

Gulf Breeze Hospital

TeenAge Volunteer (TAV) Program

High school students between 14 and 18 years of age may apply to our TAV program. Applications are accepted September 1 – January 31 for the following summer. Once the program is full, no additional applications will be accepted. Teens must reapply each year.

Each student is required to volunteer a minimum of one day per week, four hours per day (one shift).

TAV SUMMER PROGRAM

June through August (depending on when school starts). Applications are accepted September 1 – January 31 for the following summer. Interviews are held during spring break. Space is limited, students are accepted on a first come basis.

TAV OPPORTUNITIES

- Wayfinding and Information Desk – Greet patients and guests and provide directions and general information.
- Patient Care Support – Assist professional staff, maintain clean waiting room areas, etc.
- TAVs work in all areas Auxiliary volunteers work.

GULF BREEZE HOSPITAL

AUXILIARY DEPARTMENT - TEENAGE VOLUNTEER (TAV) GUIDELINES

PURPOSE - Gulf Breeze Hospital feels a responsibility to provide students the opportunity to serve the community by being able to observe and actively participate in various charitable volunteer activities within the hospital.

ELIGIBILITY REQUIREMENTS

- Maintain a good scholastic standing.
- Be between the ages of 14 and 18.
- Maintain a clean, neat appearance and adhere to the uniform policy.
- Be dependable and trustworthy and maintain patient confidentiality.
- Be kind and courteous to hospital staff, patients and visitors.
- Be able to attend all orientation trainings.
- Provide proof of a TB skin test (available at BHC Team Member Health Department) and up-to-date immunizations.
- Provide copy of Social Security Card.

SUPERVISION AND TRAINING

- Volunteers will be under the direction of the TAV Coordinator.
- Training will be provided by hospital personnel or the department's Auxiliary volunteer.
- TAVs must adhere to all department and hospital regulations, as applicable.

VOLUNTEER HOURS - Each student is required to volunteer a minimum of one day per week, four hours per day (one shift). Fifty volunteer hours are required to complete the ten-week summer program.

ASSIGNMENTS - Volunteers sign in at the Auxiliary Office and report to their assigned department supervisor at the beginning of each shift. If the volunteer is unable to report to work as scheduled or is going to arrive late, the volunteer must notify his/her assigned department supervisor and the TAV Coordinator prior to the scheduled shift. **Please note – it is not the TAV Coordinator's responsibility to contact the department for volunteers who are late or absent. It is the TAVs responsibility to get a point of contact for his/her assigned department supervisor.**

ATTENDANCE REQUIREMENTS - Failure to notify the Auxiliary office is a NO SHOW. Three no shows = dismissal from the program.

TRANSPORTATION - Volunteers are responsible for arranging their own transportation to and from the hospital.

UNIFORM POLICY

Uniform: Khaki pants and white shirts. No jeans or shorts.

Shoes: White, low-heeled, rubber-soled, closed toe shoes.

Clean white sneakers are acceptable.

Name badge: To be worn on the upper right torso **at all times.**

Jewelry: Only minimal jewelry is acceptable.

Perfumes and colognes: Prohibited.

Hair: Must be neat and tied away from the face. **No bows.**

GENERAL INFORMATION - If a volunteer is absent for a period of time or decides to leave the program, the TAV Coordinator must be notified in writing. Any injury while on duty is to be reported to the volunteer's assigned department supervisor and the Auxiliary office. Violation of any policy may result in dismissal. All problems are to be reported to the TAV Coordinator.

VERY IMPORTANT:

- Volunteers may eat lunch **before or after their shift, not during volunteer hours.** Gulf Breeze Hospital will provide a meal to volunteers each shift up to \$4.50. Anything over this amount is the TAVs responsibility. TAVs must volunteer a total of four hours to receive a meal.
- **No cell phones are to be used, and no texting is permitted during volunteer hours.** Remember to log volunteer hours at the end of each shift.

**GULF BREEZE HOSPITAL
TeenAge Volunteer (TAV) PROGRAM
PERMISSION FORM**

To be completed and signed by a parent or legal guardian ONLY.

I, _____ (parent/guardian's name) give permission for my child, _____ (child's name) to volunteer at Gulf Breeze Hospital. I will ensure his/her transportation to and from the hospital. I understand that he/she cannot arrive at the hospital more than 30 minutes prior to his/her assigned volunteer shift(s) and must be picked up promptly at the end of the volunteer shift. I also understand that TAVs are not allowed to leave their department unless approved by authorized personnel. I further understand that TAVs may not leave the Gulf Breeze Hospital campus for lunch or any other reason unless approved by the parent/guardian.

Signature of Parent/Guardian

Date

Signature of TAV

Date

**GULF BREEZE HOSPITAL
TEACHER / COUNSELOR RECOMMENDATION FOR
TEENAGE VOLUNTEER (TAV) PROGRAM**

School name and address: _____

Student name: _____ Grade Level: _____

Gulf Breeze Hospital is seeking students as applicants for the Summer TAV Program who are responsible, dependable, caring and have the ability to provide high quality service to our patients, guests and staff.

We ask that you carefully consider the criteria when evaluating your student. Thank you for taking the time to complete this recommendation. **Please fax the completed form to the GBH Auxiliary Office at 850-934-2069.**

Please circle the appropriate rating:

School Attendance	Excellent	Good	Average	Fair	Poor
Punctuality	Excellent	Good	Average	Fair	Poor
Conduct	Excellent	Good	Average	Fair	Poor
Dependability	Excellent	Good	Average	Fair	Poor
Follows Instructions	Excellent	Good	Average	Fair	Poor
Accepts Responsibility	Excellent	Good	Average	Fair	Poor
Shows Initiative	Excellent	Good	Average	Fair	Poor
Scholastic Average:	<input type="checkbox"/> 77-85	<input type="checkbox"/> 86-92	<input type="checkbox"/> 93-100		

Do you recommend this student as an application for the Gulf Breeze Hospital TAV Program? Yes No

Comments: _____

Name and position: _____

Signature: _____ Date: _____

Telephone: (W) _____ (H) _____ Best time to call: _____

**GULF BREEZE HOSPITAL
TeenAge Volunteer (TAV) PROGRAM
SCHEDULE PREFERENCES**

Name: _____ Phone: _____

Circle the two days of the week would you prefer to work:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

What shift would you prefer to work?

8AM – Noon

Noon – 4pm

4pm – 8pm is available in the following areas (circle one):

- 1) Med/Surg Floor
- 2) Emergency Department
- 3) Emergency Department Desk

BAPTIST HEALTH CARE VOLUNTEER APPLICATION

Baptist Health Care is an Equal Opportunity Employer and a Drug-Free Workplace

Applicants must complete both **Part I Pre-Application** and **Part II Application** to be considered for volunteering. Incomplete applications will not be accepted. It is very important to answer every question completely and honestly. Applications will only be valid for 60 days and after that time must be resubmitted.

PART I – PRE-APPLICATION

- ✓ Complete **Background and Criminal History**
- ✓ **Check** Questions
- ✓ Read and Agree to the following Applicant Statements:
 - **Applicant Certification**
 - **Authorization to Seek and Give References**
 - **Code of Conduct Summary**

BACKGROUND AND CRIMINAL HISTORY CHECK

Baptist Health Care conducts background screenings, including criminal histories.

You MUST answer the following questions completely and truthfully. A “YES” answer to these questions will not automatically bar you from volunteering. The nature, job relatedness, severity, and date of the criminal offense(s) and/or intentional torts in relation to the position for which you are applying will be considered. However, failure to answer the questions in this **application truthfully and completely may result in your disqualification from consideration for volunteering or discharge from volunteering if you are accepted.**

Please note that criminal offenses in your criminal history or intentional torts do not “disappear” from your record after any certain amount of time, and thus you must disclose all offenses and intentional torts in this application **regardless of how long ago the offense occurred.** If you have any questions, please ask to speak to a human resources manager.

1. Have you **EVER in your life** pled guilty to any crime or criminal offense, had adjudication of guilt withheld for any crime or criminal offense, OR been convicted, fined or sentenced, placed on probation, incarcerated, placed on house detention (sometimes called “house arrest”), assessed any costs of criminal court or had any other criminal penalty imposed upon you?

YES

NO

If No, Go To #2

- 1A. If the answer to Question 1 above is YES, please identify, explain and give details about the type(s) and circumstances of the crimes(s) or criminal offense(s) or matters related to Question 1 above:

- 1B. For each crime or criminal offense or matter identified above, please identify:

- a. The dates of the crime, conviction, plea and/or adjudication of guilt withheld AND
- b. The penalty(ies), sentence, or disposition(s) imposed for each crime or criminal offense or matter.

Background and Criminal History Check – Continued

1C. For each crime or criminal offense or matter identified above, please identify the State and location in which each crime or criminal offense or matter occurred:

2. Have you **EVER in your life** been a defendant or been sued in a civil action or lawsuit for an intentional tort (or an intentional civil wrong, such as, for example, trespass, civil theft, battery, assault, false arrest or imprisonment, employment discrimination or harassment, civil rights violations, slander, libel, fraud or deceptive trade practices)?

YES NO

If NO, Go to #3

2A. If the answer to Question 2 is YES, please identify, explain, and give details about the type or nature of each intentional tort claimed against you and circumstances of that claim alleged against you:

2B. For each intentional tort identified above, please:

- a. Identify the dates of the civil action or lawsuit.
 - b. Describe and explain the final disposition or end result of each civil action or lawsuit,
AND
 - c. Identify the date of that final disposition or end result.
-

3. Are you currently on probation for a crime, criminal proceeding or have you been off probation **LESS** than one year?

YES NO

If YES – Unfortunately, our Employment policy is that an applicant must be out of the criminal probation system for at least one year prior to be considered for employment. Since you do not meet these criteria, you are not eligible to be considered for employment at this time. Thank you for your interest in Baptist Health Care.

Remember that failure to report accurately, truthfully and completely the information requested above may result in your being disqualified from consideration for employment/volunteering or discharged from employment/volunteering if you are hired. If you have any questions, please ask to speak with a human resources manager.

READ EACH STATEMENT CAREFULLY BEFORE COMPLETING:

APPLICANT CERTIFICATION

I hereby certify that the information given by me in this application – both Part I and Part II, and during the interview process is true and complete in all respects to the best of my knowledge. I understand that all information on this application is subject to verification, and I agree that if the information is found to be **UNTRUE OR MISLEADING IN ANY RESPECT, I WILL BE DISQUALIFIED FROM CONSIDERATION FOR VOLUNTEERING OR IF VOLUNTEERING SUBJECT TO IMMEDIATE DISCHARGE.**

____ Initials – by initialing I signify that I have read, understand and agree with the **Applicant Certification** statement above.

AUTHORIZATION TO SEEK AND GIVE REFERENCES

I hereby authorize Baptist Health Care “BHC” to seek references from my high school previous employers or friends listed on this form.

I authorize the references and previous employers listed to give BHC all information and facts concerning me and my previous employment. I will not hold them responsible for any action or lack of action that may be taken by others on the information provided. I understand that the information provided to BHC may not be disclosed to me and I waive my right of access to this information.

____ Initials – by initialing, I signify that I have read, understand and agree to the **Authorization to Seek and Give References** statement above.

CODE OF CONDUCT SUMMARY

PURPOSE: This code of conduct is intended to provide guidance and reflect behaviors consistent with laws and regulations and with our commitment to service.

Baptist Health Care will/is:

- **Committed to providing the highest quality of service by meeting the needs of our patients/clients/residents with utmost care and courtesy, and performing our duties in a responsible, reliable, appropriate and cost effective manner.** 1) Respect patients' dignity, comfort, convenience, and time. 2) Listen attentively. 3) Keep them informed of treatment alternatives and risk factors. 4) Make decisions based on clinical needs and medical necessity. 5) Provide equal access to care (non-discriminatory).
- **Operate in accordance with high legal, moral and ethical standards and with all applicable laws, regulations and standards.** 1) Not pay anyone for referral of patients. 2) Not tolerate false statements to government agency or other payer. 3) Not engage in any illegal business practices intended to influence the decisions of any external representative, including bribery, kickbacks, or payoffs.
- **Perform our duties on behalf of the company and patients in a truthful and loyal manner.** 1) Not accept gifts that cannot be shared such as food, unless specifically approved by my supervisor. 2) Not become involved for personal gain with competitor, patient or supplier. 3) Not place business with any company in which there is a family relationship or conflict of interest.
- **Operate in an environment wherein the health, safety, privacy and comfort of our patients and Team Members come first.** 1) Comply with all safety rules and regulations. 2) Support an alcohol and drug-free workplace.
- **Committed to reasonably protect, support and develop our staff to its fullest potential in a fair and equitable manner. Professional growth, career development and individual empowerment are actively encouraged and rewarded.** 1) Offer equal employment opportunity. 2) Maintain a work environment free from all forms of harassment, including offensive comments and jokes.
- **Protect against the loss, theft, destruction, inappropriate use and misuse of our assets and those of others entrusted to us, including physical property and proprietary information.** 1) Safeguard confidential patient information. 2) Care for all assets, property, equipment, and supplies that belong to Baptist Health Care.
- **Promptly report to management any transaction (billing and coding) that is not recorded in compliance with our policies and procedures.** 1) Ensure accurate bills for only services actually rendered and based on documented medical necessity. 2) Not tolerate submission of false or fraudulent claims.

____ Initials – by initialing I signify that I have read and understand the **Code of Conduct Summary** statement.

ELIGIBILITY TO PARTICIPATE IN FEDERALLY FUNDED HEALTH CARE PROGRAMS

If you have ever been listed by a Federal Government Agency as debarred, excluded or otherwise ineligible for participation in federally funded Health Care programs, you are NOT qualified to work for or contract with Baptist Health Care. Please check the appropriate box below:

- Yes**, I have been listed or I am under investigation by a Federal Government Agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.
- No**, I have not been listed by a Federal Government Agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs. I agree to immediately disclose to the Company any debarment suspension, exclusion or other event that makes me ineligible to participate in any federally funded health care programs.

CONSENT TO USE IMAGE OR LIKENESS

I also give my permission for the use of any photograph or likeness taken of me during my term of volunteering to be used in Baptist Health Care publications, including those used for internal communications and those intended to promote this organization to the general community.

APPLICATION VALID FOR 60 DAYS

I acknowledge that this application will be valid for 60 days only and only for a Volunteer position.

I hereby certify that the information given by me in this application – both Part I and Part II, is true and complete in all respects to the best of my knowledge. By signing below, I signify that I have read, understand, and agree with ALL of the Application Statements.

Name (please print)

Signature

Date

**PART II
APPLICATION FOR VOLUNTEER SERVICES**

Baptist Health Care is an Equal Opportunity Employer and is a Drug-Free Workplace.

TODAY'S DATE _____

Applicants must complete both Part I Pre-Application and Part II Application to be considered for volunteering. Incomplete applications will not be accepted. It is very important to answer every question completely and honestly. Application will only be valid for 60 days, and after that time, must be resubmitted.

NAME (First, Middle, Maiden and Last)	MAILING ADDRESS (Number & Street)
PREFERRED NAME	CITY, STATE, ZIP CODE
NAME as it appears on Social Security Card	SOCIAL SECURITY NUMBER
TELEPHONE	CELL PHONE
EMAIL ADDRESS	
<p>Have you ever been Employed, served an Internship, Residency or Clinical Rotation (circle which)</p> <p>With any facility of Baptist Health Care? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, please indicate which facility:</p> <p>_____</p> <p>Dates:</p> <p>_____</p>	
<p>Do you have any relatives currently employed at any Baptist Health Care facility?</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>Are you 14 years of age or older?</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

EMPLOYMENT HISTORY – Please provide Employment History beginning with your present and/or most recent.

DATE	COMPANY/ADDRESS	POSITION	REASON FOR LEAVING

EDUCATION

SCHOOL NAME/LOCATION	#OF YEARS COMPLETED	COURSE OF STUDY	DID YOU GRADUATE? Y N	DEGREE

PREVIOUS WORK VOLUNTEER DUTIES, SKILLS AND ABILITIES:

How were you referred to volunteer at Baptist Health Care? Why would you like to volunteer? Can you commit to the ten week TAV Summer Program?

JUSTIFACTS STANDARD BACKGROUND CHECK WAIVER

A Summary of Your Rights Under the Fair Credit Reporting Act

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a “security freeze” on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer’s credit file. Upon seeing a fraud alert display on a consumer’s credit file, a business is required to take steps to verify the consumer’s identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
<p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552</p> <p>b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Administration area supervisor</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549</p>
<p>8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>

Justifacts Standard Background Check Waiver Fair Credit Reporting Act Notification

Baptist Health Care (the "company") intends to obtain and use a consumer report or an investigative consumer report from Justifacts Credential Verification, Inc., an external consumer reporting agency for employment or volunteering purposes. These purposes may include but are not limited to:

- considering your application for employment or a volunteer position;
- making a decision whether to offer you employment or a volunteer position with the company;
- deciding whether to continue your employment if you are hired by the company; or, your volunteer service;
- doing periodic rescreening of current Team Members or Volunteers, and/or;
- making any other employment decisions affecting you.

A consumer reporting agency is a person or business that regularly assembles or evaluates consumer credit information or other information on consumers. As an applicant, Team Member or Volunteer, you are considered a "consumer" under the Fair Credit Reporting Act.

A consumer report may include information about your character, general reputation, personal characteristics, or mode of living, which is used or collected for employment purposes. An investigative consumer report also involves personal interviews with sources such as employers, educators, etc.

You have a right to request disclosures of the nature and scope of any investigative consumer report that the company obtains about you. You also have other rights under the Fair Credit Reporting Act, a summary of which is available at: <https://app.justifacts.com/pdfs/SummaryOfRightsUnderTheFCRA.pdf>

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby acknowledge receipt of this disclosure and that Baptist Health Care may obtain consumer reports and investigative consumer reports about me from a consumer reporting agency and that they may consider information in consumer reports and investigative consumer reports as part of their decision making process regarding any aspect of my application for employment and/or continued employment with the company including periodic rescreening of current Team Members. I also acknowledge that I have received a copy of the Summary of Rights under the Fair Credit Reporting Act.

By selecting **AGREE** below, I acknowledge that I am creating an electronic signature and that I understand it will be legally binding and enforceable as the legal equivalent of a handwritten signature.

***AGREE ___ DISAGREE ___**

SIGNATURE: _____ DATE: _____

JUSTIFACTS STANDARD BACKGROUND CHECK WAIVER

State Specific Notices

Notice to California Residents:

Under Section 1786.22 of the California Civil Code, you have the right to request from Justifacts (5250 Logan Ferry Rd., Murrysville PA 15626 – 800-356-6885, www.justifacts.com), upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you to whom Justifacts has previously furnished within the three-year period preceding your request. Files maintained on a consumer shall be made available for the consumer's visual inspection, as follows: (1) In-person, if he appears in person and furnishes proper identification. A copy of his file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided. (2) By certified mail, if he makes a written request, with proper identification, for copies to be sent to a specified addressee. (3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer. Justifacts shall provide trained personnel to explain to you any information furnished, including coded information. You are permitted to be accompanied by one other person of your choosing, who shall furnish reasonable identification. Justifacts may require you to furnish a written statement granting permission to Justifacts to discuss your file in such person's presence.

Massachusetts Residents:

You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a copy of such report upon its completion.

New York Residents:

You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company, whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. Upon furnishing you the name and address of the consumer reporting agency to whom the request was made, you shall also be informed of your right to inspect and receive a copy of such report by contacting that agency.

Vermont Residents:

Per 9 V.S.A. §2480e. Consumer consent:

- a. A person shall not obtain the credit report of a consumer unless
 1. the report is obtained in response to the order of a court having jurisdiction to issue such an order, or
 2. the person has secured the consent of the consumer, and the report is used for the purpose consented to by the consumer.
- b. Credit reporting agencies shall adopt reasonable procedures to assure maximum possible compliance with subsection (a) of this section.
- c. Nothing in this section shall be construed to affect:
 1. the ability of a person who has secured the consent of the consumer pursuant to subdivision (a)(2) of this section to include his or her request to the consumer permission to also obtain credit reports, in connection with the same transaction or extension of credit, for the purpose of reviewing the account, increasing the credit line on the account, for the purpose of taking collection action on the account, or for other legitimate purposes associated with the account; and
 2. the use of credit information for the purpose of prescreening, as defined and permitted from time to time by the Federal Trade Commission. (Added 1991, No. 246 (Adj. Sess.), §1.)

Washington Residents:

You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation requested by the Company. Additionally, you have certain rights and remedies under Washington law as summarized below:

A SUMMARY OF YOUR RIGHTS UNDER THE WASHINGTON FAIR CREDIT REPORTING ACT:

The Washington Fair Credit Reporting Act, located at Chapter 19.182 RCW, substantially parallels the federal Fair Credit Reporting Act and the rights and remedies set forth in the Federal Trade Commission's Summary of Rights, except that, effective July 22, 2007, the Washington State law imposes greater limitations on the reasons for which an employer may obtain a consumer report. Beginning July 22, 2008, an employer may not obtain a consumer report that indicates the consumer's credit worthiness, credit standing, or credit capacity, unless (1) the information is substantially job related and the employer's reasons for using the information are disclosed in writing, or (2) the information is required by law.

You may exercise your rights and remedies under this Act by contacting:

Washington State Attorney General's Office
In State Toll-Free Number
800-551-4636
Out of State Number:
206-464-6684
Website: <http://atg.wa.gov/Default.aspx>

***AGREE ___ DISAGREE ___**

SIGNATURE: _____ DATE: _____

JUSTIFACTS STANDARD BACKGROUND CHECK WAIVER

Notification and Authorization to Conduct Employment Background Investigation

I hereby authorize Justifacts Credential Verification, Inc., an Agent for **Baptist Health Care** to ascertain information regarding my background to determine any and all information of concern to my record, whether same is of record or not, and I release employers and persons named in my application from all liability for any damages on account of his/her furnishing said information. I understand that this form indicates that a background search will be conducted and that this is my notification of that intent. I understand that the purpose of this background investigation is to determine my suitability for employment or volunteer placement and may elicit information on my character, general reputation, personal characteristics and mode of living. Additionally, you are hereby authorized to make any investigation of my personal history, educational background, military record, motor vehicle records, criminal records and credit history through an investigative or credit agency or bureau of your choice. I authorize the release of this information by the appropriate agencies to the investigating service. I understand that my consent will apply throughout my employment or volunteer placement, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time, stating that I revoke my consent and no longer allow the Company to obtain consumer or investigative consumer reports about me.

PLEASE PRINT CLEARLY

FULL NAME: _____

OTHER NAMES USED/MAIDEN NAME/DATES: _____

CURRENT ADDRESS: _____ PHONE: _____

LIST ALL ADDRESSES FOR PAST 7 YEARS:

_____ Dates: _____
_____ Dates: _____
_____ Dates: _____

EMAIL ADDRESS: _____ GENDER: _____

PHONE #: _____ SECONDARY PHONE #: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

DRIVER'S LICENSE #: _____ STATE ISSUED: _____

*** MAY WE CONTACT YOUR CURRENT EMPLOYER? YES _____ NO _____

*** HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES _____ NO _____

If yes, please explain: _____

Notice to California Applicants - You may omit minor traffic offenses, any convictions which have been sealed, expunged or statutorily eradicated, convictions more than two years old for the following marijuana related offenses: HS11357b&c, HS11360c, HS11364, HS11365, HS11550, and misdemeanors for which probation was completed and the case was judicially dismissed. **Notice to Massachusetts Applicants:** You may omit a first conviction for any of the following misdemeanors: drunkenness, simple assault, speeding, minor traffic violations, affray, or disturbance of the peace, or any conviction of a misdemeanor where the date of such conviction or the completion of any period of incarceration resulting there from, whichever date is later, occurred five or more years prior to the date of this application for employment, unless you have been convicted of any offense within five years immediately preceding the date of this application for employment. **Note: No applicant will be denied employment solely on the grounds of conviction of a crime. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position will be considered.**

TEEN SIGNATURE: _____ **DATE:** _____

PARENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

California Applicants: Under Section 1786.22 of the California Civil Code, you have the right to request from Justifacts (5250 Logan Ferry Rd, Murrysville PA 15626 – 800-356-6885, www.justifacts.com), upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you to whom Justifacts has previously furnished within the three-year period preceding your request. Files maintained on a consumer shall be made available for the consumer's visual inspection, as follows: (1) In-person, if he appears in person and furnishes proper identification. A copy of his file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided. (2) By certified mail, if he makes a written request, with proper identification, for copies to be sent to a specified addressee. (3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.

California, Minnesota & Oklahoma Applicants Only: Please check this box if you would like a copy of the background check mailed to you. Minnesota and Oklahoma applicants will receive a copy direct from Justifacts or its designee. California applicants may receive a copy from either the prospective employer or Justifacts.

NOTICE: Under federal law, you have the right to request disclosure of the nature and scope of our investigation by providing us with a written request within 60 days of our background investigation.

Subscriber certifies that consumer credit information, consumer reports, as defined by the Fair Credit Reporting Act, 15 U.S.C. 1681 at seq. ("FCRA"), will be ordered only when intended to be used as a factor in establishing a consumer's eligibility for employment and that consumer credit information will be used for no other purposes. It is recognized and understood that the FCRA provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency" (such as Justifacts) "under false pretenses shall be fined not more than \$2,500 or imprisoned not more than two years or both."

PLEASE PRINT NAME OF REFERENCE

Name _____

Address _____

City/State/Zip _____

Phone _____

To Whom It May Concern:

I have applied to Baptist Health Care to join the Volunteer Team. I hereby authorize Baptist Health Care to request such information, as necessary, to verify my qualifications/suitability for the position for which I have applied. I also request and authorize you to release this information to Baptist Health Care, release you from any liability or damage resulting from your providing such information.

Date _____

Signature _____

.....
_____ has applied for a Volunteer position with Baptist Health Care. We would appreciate your evaluation of this applicant, as to character, initiative, dependability, etc. along with any comments which you feel would be helpful.

All information received will be kept CONFIDENTIAL.

How do you know this applicant? _____

How long have you known this applicant? _____

Are you aware of any condition this person has which would adversely affect his/her ability to serve as a Volunteer? ___NO ___YES

If yes, explain: _____

Comments: _____

Thank you for your prompt response.

Date: _____

Signature: _____

VOLUNTEER CONTACT INFORMATION

Please Print:

NAME: _____

ADDRESS: _____

CITY / STATE / ZIP _____

TELEPHONE _____ CELL _____

In Case of Emergency:

Name: _____ Relation: _____

Address: _____ Telephone: _____

Next of kin not living in your household:

Name: _____ Relation: _____

Address: _____ Telephone: _____

Friend who would know where you are:

Name: _____ Relation: _____

Address: _____ Telephone: _____

GBH TEEN-AGE VOLUNTEER (TAV) PROGRAM FORM

We at Baptist Health Care are dedicated to providing the same quality of health services to our Volunteers as we do our team members. Team Member Health (TMH) mandates that all persons who work in health care facilities are cleared of Tuberculosis, Measles, Mumps, Rubella, COVID, and FLU before engaging in any patient care. This is to provide the highest level of protection to our patients throughout their stay in our facilities.

Please select your location of Volunteer Service: BH GBH Jay BMP: _____

Volunteers must receive a Tuberculin Skin Test (TST) or a TB Gold lab test (for previous past positive or BCG vaccination) followed by a Chest X-ray as necessary (positive results). You may provide proof of having it done within the past 90 days.

Volunteers also must provide proof of completion of two doses of Measles, Mumps, and Rubella (MMR) vaccine, laboratory evidence of immunity, or confirmation of disease in the past. BHC will also need proof of your COVID-19 Vaccination and FLU Vaccination.

These can be given to Volunteers at the Baptist Health Care Team Member Health Center located at 1720 N E St on the corner of Avery and E Street. Office hours are Monday-Friday 7am-4pm- please arrive no later than 3:45pm to allow time for administration as a walk-in. ***We do NOT offer TSTs on Thursdays. Volunteers will need to return to TMH in 48-72 hours to have their TST read.*** You may sign up on EASYSCHEDULE.COM.

Legal Name: _____ DOB: _____

Social Security Number: _____

Volunteer's Signature: _____ Date: _____

Parental Signature (if Applicable): _____

For Team Member Health Use:

Tubersol 5TU per 0.1ml, Intradermal

Date TST Administered: _____ Time: _____ Site: LFA RFA

TMH Signature: _____ Lot # _____ Expiration: _____

Volunteer instructed **to return on Date:** _____ for TST Read (48-72 hours).

Provided Proof: TST: YES NO COVID Vaccine: YES NO FLU Vaccine: YES NO MMR: YES NO

Date of TST Read: _____ Time: _____ Results: _____ MM

Signature of TMH: _____ Negative Positive X-ray ordered

Team Member Health (TMH)
1720 N. E. St. Pensacola, FL 32501
Phone: 850.434.4756 | Fax:



BAPTIST HEALTH CARE RELIGIOUS ACCOMMODATION REQUEST FORM

(Accommodation to COVID-19 vaccine mandate)

Team Member name: _____ Team Member I.D.: _____

Phone number: _____ Email address: _____

Based on my sincerely held religious belief, practice, or observance, I am requesting a religious accommodation related to the COVID-19 vaccine.

Please identify your sincerely held religious belief, practice, or observance that is the basis for your request for religious accommodation. _____

Please briefly explain how your sincerely held religious belief, practice, or observance conflicts with Baptist Health Care's COVID-19 Vaccine Program. _____

Describe the accommodation(s) you are requesting and the applicable time period or frequency. _____

Do you anticipate working on premises at any BHC location at any time during the 2021-2022 year?

Yes No I do not know.

Please provide any additional information that may be helpful in processing your religious accommodation request. _____

Team Member Signature: _____ Date: _____

Date Received: _____

.....
For Official Use Only by BHC

Approved Denied

Date: _____

Name: _____

Title: _____

Signature: _____

BAPTIST HEALTH CARE

COVID-19 MEDICAL EXEMPTION REQUEST FORM

Full Name: _____

Team Member ID: _____ Phone #: _____

Provider (M.D./D.O., APRN, P.A.): please review and sign if the following applies to the above individual.

By signing below, I am attesting that I have reviewed the COVID-19 vaccine recommendations from the Centers for Disease Control (CDC) and request a medical exemption based on a recognized clinical contraindication as outlined by the CDC. *In general, the CDC considers a history of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine, or an immediate allergic reaction of any severity to a previous dose, or known (diagnosed) allergy to a component of the COVID-19 vaccine, to be a contraindication to vaccination with COVID-19 vaccines. For additional information on contraindications, please refer to the CDC informational document, Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, accessed at [cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf](https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf).

I am requesting a medical exemption for the above-named individual for the following reasons.

(REQUIRED: Description of clinical contraindication meeting CDC criteria):

This contraindication is: Permanent or Temporary
If temporary: The expiration date of the exemption for this vaccine is: _____

Signature of licensed health care provider

Date

Printed name of health care provider

M.D./D.O./P.A./N.P.



OUR MISSION

Helping people throughout life's journey.

OUR VISION

To be *the* trusted partner for improving the quality of life in the communities we serve.

OUR VALUES

Guided by Christian values, we commit to the following:

OWNERSHIP | accountable, engaged, stewardship, responsive, committed

INTEGRITY | honest, principled, trustworthy, transparent

COMPASSION | empathetic, merciful, sensitive, kind, giving, forgiving, hopeful

EXCELLENCE | safety, quality, distinguished, learning, improving

SERVICE | welcoming, attentive, humble, respectful, exceeds expectations, collaborative



BAPTIST
HEALTH CARE