

Orientation \_\_\_\_\_\_\_\_\_\_\_\_ Volunteer No. \_\_\_\_\_\_\_\_\_\_\_\_ Area **Burn Center Aftercare Programs**

# UNC HOSPITALS

# VOLUNTEER REGISTRATION FORM

**2018**

Mr.

Name: Mrs.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Miss Last First Middle Initial

 Ms.

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Female \_\_\_\_\_\_ Male \_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip County

e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Work Cell

Present Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: (circle one)

 High School Professional/Technical School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 College: Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EVENT(S) YOU’RE VOLUNTEERING FOR: \_\_Camp Celebrate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this your first year volunteering with us? Y\_\_\_ No\_\_\_ # of years of service\_\_\_**

**PREFERRED volunteer assignment:**

\_\_\_ Counselor to child (Must be at camp **ALL** weekend) Age Range preference \_\_\_7-9yo \_\_\_ 10-12yo \_\_\_teens

\_\_\_ Cabin leader \_\_\_ Co-Cabin Leader \_\_photo/video team

\_\_\_ Logistics assistant \_\_\_ Counselor in Training (CIT) mentor \_\_\_ willing to assist however needed

\_\_\_ Other – Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERENCES:** **Please provide 3 NON FAMILY MEMBER REFERENCES with knowledge of your character, experience, work habits, and abilities. Include EMAIL ADDRESS. Please write legibly. New volunteers must have references checked.**

 Name Relationship Telephone Number Email Address

 Name Relationship Telephone Number Email Address

 Name Relationship Telephone Number Email Address

**EMERGENCY CONTACT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adult T-Shirt Size: \_\_\_** small **\_\_** Medium \_\_ Large \_\_ X-Large \_\_ XX Large \_\_XXXlarge

**Personal Skills, AFFILIATIONS, Abilities and Knowledge:** Check all that apply.

\_\_ Student \_\_ Professional \_\_ Firefighter – Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Jaycee \_\_ Community Volunteer \_\_ Parent or relative of burn survivor

\_\_ Burn Survivor \_\_ Medical \_\_ Friend of burn survivor

\_\_ EMT \_\_ Hospital Volunteer \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a member of the Professional Firefighters of NC? \_\_ Yes, Local Number \_\_\_\_\_\_\_ Are you an IAFF member? Y N

Swimming ability? Please check: \_\_I don’t swim \_\_ not well \_\_ ok \_\_good \_\_very well

Are you willing to swim in the pool and/or lake with the campers even if its cold? \_\_\_Yes \_\_\_No

Are you a Certified Lifeguard: \_\_ Yes \_\_No Have you had water safety experience? \_\_Yes \_\_No

List your water safety experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other helpful information about yourself ie: Languages spoken, camp skills, specialties, interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CAMP AND/OR LEADERSHIP EXPERIENCE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Dates** | **Camp & Director** | **Location** | **Camper or Staff** |
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**Applications due to the Burn Center no later than April 1st, 2018 & registration may close earlier!**

If you have any questions regarding Children’s Aftercare Programs, please contact Michele Barr at:

Michele.barr@unchealth.unc.edu 919.962.8427

Harassment: The Burn Center Aftercare Program’s policy is to prohibit all forms of harassment by our employees and volunteers. This includes sexual, racial, religious and other forms of harassment of any person including, but not limited to, workplace harassment. Have you ever been accused of harassment of any person including, but not limited to, workplace harassment? (Note: Prior accusation or conviction is not an automatic bar to participation. The type of conviction or accusation and when it occurred will be evaluated by the program before any decision is made.) \_\_\_ Yes \_\_\_ No Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Volunteer Signature Date

12/16

Volunteer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Last

 **** Male **** Female Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Health Form for Camp Participation**

Is Volunteer covered by medical insurance? **** Yes **** No

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please indicate any pertinent information or requests regarding medical conditions which may limit or alter camp participation. All medications must be turned into the Camp Nurse for the safety of the campers. Activity Restrictions:Dietary Restrictions:Medical Treatments/ please list any medications you are taking:**ALLERGIES:** Do you have any known drug, food or environmental allergies? **** Yes **** No(medications, peanuts, poison ivy, bee stings, etc)**If yes, please specify allergy and type of reaction:** **EMERGENCY AUTHORIZATION:**I hereby give my permission to the medical staff at *Camp Celebrate* to order xrays, routine tests, and routine treatment for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical staff to hospitalize, secure proper treatment for, and to order injections, anesthesia, surgery for me/my child named above. I understand and accept that UNC Hospitals and *Camp Celebrate* may use Personal Health Information (PHI) for purposes of treatment, payment, and health care operations. I hereby give permission for necessary PHI to be released to insurance carriers, health care treatment facilities, and other professionals. This includes PHI from pharmacies, hospitals and clinics.Signature of volunteer (Parent of CIT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**IMMUNIZATIONS:** Month/Year of last Tetanus immunization (DPT,DT,T) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Tetanus shot within past 10 years required for participation at camp.)** Month Year

Volunteer Name:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Last

**HEALTH HISTORY**

**General health history: check “yes” or “no” for each statement. Explain “yes” answers below.**

|  |
| --- |
| Do you have or have you had any of the following in the past 6 months? **YES NO** |
| 1. Chronic or recurrent illness? ** **
2. Illness lasting over one week? ** **
3. Hospitalizations? ** **
4. Surgery? ** **
5. Recent infectious disease? ** **
6. Recent injury? ** **
7. Asthma/wheezing/shortness of breath? ** **
8. Diabetes? ** **
9. Seizures? ** **
10. Frequent Headaches/Migraine? ** **
11. Orthopedic injury/abnormality? ** **
12. Problems with heart/blood pressure? ** **
13. Chest pain with exercise? ** **
14. Fainting or dizziness? ** **
15. Concussion/unconsciousness? ** **
16. Heat stroke/exhaustion/problem with heat? ** **
17. Head Lice. Date cleared: ** **
 |
|  |

**Please explain all “yes” answers:**

Return all forms ASAP via mail, email, or fax

Email: maria\_albani@med.unc.edu

Fax: 984-974-1870. *Please email us to confirm receipt if you fax it in!*

Mailing address:

 Camp Celebrate

 North Carolina Jaycee Burn Center

 101 Manning Drive, Campus Box 7600

 Chapel Hill, NC 27599-7600

**ACTIVITIES SHEET**

**Camp Program Skills**

We need our volunteers to help in a variety of ways during camp, this might mean time away from your cabin to help out! Please let us know about your skills. Activities offered at each camp will vary.

In the following list please indicate the following:

 **“T”** for those activities you can organize and teach as an expert

 **“A”** for those activities in which you can assist

**Adventure/Challenge Drama Sports/Fitness**

\_\_\_ challenge/Ropes course \_\_\_ clowning \_\_\_ aerobics

\_\_\_ climbing/rappelling \_\_\_ theater \_\_\_ exercise

\_\_\_ low ropes teambuilding \_\_\_ skits \_\_\_ yoga

 \_\_\_ archery

**Arts/Crafts \_\_\_** baseball/softball

\_\_\_ tie dye **Music** \_\_\_ bicycling/biking

\_\_\_ drawing/painting \_\_\_ singing \_\_\_ fishing

\_\_\_ leather craft \_\_\_ instrument (list) \_\_\_ football

\_\_\_ metal work \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ basketball

\_\_\_ beading \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ capture the flag

\_\_\_ scrap booking \_\_\_ informal games

 **Nature** \_\_\_ martial arts

**Camp Craft/Pioneering** \_\_\_ animals/animal care \_\_\_ swimming instruction

\_\_\_ geocaching \_\_\_ astronomy \_\_\_ soccer

\_\_\_ hiking \_\_\_ birds \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ track/field

\_\_\_ orienteering \_\_\_ environmental studies \_\_\_ volleyball

\_\_\_ outdoor cooking \_\_\_ flowers \_\_\_

\_\_\_ outdoor living skills \_\_\_ forestry \_\_\_

\_\_\_ overnights \_\_\_ insects

\_\_ wilderness trips \_\_\_ rocks/minerals

 \_\_\_ weather **Waterfront Activities**

 \_\_\_ canoeing

 **Photography**

 \_\_\_ 35mm \_\_\_ kayaking

 \_\_\_ digital

 \_\_\_ video camera \_\_\_ stand up paddle board

 **\_\_\_** making slide show

 **\_\_\_ 360 camera knowledge**

 **\_\_\_ virtual reality Gear VR**

**\_\_ Yes, I am willing to print pictures, sort pictures, or help with behind the scenes tasks**

**PERSONAL QUESTIONNAIRE (complete if you have been to Camp Celebrate for 3 years or less)**

**What contributions do you think you can make to the Burn Center Children’s Aftercare Program? Help us understand your interest in volunteering at Camp Celebrate.**

**Write a brief biographical sketch, including experience in camp settings, training in camping, and experience or training in other fields, which might have a bearing on the position(s) for which you are applying. Attach a separate sheet if necessary.**



Authority for Release of Information

PLEASE PRINT LEGIBLY!

NAME (First, Middle, Last) MAIDEN NAME SEX (M or F)

SOCIAL SECURITY NUMBER DATE OF BIRTH (month/day/year)

(must have to volunteer, unless international student)

HOME ADDRESS (not school address and no P.O. Box) At this address since (month & year)

CITY, STATE, ZIP

PREVIOUS ADDRESS (if home address is less than 1yr) At this address for how long?

CITY, STATE, ZIP

APPLICANT AUTHORIZATION

I hereby authorize UNC Health Care to utilize a Consumer Reporting Agency (CRA) to perform a criminal record search.

I understand that the CRA does not guarantee the accuracy or timeliness of the information obtained from other sources and that UNCHCS and the CRA shall not be liable for any inaccuracy in the information obtained from the CRA.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / /

APPLICANT’S SIGNATURE DATE

Please understand that your volunteer placement is pending this background check and cannot be guaranteed.

Revised 5/16

**Confidentiality Statement**

It is the policy of the UNC Health Care System and its affiliates (individually and collectively called “UNCHCS” herein) that users (i.e., employees, medical staff, students, volunteers, vendors, outside affiliates, and any others who are permitted access) shall respect and preserve the privacy, confidentiality and security of confidential information (“CI”). In the course of providing services for or at UNCHCS, I may encounter these types of CI: (1) patient information (such as medical records, billing records, and conversations about patients), (2) personnel information (payroll, discipline or other information about employees, volunteers, students, contractors, or medical staff), (3) confidential business information of UNCHCS, its affiliates, and/or third parties, including third-party software and other licensed products or processes, or

(4) operations, quality improvement, peer review, education, billing, reimbursement, administration, or research (such as utilization reports, survey results, and related presentations). This information from any source and in any form, including, but not limited to, paper record, oral communication, audio recording, and electronic display, is strictly confidential. **I understand and agree that I will only access, maintain, use or disclose CI on a legitimate job- related, need-to-know basis, and that I will limit my access, maintenance, use or disclosure of CI to the minimum amount of CI necessary to accomplish the intended purpose of the use, disclosure or request.**

**I further agree that:**

**1.** I will I will protect the privacy, confidentiality and security of UNCHCS patient information, including electronic medical records cords (“EMR”), in accordance with federal and state regulations and applicable policies and procedures.

**2.** I will complete all required privacy and security training for accessing EMR or other CI.

**3.** I will not maintain CI on a mobile device (laptop, smartphone, tablet, etc.) that is not encrypted and will not electronically transmit CI in an unsecured manner or to an unencrypted mobile device.

**4.** I will not disclose to another person my sign-on code and/or password, and will not use another person’s, for accessing EMR or other CI. I will not leave a secured application unattended while I am signed on.

**5.** I will not attempt to access a secured application or restricted area without proper authorization or for purposes other than official UNCHCS business.

**6.** I will not alter or destroy CI unless alteration or destruction is part of my job or services for UNCHCS, in which case I will only alter or destroy CI in accordance with applicable policies and procedures.

**7.** I will immediately report to my supervisor any known or suspected (a) use of my password by someone other than me, or (b) inappropriate access, use or disclosure of CI.

**8.** I will safeguard from loss, theft, or unauthorized use/access UNCHCS owned equipment/property on which CI is stored or through which CI may be accessed.

**9.** I will not store or transmit CI via my personal equipment/property unless permitted by and in accordance with applicable policy or procedure.

**10.** I will not post or discuss CI of any type to social media sites unless pre-approved by UNCHCS.

**11.** I will not take photographs, make videos, or make other recordings of patients, staff, or visitors except in accordance with applicable UNCHCS policies and procedures.

**12.** I understand that my access to CI and my UNCHCS email account may be audited.

**13.** I will not access or obtain my own, a friend’s, or a family member’s patient information maintained by UNCHCS without appropriate written authorization and under applicable policies and procedures.

**I agree that I have read, understand and will comply with the terms of this Confidentiality Statement and all applicable policies and procedures. I understand that my failure to comply with this Confidentiality Statement may result in termination of access to UNCHCS EMR, personal civil or criminal legal penalties, disciplinary action, up to and including termination of employment or student status, or loss of UNCHCS privileges or contractual or affiliation rights. AFTER MY EMPLOYMENT OR WORK AT UNCHCS ENDS, I WILL NOT TAKE ANY CONFIDENTIAL INFORMATION WITH ME AND I WILL NOT DISCLOSE ANY CONFIDENTIAL INFORMATION.**

|  |
| --- |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(please print)****Employee ID or last 4 digits of SSN:\_\_\_\_\_\_\_\_\_\_** **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_** |

|  |
| --- |
| **Entity:**[ ] UNC Hospitals [ ] Rex Healthcare [ ] High Point Regional Health[ ] Pardee Hospital [ ] SOM [ ] Johnston Hospital [ ] Nash Hospital [ ] Chatham Hospital [ ] Caldwell Hospital [ ] UNC Physicians Network**Affiliation:**[ ] Employee [ ] Contract Employee [ ] Medical Staff [ ] Resident [ ] Referring Physician [ ] Student [ ] Other Providers [ ] Volunteer [ ] Vendor (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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** University of North Carolina**

 **Health Care System**

101 Manning Drive

 Chapel Hill, NC 27514

**PATIENT RECORDINGS AND INFORMATION RELEASE AUTHORIZATION FORM (COMMUNICATIONS, MARKETING AND EXTERNAL AFFAIRS) – HIM #739s**

I authorize UNC Health Care System and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [name of media outlet, as applicable] to take

and/or release recordings (e.g., photographs, videos and/or audio), and related medical information, of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[patient name], for Public Relations and/or Marketing Purposes

(including internet sites, publications, public media, presentations and advertisements). I understand that I may

 be identified by name, unless I initial the statement below.

**\_\_\_\_\_\_\_\_\_\_\_ I do not consent to the use of my name.** I understand that, even though my name will not

 (initial here) be used, it is possible that someone may recognize me based on the recording(s) alone.

**•** I understand that I may revoke this Authorization at any time by sending a written request to the Office of Communications, Marketing and External Affairs, 211 Friday Center Drive, Chapel Hill, NC, 27517. Any revocation will not apply to information already released.

**•** I may refuse to sign this Authorization and UNC Health Care System will not condition my treatment or eligibility for benefits on receiving my signature on this Authorization.

**•** I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. Once disclosed, the privacy of the information may no longer be protected by federal and state privacy laws.

**•** Unless otherwise revoked, this authorization will expire in one year *or* on the following date, event, or

 condition**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**I have read and understand the information in this Authorization form.**

|  |
| --- |
| **Signature of Patient or Authorized Representative:** |
| **Printed Name:** |
| **Date: Time:** |

|  |
| --- |
| **Relationship of Authorized** **Representative to Patient (if applicable):** |
|  |

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

\*HIM739\* HDF0652 Rev. 05/07/15 Chart Location: Authorizations