Volunteer Checklist

Volunteer Name: ______________________________ Start Date: ______________

Address: ______________________________ End Date: ______________

Phone Number: ______________________________

Department: ______________________________

FORMS

Volunteer must provide all required documentation to the community prior to working.
The five documents below must be returned to Chelsea Retirement Community.

- ☐ **Volunteer Checklist**
- ☐ **Authorization for Criminal History File Search**
- ☐ **Confidentiality Agreement**
- ☐ **Notice of Reportable Conditions**
- ☐ **TB Questionnaire** *(subject to TB skin test if indicated)*
- ☐ If under the age of 18, Parent or Legal Guardian Authorization

EDUCATION

Volunteer must complete training on the following topics prior to placement in the community.
Volunteer is to check off below that provided information was reviewed with them.

- ☐ **Resident Rights and Abuse**
- ☐ **Bloodborne Pathogen and Infection Control**
- ☐ **Emergency and Disaster Plans**

I certify that the above volunteer has provided all required documentation and has received training in all topics listed above prior to placement at Chelsea Retirement Community.

____ ______________

Volunteer Signature Date

____ ______________

Volunteer Coordinator/Supervisor Signature Date

Volunteer Checklist

AUTHORIZATION FOR CRIMINAL HISTORY FILE SEARCH

In compliance with the licensing requirements all volunteers and individuals with clinical privileges at Chelsea Retirement Community will be subject to a criminal history file search following an offer of approval to be a volunteer on Chelsea Retirement Community premises or acceptance of contractual service.

Please check one of the following boxes:

☐ I have been a resident of Michigan for at least three (3) years immediately preceding the offer to be a volunteer or contractual services by Chelsea Retirement Community and authorize Brio Living Services to conduct a name-only Michigan criminal conviction search through the Michigan State Police.

☐ I have not been a resident of Michigan for at least three (3) years immediately preceding the offer to be a volunteer or contractual services by Chelsea Retirement Community and authorize Brio Living Services to conduct a name-only Michigan criminal background conviction search and national FBI criminal history fingerprint-check through the Michigan State Police.

Please complete the following information necessary to conduct a Michigan Criminal Conviction search:

____

Last Name First Name Middle Name

Please list any previous names used (maiden, alias): ______________________

Date of birth: ______________________

Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/ Alaskan Native ☐ Unknown/Other

Sex: ☐ Male ☐ Female

I understand and agree that I must notify Chelsea Retirement Community immediately upon being arrested for or convicted of one or more of the following:

1. Any felony, or attempt or conspiracy to commit a felony.
2. A misdemeanor that involved abuse, neglect, assault, battery, or criminal sexual conduct against anyone or fraud or theft against a vulnerable adult (as defined under the Michigan Penal Code), a state or federal crime that is substantially similar to such a misdemeanor.

____

Print Name of Applicant

____

Signature of Applicant Date

Personnel Operating Procedure #158

CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

1.0 In accordance with applicable federal and state laws, personal health information must be protected during its collection, use, disclosure, storage, and destruction by all Brio Living Services team members and associates, including independent contractors, volunteers, interns, researchers, and members of the Board of Directors.

2.0 Personal health information shall be defined as all information, recorded or exchanged verbally about an identifiable individual that relates to the following:

a.) The individual's health, or health care history, including genetic information about the individual or the individual's family;

b.) Observations, including conduct or behavior that may be a result of illness or the effect of treatment;

c.) The provision of health care to the individual resident;

d.) Payment for health care provided to the individual including any personal health identification assigned to a resident and any identifying information about the individual that is collected in the course of, and is incidental to, the provision of health care or M payment for health care;

e.) The individual's personal information, including financial position, home conditions, domestic difficulties or any other private matters relating to the patient which have been disclosed to team members or associates of Brio Living Services.

3.0 Use or disclosure of personal health information is acceptable on in the discharge of one's responsibilities and duties (including reporting duties imposed by legislation) and based on the need to know. Discussions regarding personal health information shall not take place in the presence of persons not entitled to such information or in public places.

4.0 Unauthorized use or disclosure of confidential information shall result in disciplinary action, up to and including discharge. A confirmed breach of confidentiality may be reported to the individual's professional regulatory body and may result in monetary fines.

5.0 Any individual who becomes aware of a possible breach of confidential information shall immediately notify the community Privacy Officer or the Corporate Compliance Officer. The Corporate Compliance Officer or their designee shall work with the Director of Human Resources to conduct an investigation and take appropriate disciplinary action if necessary.

6.0 The Corporation shall designate a Corporate Compliance Officer whose responsibilities including dealing with requests from individuals who wish to examine and copy or to correct personal health information collected and maintained by Brio Living Services.

7.0 As a condition of employment/contract/association with Brio Living Services, each individual must confirm in writing their review and agreement to abide by this procedure. Additionally, each team member of Brio Living Services will receive training regarding the protection of personal health information.

RELATED PROCEDURES

POP #365 -Formal Grievance Procedures for Non Union Team Members
POP #740-Rules of Conduct

Confidentiality Agreement

I, the undersigned, have reviewed Brio Living Services confidentiality agreement. I have been given instruction on the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIP AA) and how they affect my work as a team member at Chelsea Retirement Community.

I understand Brio Living Services and Chelsea Retirement Community procedures of how to protect written or verbal resident information that I may be exposed to, including proper storage of and/or disposal of written resident information. I understand use of Brio Living Services' electronic medical record is also protected by HIPAA laws. I agree to access the EMR only under my assigned private password and that passwords are not to be shared, under any circumstances, at any time during the course of my employment.

I hereby agree that I will not, at any time during or after my association with Brio Living Services and Chelsea Retirement Community access or use personal health information or reveal/disclose to any persons within or outside of Brio Living Services, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable law.

I further acknowledge that unauthorized use or disclosure of such information may result in disciplinary action, up to and including termination of employment/contract/association with Brio Living Services. Violations may also result in being reported to my professional regulatory body and possible monetary fines.

____

Printed Name

____

Signature Date

Notice of Reportable Conditions

Name: ______________________________ Date: ______________________

Position: ____Volunteer____________________ Department: ______________

In compliance with our established policies governing team member health, you must immediately report illnesses to your supervisor or to the Infection Control Coordinator. While this list is not all inclusive, any potential/known contagious illness must be reported. Examples of some primary illnesses/symptoms that must be reported are:

1. Temperature of I 00°F or greater;
2. Nausea/Vomiting;
3. Acute diarrheal illness with other symptoms (i.e., fever, abdominal cramps, bleeding, etc.), or diarrhea (with or without other symptoms) lasting longer than twenty-four (24) hours;
4. Orofacial herpes simplex virus (cold sores) or herpetic whitlow;
5. Diagnosed Streptococcal (Group A); sore throat;
6. Head or Body Lice (Pediculosis) or known Bed Bug exposure;
7. Skin lesions which are infected, especially on exposed body parts; Any Staph infection;
8. Any Skin rash; Poison Ivy/Oak, Impetigo; Ring Worm; Pink eye, etc;
9. Acute Upper Respiratory Infection or Flu-like illness defined as respiratory symptoms with:
   a. Fever 99.6°F or> and at least one of the following:
   b. Cough, sore throat, nasal congestion, headache, fatigue, myalgia, vomiting, or diarrhea;
10. Active infection with/or exposure to:
    a. Measles (if the team member is not immune)
    b. Mumps (if the team member is not immune)
    c. Rubella (if the team member is not immune)
    d. Varicella zoster (chickenpox/shingles) virus (if the team member is not immune)
    e. Influenza (Flu) Virus
    f. COVID-19 (coronavirus disease 2019)
    g. Herpes simplex virus (includes oral, orofacial, herpetic whitlow (herpes of the fingers), a team member is not required to report genital hemes infection)
    i. Tuberculosis-known or suspected exposure;
    j. The "Big Five" as relates to foodborne illness: Salmonella, Shigella, Shiga/E. Coli, Hepatitis A, Noro Virus
11. Needle stick/sharps accident, parenteral/mucous membrane or non-intact skin exposure to resident's blood or body fluids.

I understand that it is my responsibility to notify my supervisor or the community's Infection Control Coordinator of any actual or potential infection with a communicable disease that I may have. I understand that this notification is to protect myself, residents, and other team members.

I understand failure to report known or suspected infection and/or reporting to work ill with any of the above noted S&S/infections may result in disciplinary action and/or termination of privileges of employment with Brio Living Services. I understand I must be free of the above signs/symptoms for 24hrs before returning to work.
I understand that a return to work note from my doctor may be requested in the event I present with real or potential communicable symptoms, regardless of the number of missed work days.

The team member may be excluded from work assignments for the length of time recommended by their physician and/or the CDC guidelines, depending on the illness and risk for spread of infection to residents or coworkers.

I certify that this document has been explained to me and that I understand its contents. A copy of this document will be provided to me at the New Hire Orientation day, to be scheduled upon completion of all pre-employment requirements.

____

Signature Date

TB Questionnaire

Name: ______________________________ Department: ____________________

This form is to be used for persons who are not required to have TB screening. Please answer the questions in Part A. If there are any concerns with the answers provided a healthcare professional will evaluate and sign the recommendation section of Part B (only if needed).

PART A ***Have you experienced any of the following symptoms in the past year***

1. If YES: Circle or Highlight One:

				If YES: Circle or Highlight One		
a.	A productive cough for more than 3 weeks?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
b.	Hemoptysis (coughing up blood)?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
c.	Unexplained weight loss in past six months?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
d.	Fever, chills, or night sweats for no known reason?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
e.	Persistent shortness of breath?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
f.	Unexplained fatigue?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
g.	Chest Pain?	☐ Yes	☐ No	Rarely	Sometimes	Frequently
h.	Loss of Appetite?	☐ Yes	☐ No	Rarely	Sometimes	Frequently

2. Have you had contact with anyone with active tuberculosis disease in the past year? ☐ Yes ☐ No
   If Yes, Explain: ____

3. Purpose of this TB Test Requirement: ☐ Volunteer/Guest ☐ Annual

4. Date of last known TB Test: ____________________ Results: ____________________

5. Any history of allergic reaction to TB Test or contraindications to receiving? ____________

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

____

Volunteer Signature Printed Name Date

PART B ***To be completed by a healthcare professional if any of the answers above are of concern.***

I recommend as follows:

☐ There is no indication this person has active TB at this time and should complete annual TB screening questionnaire.

☐ There is no indication this person has active TB at this time and should have their TB Skin Test deferred until the National PPD shortage has ended.

☐ There is reason to be suspicious of TB and further evaluation including a chest x:-ray, Interferon Gamma Release Assay or other medical evaluation should be completed prior to work and the Infection Control Nurse has been notified.

____

Healthcare Professional Signature Printed Name Date

Legal Custodial Parent/Legal Guardian Authorization

Individuals under the age of 18, that wish to volunteer at Chelsea Retirement Community, must provide permission from, a Legal Custodial Parent or Legal Guardian, for us to be able to proceed with assigning volunteer related tasks.

The following must be completed by the designated Legal Custodial Parent or Legal Guardian:

As the Legal Custodial Parent or Legal Guardian of ______________________________,
I authorize Chelsea Retirement Community to conduct the required volunteer screening and have reviewed the required documents that need to be completed.

Please check each to indicate you have reviewed and approve the documents that will need the volunteer's signature:

- ☐ Volunteer Checklist
- ☐ TB Questionnaire
- ☐ Team Member Confidentiality Agreement
- ☐ Reportable Conditions
- ☐ Authorization for Criminal History File Search

First and Last Name of Legal Custodial Parent or Legal Guardian (please print):

____

Relationship to prospective volunteer (select one): ☐ Legal Custodial Parent ☐ Legal Guardian

Daytime Phone Number of Legal Custodial Parent/Legal Guardian (including area code):

____

On behalf of ______________________________, I freely and willingly consent to the disclosure of the Criminal History File Search by Chelsea Retirement Community Human Resources Team on behalf of ______________________________ as well as ______________________________'s heirs, representative agents and myself, I voluntarily release fully and forever discharge Chelsea Retirement Community and of its representatives from any claim or liability arising from such search. I understand that the results will become part of ______________________________'s volunteer record.

____

Legal Custodial Parent or Legal Guardian Signature Date