PATIENT-FAMILY ADVISOR MEMBERSHIP APPLICATION

VIDANT HEALTH™

Thank you for your interest in the Patient-Family Advisor role. Questions on this application are asked for the sole purpose of considering you for an advisor role. We do not discriminate on the basis of race, religion, sex, national origin, age or handicap status.

Mr. / Ms. / Miss / Mrs. NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

DATE OF BIRTH _____ EMAIL _____

Please select the appropriate facility:

_____ The Outer Banks Hospital
_____ Vidant Beaufort Hospital
_____ Vidant Bertie Hospital
_____ Vidant Chowan Hospital
_____ Vidant Corporate Health
_____ Vidant Duplin Hospital
_____ Vidant Edgecombe Hospital
_____ Vidant Health (Corporate Offices)
_____ Vidant Home Health & Hospice
_____ Vidant Medical Center
_____ Vidant Medical Group
_____ Vidant Roanoke-Chowan Hospital
_____ Vidant SurgiCenter
_____ Vidant Wellness Center
_____ Other *(Be specific)* _____

1. Have you worked here before? _____No _____Yes When?_____

Were you a _____Volunteer? _____ Employee? _____ Student? _____ Physician?

2. Have you or any of your family member(s) been hospitalized or received services at any of the Vidant Health facilities noted above? _____Yes _____No

Which areas have you or your family member(s) received service in?

_____

_____

3. Who should be contacted in case of emergency?

Name _____ Relationship _____ Phone _____

Physician _____ Practice _____ Phone _____

4. Why would you like to be a Patient-Family Advisor?

_____

_____

5. What areas of concern would like to see Patient-Family Advisors address?

_____

_____

6. What special interest or experience would you like to offer as a Patient-Family Advisor?

_____

_____

7. Describe any work related limitations (physical or emotional) _____

_____

8. Do you know any foreign or sign language? ____No ____Yes Specify _____

9. Have you ever pleaded guilty or been convicted of a crime other than a minor traffic violation?

_____ No _____ Yes If yes, explain _____

10. Are you related to anyone employed by Vidant Health?

_____ No _____ Yes If yes, give name and relationship _____

I hereby apply to become an advisor at Vidant Health, to abide by my commitment, to:

Maintain patient privacy and confidentiality
Support our mission
Actively participate in improving care for all patients and families
Listen to different opinions and share ideas and viewpoints
Use my hospital experience or a family member's experience to improve care
Advocate for and listen to other patients, families, staff and community members
Support positive relationships with our health system and members of the community

These statements are true and accurate to the best of my knowledge.

SIGNATURE _____ DATE _____

TRAINING/HEALTH
A Joint Commission (TJC) volunteer orientation and health screen is required before serving as an advisor. An update of the health screen and TJC competency review is required annually. All current required immunizations will be given unless documented proof is submitted with the application.

ACKNOWLEDGEMENT AND RELEASE: SUBSTANCE ABUSE PREVENTION POLICY
I have been informed and acknowledge that Vidant Health and its subsidiary corporate entities have a Substance Abuse Prevention Policy which includes a Zero Tolerance Provision. I understand that applicants for positions with these corporations may receive pre-employment drug screenings as part of the hiring process and that hiring decisions are contingent upon the results.

I specifically consent and agree to provide body fluid samples (blood and/or urine) for drug and/or alcohol screening in accordance with the policy as part of the application process.

I understand that if I am not accepted because of a positive drug screen, I will not be reconsidered for advisor service at Vidant Health or any of its subsidiary corporate entities until I can document twelve (12) continuous months of treatment for drug abuse.

I understand and specifically consent and agree that any positive drug screening results will be furnished to the appropriate department and to my professional licensing board, if appropriate. I further understand that once accepted, subsequent positive screens or refusal to provide samples when requested will make me subject to disciplinary action up to and including termination.

_____ _____
SIGNATURE OF ADVISOR SIGNATURE OF WITNESS

_____ _____
SIGNATURE OF PARENT/GUARDIAN *(If under 18 years of age)* PRINT WITNESS NAME

_____
DATE

ADVISOR CONFIDENTIALITY STATEMENT
Vidant Health has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at Vidant Health, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services. I understand that such information must be maintained in the strictest confidence.

- As a condition of my assignment, I hereby agree that I will not at any time during or after my assignment disclose any patient information. When patient information will be discussed with the health care practitioners in the course of my assignment, I will use discretion to assure that such conversations will not be held in a public place or with inappropriate individuals. I further agree to maintain the confidentiality of Vidant Health proprietary information or other information which I have obtained by virtue of my service as an advisor. To this end, I agree to obtain Vidant Health consent prior to the release or disclosure of any such information to third parties, specifically including members of the media.

I understand that violation of this agreement may result in termination of my assignment at Vidant Health.

_____ _____
SIGNATURE OF ADVISOR DATE

_____
PRINT NAME OF ADVISOR

Vidant Health conducts criminal record checks on all employee, volunteer and advisor applicants to assure a safe environment for patients receiving care and services. If the information you furnish on this form is found to be false, you will be disqualified/dismissed. You will not be considered for future employment/service for 18 months.

Please answer the following questions concerning your past history. Check all that apply:

1. Have you ever been

a. Convicted of a misdemeanor? Not necessary to include minor traffic infractions. _____Yes _____No

b. Convicted of a worthless check(s)? _____Yes _____No
(if you have paid off a check at the Magistrate's office or Courthouse this is probably a worthless check conviction)

c. Convicted of any DWIs? (Driving While Impaired) _____Yes _____No

d. Convicted of violation(s) of any drug laws, the Controlled Substances Act of North Carolina or similar laws of any state or nation? _____ Yes _____ No

e. Convicted of any crimes of violence such as assault, harassment, communicating threats, rape, kidnapping, manslaughter or murder? _____ Yes _____ No

f. Convicted of a felony? _____ Yes _____ No

g. Convicted of any crime involving child abuse, child neglect or indecent liberties with a minor? _____ Yes _____ No

h. Convicted of a violation(s) of a Professional Practice Act? _____ Yes _____ No

If the answer to any of the foregoing questions is YES, please explain each conviction in the spaces provided below, including date, county and state of conviction. If needed, additional sheets are available upon request in the office from which you obtained this application.

Date of conviction _____ County _____ State _____

Conviction (crime for which you were convicted) _____

_____

Explain (optional)

Date of conviction _____ County _____ State _____

Conviction (crime for which you were convicted) _____

_____

Explain (optional)

Date of conviction _____ County _____ State _____

Conviction (crime for which you were convicted) _____

_____

Explain (optional)

2. Please list all names you have ever been known by including birth name, previous marriage(s), legally changed, nicknames and aliases.

1) _____ 2) _____

3) _____ 4) _____

3. Please list the street, city and state where you have lived for the last ten (10) years including military and school addresses (use additional sheet if more space is needed).

Street _____ City _____

County _____ State _____ Zip _____ Dates (from) _____ (to) _____

Street _____ City _____

County _____ State _____ Zip _____ Dates (from) _____ (to) _____

Street _____ City _____

County _____ State _____ Zip _____ Dates (from) _____ (to) _____

I hereby certify that the answers on this application and this insert are true and correct, and that any misrepresentation of false information on my part will disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination.

In connection with this request, I authorize all law enforcement agencies, city, state, county and federal courts to release information they may have about me to the corporate entity of Vidant Health to which I am applying or someone acting on their behalf.

_____ _____

SIGNATURE OF APPLICANT | DATE

_____ _____

PRINT FULL NAME | SOCIAL SECURITY #

_____ _____

DATE OF BIRTH | VALID DRIVER'S LICENSE NUMBER AND STATE *(if you don't have license state reason)*

_____ _____

CURRENT ADDRESS | CITY

_____ _____

STATE AND ZIP | DATES: FROM and TO

Date of birth and social security numbers are required solely for the purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

DISCLOSURE/AUTHORIZATION STATEMENT

By this document, Vidant Health and its subsidiary corporate entities disclose to you that a criminal background report may be obtained as a part of the advisor volunteer background investigation and at any time during your advisor role.

This shall authorize the procurement of a criminal background report by Vidant Health and its subsidiary corporate entities as part of the advisor background investigation. If selected as an advisor, this authorization shall remain on file and shall serve as an ongoing authorization for the appropriate corporate entity by which I am serving as an advisor to procure criminal background reports at any time during my service as an advisor.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, educational institutions, law enforcement agencies, city, state, county and federal courts, motor vehicle bureaus, military services and persons to release information they may have about me to the corporate entity of Vidant Health with which this form has been filed or an agent acting on its behalf and release all parties involved from any liability and responsibility for doing so.

This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

I understand that I have the right upon written request within a reasonable period of time, to request additional disclosure as to the nature and scope of the investigation.

_____ _____

SIGNATURE OF APPLICANT DATE

_____ _____

PRINT FULL NAME SOCIAL SECURITY #

_____ _____

DATE OF BIRTH VALID DRIVER'S LICENSE NUMBER AND STATE
(if you don't have license state reason)

_____ _____

MILITARY SERVICE # BRANCH OF SERVICE

_____

DATES: FROM and TO