Perth and Smiths Falls District Hospital

Patients and Families THE Heart OF Care

Greetings,

Thank you for your interest in becoming a volunteer at the Perth and Smiths Falls District Hospital. I am the volunteer coordinator for both sites and will be happy to answer any questions you may have.

I have included a volunteer package which contains:

- Application Forms
- Pledge of Confidentiality
- Code of Conduct
- Occupational Health Services: Confidential Health and Immunization History Form
- Letter for Criminal Reference Check with Vulnerable Sector (you must reach out to me to obtain this letter)

Once you have completed the package in its entirety, please contact me.

**Please note – proof of COVID 19 vaccination must be sent to our Occupational Health Department, via email pthompson@psfdh.on.ca

Once I have received confirmation from Occupational Health Services that you are fit for work as a volunteer, I will contact you to set up a time to come to the SF site to complete your paperwork, give you a badge and to see Occupational Health.

Please let me know if you have any questions.

Take care,

Sarah Simmons
Employee Wellness and Engagement Advisor
Perth and Smiths Falls District Hospital
60 Cornelia Street West
Smiths Falls, ON K7A 2H9
613-283-2330 extension 1265
Sarah.simmons@psfdh.on.ca

Perth and Smiths Falls District Hospital

VOLUNTEER/AUXILIARY APPLICATION FORM

Patients and Families Heart of Care

PLEASE ENSURE ALL QUESTIONS ARE COMPLETED AS FULLY AS POSSIBLE. PLEASE PRINT

LAST NAME:	FIRST NAME:
ADDRESS:	PHONE: (HOME):
	(CELL):
	DATE OF BIRTH:
EMAIL:	
EMERGENCY CONTACT:	
RELATIONSHIP:	PHONE:
LANGUAGES SPOKEN: ENGLISH ☐ FRENCH ☐ SIGN ☐ OTHER:	

I am interested in volunteering at the: ❑ Smiths Falls site or the ❑ GWM (Perth site)

AREAS OF INTEREST: SF (Smiths Falls) GWM (Perth)				
☐ MEAL ASSIST (SF/GWM)	☐ INFORMATION DESKS (SF/GWM)	☐ GIFT SHOP (SF/GWM)	☐ TEA & TOAST (SF/GWM)	☐ CLINICS (SF/GWM)
❑ HELPP LOTTERY (GWM)	❑ PORTERING (GWM)	❑ TOURTIERES (GWM)	❑ NEWSLETTER (GWM)	❑ CRAFTS (GWM)
❑ EXECUTIVE (GWM)	❑ FUNDRAISING (GWM)	❑ GARDEN (GWM)	❑ COMMUNICATION COMMITTEE (GWM)	

I AM AVAILABLE:							
TIME	MON	TUES	WED	THURS	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

When you volunteer at the Hospital you must commit to joining the Hospital Auxiliary, there is a small fee per year in order to volunteer, unless you are a student. Smiths Falls fee: $5, GWM fee, $10

I UNDERSTAND THAT I WILL BE A MEMBER OF THE AUXILIARY AND AGREE TO PAY THE YEARLY FEE	❑ YES ❑ NO

Please drop off your membership fee to the gift shop (SF) or in the mail slot (GWM) that you are volunteering with.

CONFIDENTIALITY:

The Hospital assures the confidentiality of each patient's health information. In the course of the volunteer's contact with the patient, the patient may reveal personal or medical information. Our patients have the right to expect that all members of the health care team, including volunteers, will hold in confidence any information which may be disclosed. Volunteers must protect patients' rights.

NAME BADGE:

**Please note that our Auxiliary name badges are magnetic and could interfere with some pacemakers. Please let us know if you have a pacemaker

GWM SITE ONLY: Please print the name below how you would like it to appear on your name badge:
(ie: John Doe, J.Doe, John D)

COMMITMENT/CONSENT

- ♥ I will be punctual and carry out my duties to the best of my abilities.
- ♥ I will notify my Convener/Staff Liaison of any necessary absence from my Service as far in advance as possible.
- ♥ I will return my ID bade/parking pass and uniform when I am no longer a Volunteer
- ♥ I am willing to have my name, telephone number and email address shared with fellow volunteers, as required.
- ♥ I am over 16 years of age.

All applicants must have a criminal reference check with vulnerable sector, please contact the following Human Resources representative to obtain a letter to take to your local police station.

Please contact

Sarah Simmons
613-283-2330 ext 1265
sarah.simmons@psfdh.on.ca

I have read and understand the above information.

_____ _____

Signature Date

Perth and
Smiths Falls
District Hospital

PLEDGE OF CONFIDENTIALITY

I understand that all hospital and patient information to which I may have access must be treated as privileged and confidential information at all times. I acknowledge that I have been provided with a copy of the Hospital's policy entitled "Confidentiality of Personal Information" and that I have read and fully understood its contents. In addition, I understand that:

- all confidential and/or personal health information that I have access to or learn through my employment or affiliation with Perth & Smiths Falls District Hospital is confidential,
- as a condition of my employment or affiliation with the Perth & Smiths Falls District Hospital, I must comply with these policies and procedures, and
- my failure to comply may result in disciplinary action, up to and including the termination of my employment or affiliation with the Perth & Smiths Falls District Hospital, and may also result in legal action being taken against me by the Perth & Smiths Falls District Hospital.
- the Perth & Smiths Falls District Hospital also reserves the right to report non compliance to a physician's or employee's medical college or professional association where deemed appropriate by the Chief Privacy Officer, Department Manager and/or Chief of Staff.

I agree that I will not access, use or disclose any confidential and/or personal health information that I learn of or possess because of my affiliation with the Perth & Smiths Falls District Hospital, unless it is necessary for me to do so in order to perform my job responsibilities. I also understand that under no circumstances may confidential and/or personal health information be communicated either within or outside of the Perth & Smiths Falls District Hospital except to other persons who are authorized by the Perth & Smiths Falls District Hospital to receive such information.

I have reviewed the Social Media policy and understand that any violation of privacy and confidentiality through a social media application will result in disciplinary action and possible termination.

I agree that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the policies and procedures.

I agree to keep any computer access codes (for example, passwords) confidential and secure. I will protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed.

I will not lend my access codes or devices to anyone, nor will I attempt to use those of others. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I will immediately notify the Human Resources department or the Privacy Officer.

Name: (please print): _____

Signature: _____

Witnessed: (please print): _____

Signature: _____

Date: _____

Perth and Smiths Falls District Hospital

Code of Conduct

COMPASSIONATE CARE

We demonstrate compassion, honesty and kindness while respecting each other's privacy and dignity.

- I will make every effort to address each person's needs and wants, treating them with dignity and respect.
- I will show them I care by expressing concern, empathy and taking initiative to assist them in their care, while respecting their right to choice.
- When providing service, I acknowledge the patient/family, introduce myself, provide explainations, set expectations and attempt to provide them with a positive experience in every interaction.
- I protect and respect their personal and information policy.

TRUSTWORTHINESS AND FAIRNESS

We conduct ourselves with the highest standard of personal and professional behaviour.

- I take responsibility for my work and follow through with all tasks. I show respect by active listening, showing empathy and by being considerate.
- I can be relied on by patients and coworkers to support excellence in all aspects of care.
- I support and recognize positive qualities of the Hospital's providers and staff.
- I seek to be consistent in my dealings with all patients and staff, treating all individuals fairly but acknowledging their particular needs.

INTEGRITY, RESPECT AND DIGNITY

We respect each other and recognize that we each bring valuable skill, experience and knowledge to our work.

- I bring enthusiasm to the work I do and I perform my job to the best of my abilities.
- I acknowledge that body language and tone of voice are as important as verbal communication and am conscious of presenting myself in a professional manner.
- I share my knowledge with others and I ask for help if a concern is beyond my knowledge, ability or scope of authority.
- I respect, recognize and reward the contributions of others and I respect diversity.

COLLABORATION, COOPERATION AND TEAMWORK

We work together for the care and safety of our patients, community and each other.

- I seek to ensure that opinions and concerns of others are heard and acknowledged and respected.
- I am a positive member of my team and contribute to its success.
- I take personal responsibility for the Hospital's successful fulfillment of its Vision, Mission and Values and stay current with the Hospital's communications to focus my efforts.
- I promote cooperation between departments and look for ways to collaborate and build the Hospital as a whole.

TRANSPARENCY AND ACCOUNTABILITY

We will be responsible for our actions, will be open and honest in our communication and strive to ensure that information provided is timely, relevant and reliable.

- I will follow all organizational policies and procedure.
- I will recognize and encourage positive behaviours.
- I will accept accountability for my actions.
- I will smile, make eye contact, greet others and speak in ways that are easily understood and show concern and interest.
- I will wear my name badge at all times while working.
- I am 100% accountable for my actions and 100% accountable for what I see and hear in my work environment.

QUALITY IMPROVEMENT

We will support continuous improvement in the Organization's processes, facilities and equipment.

- I make suggestions for improvement when I see an opportunity.
- I recognize that change for improvement is necessary and I actively participate in the change process.
- I support building a stronger and more capable Hospital.
- I accept risk and failure are part of the process and that we learn from mistakes to move forward without blame.
- I will support the implementation of new technology and processes that have a positive sustainable impact on the effectiveness and/or efficiency of the delivery of care to patients or which supports those providing care.

- I agree to be **"Fit for Duty"** and understand that this means that I am able to work safely and/or acceptably perform assigned duties without any limitations resulting from, but not limited to: the use or after-effects of illicit drugs, drugs, recreational or medical cannabis, alcohol, and/or medications; the misuse of and/or failure to take prescribed medications; and/or extreme fatigue/stress.

I commit to this Code of Conduct for the Perth and Smiths Falls District Hospital.

Print Name: _____

Signature: _____

Date: _____

Perth and Smiths Falls District Hospital

Occupational Health Services
Confidential Health & Immunization History Form
(Volunteers & Students)

Under Regulation 965 of the Public Hospitals Act, we require the following information for all persons carrying on activities at the Perth and Smiths Falls District Hospital including employees, physicians, contract workers, students and volunteers. The attached immunization record is to be completed by your treating healthcare practitioner or healthcare employer. The completed form must be returned to Occupational Health Services (pthompson@psfdh.on.ca) prior to commencement of employment or student/volunteer placement. In the event that your records do not exist, this will be reviewed at your Occupational Health on-boarding appointment.

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

Position: Department _____ Start Hire _____

Clinical Student ❑ Non-Clinical Student ❑ Co-Op Student ❑ Volunteer ❑

Date of Placement (Students) _____

Family Physician: _____

Allergies: _____

Medical Alert: _____

Do you have a disability requiring workplace accommodation? Yes ❑ No ❑
If yes, please specify restrictions: _____

N95 and/or Elastomeric Respirator Fit Testing (attach record):

Date tested: _____ Mask Type: _____
Date tested: _____ Mask Type: _____

Tuberculin Skin Testing (TST):

A TST is required within 2 weeks of hire. If the healthcare worker does not have a record of a 2-Step test, a 2-Step TST will be given by Occupational Health Services. TST results must be read within 48-72 hours after being administered. 2nd Step must be given 7 to 28 days after 1st test in opposite arm if test is 1st step is negative (0-9mm):

Two Step Test

Date of Step 1: _____ Result: _____ Induration in mm: _____
Date of Step 2: _____ Result: _____ Induration in mm: _____

Single Step Test (will be completed by Occupational Health if 2-Step result is available):

Date of 1 Step: _____ Result: _____ Induration in mm: _____

Past Positive TST *(greater than 5mm (with risk factors) or greater than 10mm):*

Referrals will be made to both Public Health and the Primary Care Physician to review risk for active pulmonary TB and/or treatment of latent TB disease.

X-ray Date: _____ Result: _____

Immunization/Vaccination History

Name: _____

Immunizations and Immunity:

Measles Mumps Rubella (MMR): 2 doses required at least 4 weeks apart on or after 1st birthday

MMR #1 Date: _____ MMR #2 Date: _____
Additional Booster Date: _____

Or Laboratory Evidence of Immunity:

Measles Titre: Date of Test: _____ Result: _____
Mumps Titre: Date of Test: _____ Result: _____
Rubella Titre: Date of Test: _____ Result: _____

Varicella:

Varicella Vaccine (2 doses required at least 4 weeks apart)

#1 Dose Date: _____ #2 Dose Date: _____

Or Laboratory evidence of immunity or laboratory confirmation of disease:

Date: _____ Result: _____

Hepatitis B

Hepatitis B Vaccine Series:

#1 Dose Date: _____ #2 Dose Date: _____ #3 Dose Date: _____

And Laboratory Evidence of Immunity:

Titre: Date of Test: _____ Result: _____

Date of Booster Doses: _____

Tetanus/Diphtheria (required every ten years)

Date of last Tetanus/Diphtheria immunization: _____

Date of Tetanus/Diphtheria/Pertussis (Tdap - Adacel) adult dose: _____

Influenza Vaccine:

Date: _____

Pneumococcal Vaccine (OHS to screen for eligible candidates):
Referral to primary care practitioner or Public Health for follow-up
Date Received: _____

Meningococcal Quadrivalent Vaccine (offered to Laboratory Staff – MLTs)

Date of vaccine: _____ Date of Last Booster: _____

Covid 19 Vaccination

Vaccine and Vaccine Date #1 _____ Vaccine and Vaccine Date #2 _____

Form completed by: _____ **Date:** _____ Rev: Jan 22/21