Volunteering at
Ogden Regional Medical Center

(Please keep these sheets for your information. Return the completed application only)

Thank you for your interest in volunteering at Ogden Regional Medical Center. We look forward to the opportunity to work with you. Following are answers to frequently asked questions that are intended to simplify the application process. Minimum age is 17 for patient areas and 21 for the Emergency Room. Court ordered community service, attendance credit hours, internships and shadowing cannot be signed off at Ogden Regional. After reviewing this process, if you feel Ogden Regional Medical Center is a good match for your service, please complete and submit the attached application.

Application - Complete an application, answering all questions fully. It is imperative that we are able to contact you by e-mail, so include an e-mail address. Please thoughtfully respond to each question. Phrases such as "I want to give back to the community," need to be followed with deeper reflection. Return application to the volunteer office:

Ogden Regional Medical Center
Attn: Trudy Peterson, Volunteer Director
5475 South 500 East, Ogden, UT 84405
Phone- 801-479-2075 Cell-801-644-5682
Trudy.peterson@mountainstarhealth.com

Immunize – Disease History Most people can use the following guidelines to approximate their immunization/ and communicable disease history. For Utah students who started school after 1960, before entering kindergarten, most had the polio, MMR, and Tdap (Tetanus/diphtheria) vaccine. At age 12, before entering Junior High school, most Utah students had an MMR and Tetanus booster. Write "No" in the year if you did not have the vaccination/disease. If you are selected for a position, those age 19-64 without memory or record of the vaccination/disease will be required to have a Tdap booster and Varicella (chicken pox) vaccine. Our Infection Control Nurse will counsel you if needed. *(Applicants do not need to get vaccinations. We will address vaccinations if you are selected for a position.)*

Background - A background check is required. You must be willing include driver's license, social security number and former addresses. Any offense revealed on a background check that has not been fully taken care may disqualify applicant.

Drug Test- A drug test is required. This will be done through our lab.

Commitment -Due to the resources and time invested in volunteer training, **we require a minimum commitment of 100 hours.** This can be accomplished by volunteering in one department weekly for 6-months, or through a more intense schedule. Please do not apply if you are unable to make the commitment. There is a system in place that allows for reasonable absence, vacation and family time-off.

As a general rule, volunteers are asked to serve a minimum 4- to 5-hour shift, one day per week. We offer limited openings in clinical areas; however, these positions are peripheral support in nature as volunteers are not permitted to offer patient medical care.

Interview - After an application review, you may be contacted for an interview appointment. Interviews are scheduled based on current openings. The interview objective is to determine if this is a good match for you and us. For those offered a position, you can expect the following:

TB Test - This simple Tuberculosis test is mandatory before beginning service.

Badge - Human Resources will take a photo for the volunteer badge or you can provide your own.

Flu Vaccine- As a volunteer, we want to protect you and our patients. Therefore, volunteers are required to have the annual flu vaccine. If you have not had the vaccine, it will be offered to you at no cost by the hospital. If you have had the vaccine, please attach documentation. October-May

Covid Vaccines- Proof of the Covid vaccine is requested.

Uniform - We will provide one Navy blue uniform top. The remainder of the uniform consists of tan/khaki ankle length slacks, closed-toed shoes and socks (volunteer responsibility).

Orientation - Before you start, you will need to attend a two-three hour volunteer orientation.

Volunteer Defined: A volunteer is an individual who donates services without contemplation of payment for a public spirited or charitable purpose. Volunteer must have: the ability to traverse long distances; acceptable visual and audio acuity; possess excellent interpersonal and communication skills; be alert and able to problem-solve; have the ability read/write English legibly; be of sound mental and emotional health; and be flexible.

Time spent in these preparatory steps is necessary and informative. You will feel more at home in the hospital atmosphere, and you will be well prepared to serve. We expect you will enjoy your volunteer service and benefit personally from this fulfilling experience. We are excited to get acquainted with you and put your talents to use.

OGDEN REGIONAL MEDICAL CENTER

VOLUNTEER APPLICATION

Attn: Trudy Peterson, Volunteer Manager
5475 South 500 East, Ogden, UT 84405
PH: (801) 479-2075
Trudy.peterson@mountainstarhealth.com

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birthday _____ Home Phone # _____ Work/Cell# _____

E-mail address _____

1. Volunteer positions generally require a minimum commitment of one day per week, for 4-6 hours. The minimum commitment is 100 service hours. Are you able to fulfill this commitment?

   _____

2. Volunteer positions require the ability to traverse long distances; acceptable visual and audio acuity; excellent interpersonal and communication skills; alertness, ability to problem-solve; ability read/write English legibly; sound mental and emotional health; and flexibility. Are you able to perform the essential functions of volunteer service for which you are applying without accommodations? _____ If no, explain accommodation:

   _____

   _____

3. Describe employment, school or community experience and skills applicable to the volunteering _____

   _____

   _____

4. What specifically brought you to volunteer at this time in your life?

   _____

   _____

   _____

5. How did you hear of us?

   _____

   _____

   _____

ORMC VOLUNTEER ASSIGNMENT PREFERENCE

Please indicate service area(s) of interest to you. Check day(s) and time(s) you are available to volunteer on a regular weekly basis.

- ☐ **Information/Reception** *(day & evening)*
- ☐ **Nursing Station**
- ☐ **Mail Delivery/Materials Management** *(daytime only)*
- ☐ **Total Joint Center** *(knee/hip replacement experience preferred)*
- ☐ **Emergency Room** *(Ogden or Pleasant View 21 yrs. & older)*
- ☐ **Pet Therapy**
- ☐ **Anything available** *(clerical, gift shop etc)*

Day Available	Morning	Mid-day	Eve 4 –8 pm
☐ Sunday	☐	☐	N/A
☐ Monday	☐	☐	☐
☐ Tuesday	☐	☐	☐
☐ Wednesday	☐	☐	☐
☐ Thursday	☐	☐	☐
☐ Friday	☐	☐	☐
☐ Saturday	☐	☐	☐

Positions are filled based on qualifications, current openings and the applicant's availability.

In case of illness or personal emergency during my volunteer assignment, please contact:

1)_____
Name Relationship Phone(s)

2)_____
Name Relationship Phone(s)

3) Under age 18 requires parental permission.

Parent's signature:_____

I AM ORMC

As a volunteer at Ogden Regional Medical Center I commit to:

OWN
Offer solutions to problems. Offer help to others, even if it is not my job. Accept ownership of my concerns.
Work area – Keep clean and organized. Care for all equipment and return to proper storage.
Negativity is unacceptable – Be positive with all patients, visitors, customers, all hospital staff, employees,
volunteers and physicians.

RESPECT
Recognize and acknowledge the good in my fellow co-workers.
Each of us is responsible: I am accountable for my attitude and actions.
Stay informed.
Proper tone of voice. Use appropriate verbal and nonverbal language. Be non-judgemental.
Employees manage up – "Manage up" everyone!
Core Values–Maintain honesty, integrity, compassion, trustworthiness, kindness, hospital loyalty, professional image (includes dress code).
Teamwork.

MESSAGE
Make sure patients, families, and physicians are kept informed.
Escort patients and visitors to their destination.
Scripts! I will use them!
Save personal conversations for a time away from patients – Never complain to a patient
Always say what I CAN do, not what I can't do.
Greet each patient with a smile and maintain eye contact.
Everyone - Use the ICARE model.

CARE
Communication - Complete and maintain the whiteboard at all times.
Actively LISTEN to the patient without interrupting.
Relationships are very important – Build them with customers and patients.
Environment – Keep the noise level down and check the comfort level of patients & guests.

_____

Volunteer Signature Date

For HIPAA purposes, if I am hospitalized at Ogden Regional Medical Center, I grant permission to my volunteer colleagues, hospital staff and leadership to acknowledge my visit with a remembrance or visit during my stay. This authorization applies to all future admits including those while I am volunteering, and those following my volunteer service.

_____

Volunteer Signature Date

Confidentiality and Security Agreement

I understand that the facility or business entity (the "Company") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINS, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

☐ *General Rules*

1. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.

☐ *Protecting Confidential Information*

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
2. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
3. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy.
4. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available
5. I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
6. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards.

☐ *Following Appropriate Access*

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

☐ *Using Portable Devices and Removable Media*

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes company data ***(e.g.,*** Company email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Company has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes company data regardless of it being a Company or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Company network.

☐ *Doing My Part - Personal Security*

1. I understand that I will be assigned a unique identifier ***(e.g.,*** 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. I will:
    a. Use only my officially assigned User-ID and password (and/or token *(e.g.,* SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
3. I will never:
    a. Disclose passwords, PINS, or access codes.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect unauthorized systems or devices to the Company network.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
    a. my password has been seen, disclosed, or otherwise compromised;
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;
    d. I am aware of any activity that violates this agreement, privacy and security policies; or
    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

☐ *Upon Termination*

1. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Volunteer Signature	Facility Name and COID Ogden Regional Medical Center 34415	**Date**
Volunteer Printed Name	Business Entity Name Ogden Regional Medical Center	

Ogden Regional Volunteer Health History

Name:_____ **Start Date:**_____
Last First Middle Previous

Home Phone:_____ **Cell Phone:**_____ **DOB:**_____

Address:_____ **SSN:**_____
Street City State Zip

Department:_____ **Job Title:**_____

Previous HCA Employee? Yes No **If Yes, what facility?**_____

Do you have or have you experienced any of the following? If yes, explain under "Medical Conditions"

1	Balance problems, hearing loss or abnormal hearing test?	Yes	No
2	Seizures, convulsions or epilepsy?	Yes	No
3	Insulin Dependent Diabetes?	Yes	No
4	Shortness of breath, asthma or chronic lung problems?	Yes	No
5	Heart problems or chest pain?	Yes	No
6	Disease or medications affecting the immune system?	Yes	No
7	Joint or muscle pain? Difficulty with lifting?	Yes	No
8	Any other problems that cause activity limitations?	Yes	No
9	Persistent numbness, tingling or pain in the arms, hands or wrists?	Yes	No
10	Diagnosed with a back or neck injury?	Yes	No
11	Had a gastrointestinal infection with Campylobacter, Salmonella, Typhoid, Shigella or E. Coli in the last six months?	Yes	No
12	Fertility or reproductive concerns?	Yes	No
13	Have you seen a doctor concerning liver or kidney problems in the last year?	Yes	No
14	Contact with (preparation, administration, handling, disposal, cleaning or interfaced with) anti-neoplastic drugs, waste anesthetic gasses or other hazardous materials?	Yes	No
15	Please circle all the apply and comment below as necessary: A. Skin: Cracking, Rashes, Burns, Blisters B. Eyes: Swelling, Irritation C. Mucus Membranes: Nasal Irritation, Throat Irritation, Dry Cough, Chest Pains D. Neurological: Numbness, Tingling, Weakness, Headaches, Drowsiness, Coordination Problems		

Describe any Current Medical Conditions:

_____

_____

_____

_____

_____

Do you or have you had in the past any physical or emotional condition that restricted your ability to work, or caused you to miss work?
YES NO If yes, please explain:

_____

_____

_____

Do you or have you been tested for Latex allergy or sensitivity? Have you ever had a problem wearing gloves?
YES NO If yes, please explain:

_____

Do you have any allergies to:

A. Chemicals or household products? B. Fragrances? C. Other Allergies-Please list below:

_____

_____

Please list any current medications that would affects your ability to perform your job duties (prescription or over-the-counter):

_____

_____

_____

Have you ever had a positive TB test? Yes No

If you had a POSITIVE reaction, please answer the following questions:

Did you take medication for your reaction?	Yes	No
Do you have night sweats?	Yes	No
Do you have a chronic cough?	Yes	No
Have you coughed up blood?	Yes	No
Have you noticed an unexplained weight loss?	Yes	No
Did you have a chest X-ray taken?	Yes	No

Date of chest X-ray_____

The information on this Health History Form is complete and accurate to the best of my knowledge. I understand that the information contained in this form is confidential. The information is needed by Occupational Health to address health and safety concerns and provide employees with the necessary information.
If you are pregnant or planning pregnancy, please discuss this with the Occupational Health Nurse so that information you should know for fetal protection may be provided. You should discuss the type of work you are doing with the Healthcare Provider monitoring your pregnancy.

EMPLOYEE/VOLUNTEER SIGNATURE: _____
Date:_____
OHN SIGNATURE: _____
Date:_____

Ogden Regional Volunteer Immunization History

Name: Date:

Address: Phone:

City, State, Zip: Date of Birth:

SSN: Job Title: Department:

Allergies: Y N If Yes, please list:

Latex Allergy: Y N If Yes, type of reaction?

Have you ever lived outside of the United States? Y N If Yes, Where?

Have you ever had a positive TB test? Y N BCG (TB) Immunization? Y N

If Yes to positive test: -Date of positive: _____ -Size of positive: _____
-Any Treatment Taken? Y N -Last Lab Taken: _____
-Last Chest X-Ray: _____

Date	QFG or PPD (mm)	Follow-Up on Abnormalities	Notes

Titer History

Test	Result	Date
Rubella Titer		
Rubeola Titer		
Mumps Titer		
Hep B Antibody		
Varicella Titer		

Immunization History Dates

Tetanus Toxoid: _____
Tdap: _____
Polio: _____
MMR #1: _____
MMR #2: _____
Hepatitis B #1: _____
Hep B #2: _____
Hep B #3: _____
Hepatitis A #1: _____
Hep A #2: _____
Varicella #1: _____
Varicella #2: _____
Zostrix: _____
Influenza: _____

GINA

The Genetic Information Nondiscriminatory Act of 2008

Safe Harbor Language: The Genetic Information Nondiscriminatory Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family members of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual or his/her family member's genetic tests, the fact that an individual or his/her family member sought or received genetic services, and genetic information of a fetus carried by an individual or his/her family .

I have read and certify that all of the above information is true to the best of my knowledge.

Signature _____ **Date** _____

Ogden Regional Medical Center - Volunteer # 11259
APPLICANT INFORMATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1] _____

Email address: _____ (Provide if you prefer to receive information via email)

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

You MUST read this section carefully before answering the question below.

- Do not report a record of any arrest, detention, diversion, supervision, adjudication or court disposition that was subject to the process and jurisdiction of a juvenile court.
- Do not report any conviction that has been sealed, expunged, statutorily eradicated, annulled, dismissed, dismissed under a first offender's law, pardoned by the Governor or which state law allows you to lawfully deny as set forth below.
- You MUST review the state law information before answering.
- You are not required to disclose violations, infractions, petty misdemeanors (MN) or summary offenses (PA).
- By selecting either "Yes" or "No" below, you are stating that you have read the applicable state notices provided above and that you provide a true and accurate statement below.
- A conviction will not necessarily be a bar to employment. This information will only be used for job-related purposes consistent with applicable law and in determining whether the conviction is related to the job for which you are applying.
- If you answer "Yes" below, provide city, county, and state where offense occurred, conviction date and nature of the offense, along with sentencing information.

QUESTION: Have you ever been convicted of, plead guilty, no contest, or nolo contendere to a misdemeanor or felony? Yes ☐ No ☐ (Please attach a separate sheet of paper to provide additional entries.)

Offense _____ County _____ State _____ When_____

Offense _____ County _____ State _____ When_____

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency. (Please attach a separate sheet of paper to provide additional entries)

1. **City:**_____ **State:**_____ **Zip Code:**_____ **Date From:**_____
   Date To:_____
2. **City:**_____ **State:**_____ **Zip Code:**_____ **Date From:**_____
   Date To:_____
3. **City:**_____ **State:**_____ **Zip Code:**_____ **Date From:**_____
   Date To:_____
4. **City:**_____ **State:**_____ **Zip Code:**_____ **Date From:**_____
   Date To:_____

Additional Questions

1. Your signature below indicates that you grant permission to contact your current employer for verification purposes.
   _____

STATE LAW NOTICES

California applicants or employees only: Please mark this field ____ to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

California applicants or employees only: A copy of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW is also being provided to you.

Colorado applicants or employees only: If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

Connecticut applicants or employees only: If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

Maryland applicants or employees only: If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

Massachusetts applicants or employees only: The precise nature and scope of any investigative consumer report (which commonly includes information regarding your character, general reputation, personal characteristics, and mode of living) will be the same types of information described above. You have a right to have a copy of any investigative consumer report upon request from PreCheck, Inc, 3453 Las Palomas, Alamogordo, NM 88310; 1-888-773-2432.

Minnesota applicants or employees only: You have the right to request a complete and accurate disclosure of the nature and scope of any consumer report from PreCheck, Inc, 3453 Las Palomas; Alamogordo, NM 88310; [1-888-773-2432. Place an X here _____ for a disclosure to be sent to you. Place an X here _____ for a free copy of your consumer report to be sent to you.

Montana applicants or employees only: You have a right to request from Company disclosures of the nature, scope, and substance of any investigative consumer report.

New Jersey applicants or employees only: The precise nature and scope of any investigative consumer report (which commonly includes information regarding your character, general reputation, personal characteristics, and mode of living) will be the same types of information described above. You have a right to have a copy of any investigative consumer report upon request from PreCheck, Inc, 3453 Las Palomas; Alamogordo, NM 88310; 1-888-773-2432, www.precheck.com.

New York applicants or employees only: Company may request or utilize subsequent consumer reports (other than investigative consumer reports) on you throughout your employment. Upon request, you will be informed whether or not a consumer report was requested, and if such report was requested, informed of the name and address of the CRA that furnished the report. Upon written request, you will be informed whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the CRA to whom the request was made. Your written request should be made to Company. Upon furnishing you with the name and address of the CRA, you will also be informed that you may inspect and receive a copy of such report by contacting that agency. Please mark this field to receive a copy of Article 23-A that will be presented once you complete this process: ____.

Oklahoma applicants or employees only: Mark an X here ____ you would like to receive a free copy of your report.

Oregon applicants or employees only: If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

Washington State applicants or employees only: 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 any "investigative" consumer report we may have requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act. Any requests under this paragraph to the CRA should be made to PreCheck, Inc, 3453 Las Palomas; Alamogordo, NM 88310; 1-888-773-2432, www.precheck.com. If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

Vermont applicants or employees only: If the Company obtains information bearing on your credit worthiness, credit standing or credit capacity, it will be because the information is substantially related to the job for which you are being considered/are currently occupying and to evaluate whether you would present an unacceptable risk of theft or other dishonest behavior in the job for which you are being considered/are currently occupying.

I have read and understand the above information and assert that all information provided by me is true and accurate.

By signing below, I agree that my present employer may be contacted for verification of employment.

Signature: _____ **Date** _____

Parent/Guardian Signature: _____ **Date** _____

[1] The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

Nevada Private Investigator License # 1618

Ogden Regional Medical Center - Volunteer # 11259
DISCLOSURE

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1] _____

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Ogden Regional Medical Center - Volunteer and related entities ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract for services, appointment, volunteering or clinical rotation. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, drug screening, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report.

Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd.Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization.

Ogden Regional Medical Center - Volunteer # 11259
AUTHORIZATION

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports," including criminal background checks, by the Company at any time after receipt of this authorization and throughout the hiring process and the term of my employment, contract or privileges, if applicable. I authorize the Company throughout the term of my employment or contract, to share any consumer report received with a related entity. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 LasPalomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ **Date** _____

First Name: _____ **Middle Name:** _____

Last Name: _____

DOB _____ **Last four digits of SSN** _____

Parent/Guardian Signature: _____ **Date** _____