Saint Agnes Medical Center

Thank you for your interest in becoming a Saint Agnes Medical Center Experience Advisor volunteer. Our Experience Advisors bring a unique perspective to the delivery of health care, and we embrace their input into our continuous improvement efforts around patient experience, safety, quality and education. All efforts are aimed at shaping a culture that embraces patients and the community as true partners in the delivery and environment of health care.

Please complete and return these three forms to the Volunteer Services office.
All information submitted will remain confidential.

- *Application*
- *Ethics Guidelines Agreement*
- *Volunteer Consent for Release of Background Information*

We will review your application and contact you to schedule an interview.

If you have any questions please call Volunteer Services at (559)450-3521, or Service Excellence at (559)450-5239. Thank you once again for your interest in volunteering at Saint Agnes Medical Center.

Sincerely,

Volunteer Services and Service Excellence

Please return completed forms to:

Saint Agnes Medical Center
Volunteer Services
1303 E Herndon Mail Stop 700
Fresno, CA 93720

Saint Agnes Medical Center
Experience Advisor Application

Name ____Date _________________

Home Address ____________________________ City _______________________Zip __________________

Home Phone #: _____________________________ Cell Phone # :_____________________________

E-Mail Address: ____

What is the Best Way to Contact You? (Please circle one) Home Phone Cell Phone E-mail

In Case Of Emergency Notify: _______________________________ Phone______________________________

Are There Any Reasonable Accommodations That We Need To Be Aware Of In Order For You To Volunteer?
Yes____ No____
If Yes, Please Explain: ____

Education (Circle Last Year Completed) **High School** 9 10 11 12 **College** 1 2 3 4 **Graduate** 1 2 3 4

Degrees and/or Special Training:____

Career Experience and/or Special Skills that You Would Like to Share with Us:
____
____

Tell us more about yourself.
Have you or your family had health care experiences with Saint Agnes that you would be comfortable in discussing and helping us improve or expand? Please indicate when those services were received. Check all that apply.
☐Emergency room _______ ☐Inpatient Medical Unit _______ ☐Inpatient Surgery _______
☐Laboratory Services _______ ☐Radiology _______ ☐Obstetrics _______
☐Rehabilitation Services (Physical Therapy/Occupational Therapy/Speech Therapy) _______
☐Cancer Services _______ ☐Cardiovascular Services _______ ☐Neuro/Spine Services _______
☐Outpatient Services, Please list: ____
☐Other not listed: ____

What would you like us to know regarding your past experience(s) receiving care at Saint Agnes Medical Center?
____
____
____

Tell us why you are interested in being an Experience Advisor.
____
____
____

How did you hear about this opportunity? ____

Times available to volunteer:
(check all that apply)

	M	T	W	TH	F	S	SUN
Morning							
Afternoon							
Evening							

These questions are optional, but will help us make our committees as diverse as possible: Please check all that apply.

Ethnicity ☐Hispanic or Latino ☐American Indian or Alaska Native ☐Asian ☐Non-Hispanic/Latino
☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Other ________________________
Language(s) Spoken: ____
Religion: ____

The following list reflects the many ways that patients, family and community members can be involved in our Patient and Family engagement efforts. We will provide you with an orientation and training depending upon the activity that interests you and what opportunities exist. Please check all that apply:

☐**Patient and Family Advisory Council Volunteer:** Membership on a hospital committee. The work will include regular meetings, and might include activities such as helping to design or improve a new or current program, service, policy or process. It involves working closely with different clinical and non-clinical staff. Your role will be to bring the patient or family perspective. A minimum of a 1 year commitment is requested.

☐**Focus Group Participant:** Occasionally we bring groups of past patient or family member together to hear perspectives and ideas on a specific topic. This is a time-limited experience, often only one time.

☐**Communication Reviewer:** Your role would be to make suggestions and recommendations on draft brochures, patient education materials, websites, policies, newsletters, and marketing materials. This work would be done electronically and from you own home. Requests for this assistance are variable. ***If you have marketing or advertising experience please indicate that on page 1 of the Application under Career Experience.***

☐**Experience Sharing:** Our Experience Advisors are often asked to share their person healthcare experience as a way for us to learn what was helpful and what was not. You may be invited to share your story at new employee orientation, educational seminars for professionals or at department or committee meetings. You might also be asked to play the role of a patient in an educational simulation as part of a staff training.

Please List Two References (Business, Religious, Academic)
Please DO NOT include relatives or personal references.

Name	Relationship	Address	Telephone #

Note: We ask the following questions to avoid potential conflicts of interest only, it does not disqualify you from consideration.

Have you ever worked as a paid Saint Agnes employee? Yes____________ No____________

If Yes, Position Held____________________________________Manager Name________________________________

Is anyone in your family a paid Saint Agnes employee or a Medical Provider? Yes____________ No____________

If Yes, Name & Position____

Note: Answering "yes" to any of the following questions will not automatically disqualify you from consideration. Misstatements and/or omissions on this question may disqualify you from consideration.

Are there any criminal charges pending or being considered against you? Yes____________ No____________

If Yes, state the charge(s) pending and the name and location of the Court in which pending:

____

Have you ever been convicted of a misdemeanor or a felony? Yes__________ No____________

If Yes, state circumstances: ____

____

SAINT AGNES EXPERIENCE ADVISOR VOLUNTEER
ETHICS GUIDELINES AGREEMENT

If accepted as a Experience Advisor volunteer, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from or about a patient.

2. My services are donated to the hospital without contemplation of compensation, benefit or future employment, and given with humanitarian, religious or charitable reasons.

3. I shall not sell or attempt to sell goods or services, request contributions or to solicit persons to sign or distribute political petitions or religious material on hospital premises, unless I receive the express authorization of the Service Excellence Director to engage in these activities.

4. I shall attempt to resolve any problems related to my volunteer activities with my the Service Excellence Director, and if unsuccessful, attempt to resolve any such problems in the manner set forth by the Volunteer Department.

5. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

6. I shall at all times uphold the philosophy and standards of the hospital.

7. I understand that the Director of Service Excellence reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, performance or appearance; or (d) any other circumstances which, in the judgment of the Ethics Committee, would make my continued service as a volunteer contrary to the best interest of the hospital.

8. For those applying to be Patient and Family council volunteers only:
    - I shall, if requested, submit to examinations, which may include chest X-rays, skin tests, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer service. If requested, I hereby authorize my doctor(s) to furnish the hospital information concerning my health. I also authorize the person(s) making X-ray films to report the results to the hospital.
    - I shall be punctual and conscientious, conduct myself with dignity, courtesy and in consideration of others, and endeavor to make my volunteer services excellent in quality.
    - When my term on the Patient and Family Advisory Council is finished, I will return my volunteer identification badge and parking pass to the Volunteer Services Department.

____________________________ ____________________________________

DATE **SIGNATURE OF VOLUNTEER APPLICANT**

NOTIFICATION AND AUTHORIZATION TO OBTAIN INFORMATION

In connection with my application for a volunteer assignment with Saint Agnes Medical Center, I understand that prior to or at any time after my volunteer placement commences a Consumer Report may be requested for volunteer placement purposes from public records including; but not limited to Social Security number, motor vehicle operation history, criminal history and OIG Sanction to the extent permitted by law from various local, state and federal agencies. Further, I understand that an Investigative Consumer Report may be requested and, as required under the Fair Credit Reporting Act, XV U.S.C. § 1681 d(a)(1), I understand that this Report will include information as to my character, general reputation, personal characteristics, mode of living, work habits, performance, experience, along with reasons for termination of past employment, whichever are applicable, obtained through personal interviews with associates who have knowledge concerning such item of information.

I voluntarily and knowingly authorize any present or past employer or supervisor, college or university or other institution of learning, administrator, law enforcement agency, state agency, local agency, federal agency, credit bureau, collection agency, private business, military branch or the national personnel records center, personal reference, and/or other persons to give records or information they may have concerning my criminal history, motor vehicle history, social security number, earnings history character, and employment (including reasons for termination) or other information requested.

I understand that I have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested. Further, I am entitled to know if a volunteer assignment is denied because of information obtained by my prospective Volunteer Supervisor from a Reporting Agency. If so, I will be advised in writing and be given the name and address of the agency, a statement of that action was based in whole or in part on information contained in the Report, and written notice that I have the right(i) if I request, to obtain within sixty days a free copy of the Report from the Reporting Agency, and from any other consumer credit Reporting Agency which compiles and maintains filed on consumers on a nationwide basis; and, (ii) to dispute the accuracy or completeness of any information in a consumer credit report furnished by the Reporting Agency. I understand that upon my request with reasonable notice, the vendor who completed the request will supply me with investigative information in my file during normal business hours in person or upon written request, by mail or telephone as permitted by law.

I understand that any Consumer Report or Investigative Consumer Report requested will be used strictly for volunteer placement purpose as defined under the Fair Credit Reporting Act §603(h). I further understand that any volunteer placement offer or volunteer reassignment will be conditioned upon the receipt of satisfactory information as required and that to be accepted for a volunteer assignment or reassignment; I must authorize the procurement of such Report(s). A photographic or faxed copy of the Notification and Release Authorization shall be as valid as the original.

The following must be COMPLETED and SIGNED for your application to be considered (please print).

Last Name: ______________________ First Name: ______________________ Middle Name: __________

Home Address: ____

City: ______________________ State: ______________________ Zip: __________

Phone Number: ______________________ Social Security Number: ______________________

Date of Birth: ______________________ Email Address: ______________________

List other cities/states where you have lived in the past 7 years: ______________________

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SIGNATURE: ______________________________________ **DATE:** __________

Authorizing the procurement of the Consumer Report and/or Investigative Consumer Report