressive discipline policy (HR-770), up to and including dismissal, or such action allowed by law or contract.

AGREEMENT

I accordingly agree that, except as directed by Administration:

- I will not at any time during or after my volunteer service to SMH, disclose of any such services or information to any person or permit any person to examine or make copies of any reports or documents prepared by me or coming into my possession or under my control;
- I will retain all information belonging to any vendor, provider, patient or SMH in strictest confidence, and will not release such information or materials to anyone or use any such information for any purpose except to perform my duties at SMH;
- I will at all times comply with the confidentiality and information systems security policies in effect at SMH.

I have read and understand all of the above sections of this agreement.

Signature

Date

Print Name