St. Dominic Hospital
Volunteer Services

I understand that the volunteer online orientation contains general information and guidelines. It is not intended to be comprehensive or to address all applications of, or exceptions to the general policies and procedure described. I am volunteering solely for personal purposes or benefit without promise or expectation of compensation, benefits or future employment from St. Dominic Hospital.

I agree to familiarize myself with, and abide by, the St. Dominic Hospital's rules and policies regarding conduct, confidentiality, safety and welfare. I understand that I may be subject to the same pre-employment screening and background checks as paid employees.

My signature below represents my acknowledgment that I understand and will abide by the policies and procedures of the Hospital as outlined in the on-line Orientation to include:

- HIPPA – Patient Confidentiality
- Safety
- Emergency Preparedness
- Infection Control
- Customer Service
- Parking and Meal Benefit
- Human Resources Requirements

_____ _____

Volunteer Signature Date

_____

Print Name

St. Dominic's Hospital
Information Systems Security
Acknowledgment and Nondisclosure Agreement

It is the policy of St. Dominic-Jackson Memorial Hospital that all hospital information or patients' individually identifiable health information, in any form, whether written, spoken, recorded electronically, or printed, will be protected from accidental or intentional unauthorized modification, destruction, or disclosure. All information system equipment, such as computers, must be protected from misuse, unauthorized use, and destruction. Physical and software-oriented security measures will be used to protect information and equipment. Confidential information is valuable and sensitive and is protected by law and by strict St. Dominic-Jackson Memorial Hospital policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires protection of confidential information contained within a healthcare information system. Inappropriate disclosure of patient data may result in imposition of fines up to $1,500,000 and a felony conviction under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

All associates of St. Dominic's will agree to abide by the following statements. Associates include employees, students, volunteers, physicians, consultants, and contractors.

A. In the performance of my duties, I may come in contact with confidential or sensitive information contained in written, verbal, or electronic records, documents, ledgers, or correspondence, or some other medium. This information may be related to hospital business or to patients, employees or other associates of the organization. I agree not to disclose any confidential or sensitive information unless release of such information is directly required for the delivery of care for my patient or I have been authorized by administration to disclose such information, or pursuant to a court order. This nondisclosure agreement applies during and after my affiliation with St. Dominic-Jackson Memorial Hospital.
B. All passwords to information are confidential. Under Mississippi Code 1972: Sec. 97-45-5 (1)(b) , it is a computer crime to use another person's password or disclose passwords to another for the purpose of obtaining unauthorized access to computer systems. I will not disclose any password(s) I am assigned, and I will not write such passwords(s) or post them where they may be viewed by another. I understand that I will be held responsible for all computer activity performed with the use of my password.
C. I will not violate any computer security system by using or attempting to access any software, files, medical records, or other resources that I am not authorized to use. All access is granted on a need-to-know basis only, as required to accomplish certain job responsibilities. Unauthorized access may constitute a violation of federal and state laws.
D. I will not deliberately sabotage computer equipment or software. I will not make or distribute unauthorized copies of software. I will not load unlicensed software or software unauthorized by the organization on any computer belonging to St. Dominic-Jackson Memorial Hospital.
E. I agree to comply with all policies and procedures of St. Dominic's that have been adopted to safeguard information and resources. I will not conduct any activity that might violate state or federal laws. I acknowledge that I understand the security policies outlined above.
F. I understand that failure to comply with any of these conditions may result in disciplinary action, including loss of medical staff and clinical privileges. I understand that St. Dominic-Jackson Memorial Hospital retains the right to pursue any other legal remedies available when misuse of its information and/or information resources is suspected.

My signature below represents my acknowledgment that I understand and will abide by the security policies as outlined above.

_____ **(Signature)**

_____ **(Print Name)**

_____ **(Position)**

_____ **(Date Signed)**

Consent to Volunteer at Hospital

I have volunteered to participate in a non-clinical experience at St. Dominic-Jackson Memorial Hospital ("Hospital"). In addition to the other training and expectations about which I have been informed I understand that I will need to strictly follow all Hospital guidance relating to the use of personal protective equipment ("PPE") and other directives which are part of the Hospital's COVID-19 plan. I acknowledge that I have been provided training on these issues and have been given the opportunity to ask any questions I may have about these matters. I understand that PPE may not be effective in preventing viral transmission and that there is a risk I could contract COVID-19 or other illness while participating in the non-clinical experience. I understand that the Hospital may require that I monitor my temperature or may take my temperature and/or assess other symptoms or safety issues relating to me. This could include, but is not limited to, my travel or other potential exposure risks. I may be required to take a COVID-19 test at any time and provide those results to the Hospital. I must promptly inform the Hospital of any symptoms, positive test, or exposure issues prior to coming on Hospital property during the term of any non- clinical experience. I may be required to quarantine and may be prevented from coming on Hospital grounds except for treatment purposes at the sole discretion of the Hospital at any time.

I waive any and all rights or claims I may have against the Hospital for any liability relating to my acquiring COVID-19 or any other illness regardless of how such illness is contracted, except for liability for damages caused by gross negligence or willful misconduct.

_____

Individual's Printed Name

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Signature of Individual (or Parent/Guardian if Individual is a minor)

Date:_____