**Charlotte Hall Veterans Home**
**29449 Charlotte Hall Road**
**Charlotte Hall, MD 20622**
***Serving Those Who Served!***

VOLUNTEER AGREEMENT: I agree to adhere to the policies and procedures of this healthcare facility and to respect the confidentiality of information pertaining to the patients and their treatment. The Charlotte Hall Veterans Home is a state building and, as such, must be open to the public. Our employees, patients and volunteers come from diverse backgrounds. Eligible veterans are entitled to services offered by the Maryland Department of Veterans Affairs, even if they have had problematic incidents in their past – unless the law specifically disqualifies them. Our job is to provide veterans care and to protect our employees, patients and volunteers as that care is provided. If a patient, staff member, volunteer and/or visitor is abusive, makes inappropriate gestures, advances or conversation that is in a manner which makes me feel uncomfortable, I will immediately inform my supervisor or the Director of Volunteer/Community Outreach.

Signature: _____ Date: _____

NAME: DATE:

ADDRESS: HOME PH:

WORK PH:

AGE RANGE: 18-29 30-49 50-64 65+

Please give a brief description of any previous volunteer or community service:

Please List the names of any veteran or community organizations you are a memeber of:

Please list any hobbies or skills you want to share with our veterans:

Please list any health and/or physical problems, limitations:

Please mark the best time for you to volunteer:

| | MON | TUES | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| MORNING | | | | | | | |
| AFTERNOON | | | | | | | |
| EVENING | | | | | | | |

Please mark the areas/departments you would like to volunteer your services:

| | | | | |
|---|---|---|---|---|
| Activities | Housekeeping | Personnel | Admissions | Maintenance |
| Business Office | Medical Records | Social Services | Food Services | Nursing |

I would like to participate:

Weekly Monthly Occasionally on request

Please provide a brief work history:

Have you ever been arrested or convicted of a crime? If yes, please explain:

Parental Permission (if under 18):

When was your last TB vaccination:

Are you a Veteran? if yes, please provide branch of service and years served:

Please provide 3 references (excluding relatives):

NAME CONTACT # RELATION:

Name of High School if still attending:

Please provide us with a contact in case of emergency:

Name:

Address:

Contact #

Your Signature:

## MEDICAL HISTORY FORM

Please provide the following information regarding you/your child's health history:

NAME: _____

SOCIAL SECURITY NO.: _____ / _____ / _____

DATE OF BIRTH: _____ / _____ / _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

EMERGENCY CONTACT: _____
PHONE NO.: _____
RELATIONSHIP: _____

Please answer YES or NO to the following questions and provide additional details where requested.

| | | YES | NO |
|---|---|---|---|
| 1. | Have you ever had an epileptic seizure? | _____ | _____ |
| 2. | Have you ever been told by a doctor that you have epilepsy? | _____ | _____ |
| 3. | Have you ever been treated for diabetes? | _____ | _____ |
| 4. | Have you ever been told by a doctor that you were anemic?<br>When? _____ What treatment? _____ | _____ | _____ |
| 5. | Do you have or have you ever had high blood pressure?<br>List any medication: _____ | _____ | _____ |
| 6. | Do you have or have you had the following diseases?<br>(Heart disease, heart murmur, rheumatic fever, other)<br>Give name and date: _____ | _____ | _____ |
| 7. | Lung disease (pneumonia, other)?<br>Give name and date: _____ | _____ | _____ |
| 8. | Kidney disease (infections, other)?<br>Give name and date: _____ | _____ | _____ |
| 9. | Liver disease (mononucleosis, hepatitis, other)?<br>Give name and date: _____ | _____ | _____ |
| 10. | Have you ever been told by a doctor that you have asthma?<br>List any medication: _____ | _____ | _____ |
| 11. | Do you have or have you ever had a hernia or "rupture"? | _____ | _____ |
| 12. | Have you ever become unconscious in the past 3 years?<br>If so, describe and give date(s): _____ | | |

| | | YES | NO |
|---|---|---|---|
| 13. | Have you had a concussion or other head injury in the past 3 years?<br>If so, describe and give date(s): _____ | _____ | _____ |
| 14. | Have you stayed overnight in a hospital due to a head injury? | _____ | _____ |
| 15. | Have you ever had a neck injury involving bones, nerves or disks that disabled you for a week or longer?<br>Type of injury _____ Date(s): _____ | _____ | _____ |
| 16. | Do you wear glasses or contacts? | _____ | _____ |
| 17. | Have you had a broken bone (fracture) in the past two years?<br>What bone? _____ Right or left? _____<br>Date(s): _____ | _____ | _____ |
| 18. | Have you had a shoulder injury in the past two years that disabled you for a week or longer (dislocation, separation, etc.)?<br>Type of injury _____ Right or left? _____<br>Date(s): _____ | _____ | _____ |
| 19. | Have you ever injured your back? | _____ | _____ |
| 20. | Do you have back pain?<br>Circle all that apply:<br>seldom, occasionally, frequently, with exercise, with heavy lifting | _____ | _____ |
| 21. | Have you had a shoulder injury in the past 2 years that disabled you for a week or longer (dislocation, separation, etc.) | _____ | _____ |
| 22. | Have you ever had shoulder surgery?<br>What was done and why? _____ | _____ | _____ |
| 23. | Have you injured your knee in the past 2 years? | _____ | _____ |
| 24. | Have you been told by a doctor that you injured cartilage in your knee?<br>Right or left knee? _____ Date(s): _____<br>Have you ever had knee surgery?<br>What was done and why? _____ | _____<br><br><br>_____ | _____<br><br><br>_____ |
| 25. | Have you ever been treated for depression or anxiety? | _____ | _____ |

Do you have any other conditions that we should be aware of (i.e., ulcers, pregnancy, food or insect allergies, tendonitis, etc?) _____

Please give the dates of your last known tetanus and polio shots:

Tetanus: _____ Polio: _____

I certify that the responses to the questions on this form have been answered completely and truthfully to the best of my knowledge (or by parent, if completed on behalf of a minor).

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature: _____
(if volunteer is a minor)

Health Management Resources, Inc.

# PRIVACY ACKNOWLEDGMENT AND NON-DISCLOSURE AGREEMENT

Facility is committed to protecting the privacy of all Residents and protecting the confidentiality of their health care information. The following specific principles are applicable to all of Facility employees, independent health care professionals involved in the care of Residents at the Facility, volunteers, students, faculty, vendors, and contractors regardless of their job classification or position. While working with Residents at or for Facility, I realize that I may have access to or become aware of confidential Resident medical information, whether or not I am directly involved in providing care to that Resident. I understand that I must keep this information in the strictest of confidence. As a condition of my employment or work at Facility, I agree that I:

- Will not verbally or in any written form disclose confidential Resident information to any unauthorized person.
- Permit any unauthorized person to examine or make copies of any Resident's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at Facility.
- Will not examine, use, or disclose confidential Resident medical information except as needed to perform the duties of my job.
- Will not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
- Will not remove or copy any record or report from the office where it is kept except in the performance of my duties.
- Will report any violation of this policy.

If I have access to computerized information or programs at Facility, I understand that the information accessed through all Facility information systems contains sensitive and confidential Resident care, business, financial, and Facility employee information that should only be disclosed to those authorized to receive it. I commit to:

- Respect the ownership of proprietary software.
- Respect the finite capability of the systems, and limit my own use so as not to interfere unreasonably with the activity of other users.
- Respect the procedures established to manage the use of the system.
- Prevent unauthorized use of any information in files maintained, stored or processed by Facility.
- Not operate any non-licensed software on any computer provided by Facility.
- Not utilize anyone else's authentication code or device in order to access any Facility system.

- Respect the confidentiality of any reports printed from any information system containing Resident/member information and handle, store and dispose of these reports appropriately.
- Not release my authentication code.
- Understand that all access to the system will be monitored.
- Understand that my computer system privileges hereunder are subject to periodic review, revision, and if appropriate, renewal.

I understand that a violation of this Agreement may result in corrective action up to and including discharge or termination of my employment or work at or for Facility and that my obligations under this Agreement will continue after termination of my work at Facility. By signing this, I agree that I have read, understand and will comply with the Facility's policies concerning confidentiality of information and use of computerized information systems and the statements made in this Agreement.

_____

Signature

_____

Printed Name

_____

Position at Facility

_____

Date