

2025 COLLEGE VOLUNTEER ANNUAL AGREEMENT FORMS PACKET

As part of your volunteer Annual In-Service requirements, each year active volunteers must sign the enclosed Volunteer Agreement & Acknowledgment forms.

Please SIGN & RETURN ALL ATTACHED PAGES by July 7th.

CHECKLIST:

- 2025 Volunteer Agreement Form
- 2025 Standards of Conduct for Volunteers Agreement
- 2025 Infection Control Agreement
- Consent Form for Interviewing, Photographing, Filming, Video/Audio Taping
- Media Release
- Confidentiality Statement
- Acknowledgement Form for HIPAA Privacy & Security Awareness Training
- Annual Tuberculosis Screening form

Return by email to: lakisha.hudson-benbow@emoryhealthcare.org

or by mail/Drop off to:

**Lakisha Hudson-Benbow
Volunteer Services Suite 202
Emory Johns Creek Hospital
6325 Hospital Parkway
Johns Creek, GA 30097**

If you have any questions, please contact Volunteer Services at:

lakisha.hudson-benbow@emoryhealthcare.org

Office – 678.474.8330

EJCH COLLEGE VOLUNTEER PROGRAM

2025 Volunteer Agreement

As a Hospital Volunteer, I Agree:

1. To contribute 100+ scheduled hours per year of personal service for Adult volunteers, or 80+ hours for College volunteers, as stated in the Volunteer Handbook & Procedures.
2. To abide by the uniform policy as stated in the Volunteer Handbook & Procedures.
3. To adhere to my schedule, always notifying the Volunteer Services office and my department in case of absence. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments I accept.
4. To accurately document my service time by using the sign-in/out system (VicTouch) or calling my time into the Volunteer Services office, if I forget to sign in or out.
5. To abide by the Volunteer Services Department's meal benefit – a free snack/meal for every four (3) hours of volunteered service not to exceed a total of \$8 per day.
6. To treat all colleagues and customers with courtesy, respect and without regard to race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age, disability or genetic information – embracing cultural differences.
7. To always demonstrate appropriate use of language, have a positive attitude and maintain professional behavior. I understand my relationship with fellow volunteers, employees and patients is professional and not personal.
8. I will **absolutely hold all information confidential** that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from a patient.
9. To respect federal and state laws applicable to protect patient health information. I will not use social media to post confidential information about Emory Healthcare's patients, including protected health information. Furthermore, I will not unlawfully disparage Emory Healthcare's services or the products or services of its vendors or competitors.
10. My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian, religious, or charitable reasons.
11. That it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on and off hospital property and will report all occurrences.
12. I shall not sell, or attempt to sell, goods or services, request contributions or solicit persons to sign or distribute political petitions on hospital premises.
13. I shall fulfill my annual in-service requirement and shall submit to a yearly health screening, which includes an annual Tuberculosis Health Questionnaire and a flu vaccination. Upon request, I will authorize my doctor(s) to furnish the hospital with necessary information regarding my health.
14. I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and if unsuccessful, attempt to resolve any such problem with the Volunteer Services staff.
15. I shall, at all times, uphold the mission, vision and values standards of the hospital. I will always exceed customer service expectations to help Emory Healthcare deliver great service.
16. That the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
 - a. Failure to comply with hospital policies, rules, and regulations not limited to but including HIPAA compliance.
 - b. Unsatisfactory attitude, work or appearance. This includes properly wearing a mask where/when required.
 - c. Aggressive behavior, abusive or sexual language, verbal harassment, threats, physical assault
 - d. Any other circumstances which, in the judgment of the Volunteer Services Department Director, would make my continued service as a volunteer contrary to the best interest of the hospital.
17. That the Volunteer Services Department reserves the right to accept or reject my application at its sole discretion.
18. **I shall notify the Volunteer Services Department in writing if I should have to resign from volunteer service, and return my badge and parking pass.**

I have read each of the conditions and I agree to be bound by them.

Volunteer Signature

Date

Volunteer Name (Print)

EJCH COLLEGE VOLUNTEER PROGRAM

2025 STANDARDS OF CONDUCT FOR VOLUNTEERS AGREEMENT

(Read the following agreement and indicate your answer below.)

Like employees, all volunteers must take personal responsibility for their actions and conduct themselves in a positive and ethical manner, and adhere to all Emory Healthcare's (EHC) policies and standards of conduct. Types of unacceptable conduct for which immediate disciplinary action, including termination, may occur include, but are not limited to, the following:

- Neglect of duty (including leaving patients/residents without care) or any conduct harmful to patients, visitors, residents, medical staff and/or employees.
- Inappropriate handling or disclosure of confidential information or records contrary to EHC confidentiality policies.
- Falsification of forms, time and attendance records, patient records, or other documents, including but not limited to application, employment, promotion or transfer documents.
- Solicitation/distribution of materials contrary to EHC's no-solicitation policies.
- Acts of physical misbehavior or acts of violence or threats of violence, including but not limited to provoking or participating in fighting or making threats
- Possession of firearms, weapons, explosives or dangerous materials on ECH property unless authorized for a volunteer related assignment.
- Performance of duties in an irresponsible, careless, or unsafe manner or behavior not conducive to a safe and appropriate work environment, including but not limited to failing to adhere to the no-smoking policy.
- Non-compliance with EHC's commitment to equal opportunity and affirmative action.
- Commission of acts of discrimination or harassment.
- Pleas of nolo contendere or conviction for an illegal act, committed on or off an Emory site, which adversely impacts volunteer performance, attendance or the reputation of Emory Healthcare.
- Unauthorized access, inappropriate use, or abuse of EHC's equipment or property, such as but not limited to, copiers, computers, computer software, internet access, fax machines and telephones.
- Refusal to perform volunteer-related duties and assignments, including refusal to cooperate with an organizational investigation.
- Failure to follow EHC's policies or procedures.
- Misuse, defacement, or destruction of EHC, employee, patient/resident, medical staff or visitor property.
- Unlawful manufacture, distribution, sale, possession, or use of any controlled substance, illegal drugs, or alcohol.

Volunteers may be terminated for gross misconduct, which includes but is not limited to the following types of misconduct:

1. unlawful manufacture, distribution, sale, possession or use of any controlled substance,
2. defacing or destroying EHC patient, visitor and/or employee property
3. falsification of forms, time and attendance records, patient records, or other documents or information, including but not limited to application, employment, promotion or transfer documentation,
4. unauthorized possession, removal or use of property belonging to EHC or an employee, student, guest or visitor,
5. unauthorized possession of firearms, weapons, or dangerous materials on EHC property,
6. commission of a criminal act in connection with volunteer performance, or which victimizes or is abusive to an EHC employee, student, patient, guest or visitor.

ATTESTATION: By checking the box, I agree that I will abide to the standards of conduct & behavior. *

- I agree I do not agree

Signature: _____ Date: _____

Print Name: _____

EJCH COLLEGE VOLUNTEER PROGRAM

2025 Infection Control Agreement

Health Requirements:

As a Volunteer, I Understand That:

1. I should refrain from volunteer service if I am ill with a cold, flu, fever, nausea, vomiting, diarrhea, etc.; or any symptoms associated with COVID-19, some of which include a temperature above 100°, new onset of cough, sore throat, shortness of breath, loss of taste/smell.
2. If I should take a leave of absence from active service due to health reasons, a doctor's approval is required to return to active service.
3. I am required to complete an annual Tuberculosis Health Questionnaire and annual influenza vaccination.
4. I must be able to exhibit interpersonal skills, physical and emotional stability.
5. In the event I am involved in an incident or circumstance, on or off the job, which places my health in jeopardy, the hospital will exercise its right to review my active status.

Infection Control:

As a Volunteer, I Understand:

1. The directives on infection prevention for patients, employees and volunteers.
2. Universal precautions were developed and implemented to prevent healthcare workers from unnecessary exposure to infectious processes transmitted in blood and body fluids, while also protecting patients and their families from unnecessary exposure to contaminants.
3. The procedure for proper **HANDWASHING** techniques, including the proper use of hand sanitizer and gloves.
4. That I must abide by all hospital requirements regarding PPE, which includes the proper wearing of face masks, and any social distancing restrictions, when/where required.
5. That I am **not** to transport any blood or body fluids or any blood or body fluid contaminated linen or equipment.
6. That I will not enter restricted or isolation designated rooms or departments.
7. That a copy of this acknowledgement will be placed in my records as required by Federal regulations.

Volunteer Signature

Date

Volunteer Name (Print)

EJCH COLLEGE VOLUNTEER PROGRAM

Consent for Interviewing, Photographing, Filming, Video/Audio Taping or Other Recording

EMORY
HEALTHCARE

I, the undersigned, consent to being interviewed, photographed, filmed, video/audio taped, and/or having my voice or image recorded by other electronic or non-electronic means by Emory University or its affiliated entities (including, but not limited to Emory Healthcare, Emory University Hospital, Emory Crawford Long Hospital, The Emory Clinic or the Wesley Woods Center) (collectively "Emory"), its employees, or such agents as it may engage for this purpose. I also authorize Emory to permit other individuals and entities, including but not limited to representatives of commercial or noncommercial newspaper, magazine, radio, or television related organizations, to interview, photograph, film, video/audio tape, and otherwise record me on any of the Emory premises.

I grant Emory permission to use any such interviews, photographs, films, video/audio tapes and other recordings or images in Emory's own publications or in any other broadcast, print or electronic media, including without limitation newspaper, radio, television, magazine, Internet, or other computer transmission. I understand that, unless otherwise noted, I may be identified by name. I further grant permission for any such interviews, photographs, films, video/audio tapes, and other recordings or images to be edited and/or incorporated into any compilation or derivative work as is deemed necessary or appropriate. I waive any right to inspect or approve my depictions in these works. I further understand that once such materials are in the possession of the media or members of the general public, Emory does not retain control over their editing or use.

I understand that this consent is voluntary and that I will receive no compensation for this consent or any interview, photograph, film, video/audio tape, or other recording or image authorized above. I further understand that I will have no economic and/or intellectual property right, title or interest, or any other property right or license in the interviews, photographs, films, video/audio tapes, or other recordings or images authorized above.

I understand that my refusal to consent will in no way affect my eligibility to receive medical care or services at any Emory health care facility.

I understand that this consent will remain in effect indefinitely. I further understand that I may revoke this consent at any time, except to the extent that Emory has already relied upon it. I further understand that any such revocation must be in writing.

I hereby release Emory University and its affiliated entities, including but not limited to Emory Healthcare, Inc., Emory University Hospital, Emory Crawford Long Hospital, The Emory Clinic, Inc., the Wesley Woods Center, and each of their trustees, officers, employees and agents, from any and all claims, liability, and damages, which might arise from the use of my name, or for taking or using any interviews, photographs, films, video/audio tapes, or other recordings or images authorized by me.

Name of Subject Print

Signature of Subject (or Subject's Representative)

Date

Description of authority to sign for/on behalf of Subject, if applicable



EMORY
UNIVERSITY

EMORY
HEALTHCARE

Media Release

For good and valuable consideration herein acknowledged as received, I hereby grant to Emory University, its affiliates, legal representatives, and assigns, and those acting with Emory’s authority and permission, the irrevocable and unrestricted right and permission to create, use, reuse, publish and re-publish video recordings, audio recordings, photographs, or other media that contain or capture my likeness or voice or in which my likeness or voice may be included (the “Recordings”) in connection with any publication or materials relating to or serving the mission and goals of Emory University or Emory Healthcare, including advertisements, brochures, or other promotional materials. The Recordings may be used with or without my name, and in any and all media now or hereafter known. I acknowledge and agree that Emory owns all right, title, and interest in and to the Recordings, including all copyrights therein and the full and unrestricted right to edit and modify the Recordings, and I hereby assign and agree to assign any such interest that I may own or control to Emory. I also consent to the use of any printed matter in conjunction with the Recordings. I hereby waive any right I may have to inspect or approve the Recordings or any finished product or products incorporating the Recordings and any written or other print material that may be used in connection therewith, including print material containing my name. I acknowledge that nothing in this Agreement obligates Emory or any third party to make any use of the Recordings. If the Recordings will be created at a public event, I understand and agree that media and other entities may be present and creating their own recordings; and that such entities will be free to edit, display, and otherwise use any such recordings as they determine in their own discretion, including any recordings that include my name, image, likeness, voice, and any spoken remarks at the event.

I hereby warrant that I am of legal age and have the right to contract in my own name. I have read the above Media Release prior to its execution, and I am fully familiar with its contents. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Name (Print) _____ Date _____

Signature _____ Phone _____

Address _____ City

_____ State _____ Zip _____

If the subject is a minor, have parent or guardian complete below:

Parent Name (Print) _____ Date _____

Parent Signature _____ Phone _____

On behalf of Minor Name (Print) _____

Address _____

City _____ State _____ Zip _____



CONFIDENTIALITY AND SYSTEM ACCESS TERMS– (Revised 7/2022)

In order for Emory Healthcare and its affiliated entities and healthcare facilities (which are individually and collectively referred to as “EHC” in these Terms) to permit authorized users access to certain of EHC’s electronic systems, including but not limited to functionality related to EHC’s electronic health records (which are referred to as “EHC Systems” in these Terms), users must agree to be bound by these Confidentiality and System Access Terms (which are referred to as the “Terms”). Users may require access to EHC Systems based on their work for or other affiliation with EHC (which are referred to as the “EHC Affiliation” in these Terms). Examples of EHC Affiliation for which a user requires access to EHC Systems include, but aren’t limited to, working for EHC as an employee, contractor or other service provider, being a medical staff member, and providing treatment or certain other services to current or former EHC patients on behalf of a non-EHC provider or vendor. Users who do not agree to these Terms are not permitted to access or use any EHC Systems.

Certain provisions of these Terms may be superseded by expressly designated legal notices or terms located on particular pages within an EHC System. The Terms may be updated from time to time. The most current version of the Terms will be posted in the [EHC Policy Management System](#). Accordingly, it is the user’s responsibility to periodically review this page to ensure familiarity with the most current version of these Terms. A user’s continued access and use of any EHC System after modifications of the Terms are posted will constitute the user’s agreement to be bound by such updated Terms.

It is the policy of EHC that any patient, financial, employee, vendor, payroll and related information is strictly confidential and/or proprietary information.

I understand that, in the course of my EHC Affiliation, I may learn information which is confidential or privileged under federal or state law or which is considered sensitive, confidential and/or proprietary by EHC (all such information is referred to as “Confidential Information” in these Terms). Depending on the nature of my EHC Affiliation and responsibilities, Confidential Information to which I have access to may include, but is not limited to, patient medical, financial and personal information, employee and payroll information and other non-public and proprietary financial, technical, operational, as well as vendor and other third-party information. I agree to keep confidential all such Confidential Information, whether verbal, written or electronic, which I learn in the course of my EHC Affiliation and to only use or disclose Confidential Information as specifically permitted by EHC for purposes of my specific EHC Affiliation. I will not discuss patient or family information with anyone not immediately concerned with or involved with a particular patient’s care or treatment. I will not discuss patient information or other Confidential Information with anyone who does not have a legitimate business-related need to know. In addition, I will not discuss patient or other Confidential Information in public areas (such as elevators, cafeterias, public hallways, etc.).

I will not access or attempt to access or use any EHC System or information unless the information is relevant to my EHC Affiliation and I am clearly authorized to access it. I understand that the logon ID, computer password, time and attendance identification number and other credentials (individually and collectively called the “Credentials” in these Terms) that may be assigned to me by EHC are to be used solely by me in connection with my authorized access to and use of EHC Systems and information. I understand that use of my Credentials by anyone other than me is strictly prohibited. I will not share any Credentials with anyone, and I will take all necessary steps to protect the confidentiality of my Credentials.

I understand that the EHC (xxx.xxx@emoryhealthcare.org) and Emory University (xxxx@emory.edu) electronic mail, including messaging within the EHC electronic medical record, is EHC property and subject to organizational review and should be used only for business purposes unless otherwise permitted by relevant EHC policies. I also understand and certify that use of my electronic or digital signature to authenticate documents is the equivalent of my handwritten signature on the documents.

I understand it is my responsibility to read and to abide by any and all policies and procedures regarding the access and use of EHC Systems and the access, use and disclosure of Confidential Information and other information or data owned by EHC, as such policies are currently in effect or which may be implemented or revised from time to time. I understand that EHC Systems and information access may be monitored and violation of EHC's policies and procedures may result in disciplinary action against me, which depending on the nature of my EHC Affiliation may include, but is not limited to, loss or limitation of access to EHC Systems, termination of employment or other affiliation(s) with EHC, including loss of clinic and/or hospital privileges, reporting to my employer (if different from EHC) or law enforcement, as well as civil and criminal prosecution to the fullest extent of the law.

I understand that when my EHC Affiliation ends for any reason, whether because of termination of my employment or contractor status or otherwise, I am not permitted to keep or take, or have in my possession or continue or attempt to access or use, any confidential or proprietary information from EHC or access any EHC Systems, unless specifically authorized by EHC policy. I understand that when my EHC Affiliation ends for any reason my obligations with regard to the use and disclosure of patient and employee information will continue indefinitely and that my confidentiality obligations with regard to all other Confidential Information will continue for so long as the information is not generally available to the public without fault by me.

I UNDERSTAND THAT EHC IS GRANTING ME ACCESS TO CONFIDENTIAL INFORMATION AND EHC SYSTEMS IN CONSIDERATION OF AND RELIANCE ON MY AGREEMENT TO THESE TERMS. BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO COMPLY FULLY WITH THESE TERMS.

Signature

_____/_____/_____
Date

INSTRUCTIONS FOR COMPLETING AND RETURNING FORMS:

- If you are accessing and signing these Terms within the EHC New Applicant System, the signed Terms will be automatically sent to EHC following signature.
- If you are requesting Emory Healthcare Link (EpicCare Link) access, you must attach these signed documents to your Emory Healthcare Link access request.
- If you are requesting EpicCare (Epic Hyperspace) access, you must attach these signed documents to your EpicCare access request.
- Otherwise, you must sign and date the Terms, and **email the scanned signed and dated Terms to your access coordinator.**
- You may contact your Access Coordinator with questions regarding logon ID access.
- **DO NOT FAX THIS** form to the EHC Office of Compliance Programs.
- Please note that the completed and signed Acknowledgement of Privacy and Security Awareness Training document must also be received by EHC before access may be granted.



Acknowledgement of Privacy and Security Awareness Training

Scope:

For Emory Healthcare Employees, Temporary Employees, Contractors, Vendors, Students, Emory University Employees, Physicians, Community Physicians and All Other Users with Access to ePHI/PHI.

I am, or in the future may become, a user of one or more EHC information technology devices or systems that may include ePHI and PHI in any other medium and I hereby certify that:

1. I have read and understand the EHC “Privacy and Security Awareness Training” handout.
2. I understand the importance of maintaining the confidentiality and integrity of all ePHI and PHI.
3. I understand that it is against EHC policy to access my PHI and ePHI through EHC Systems including the EeMR except as permitted for patients generally (for example, using the EHC patient portal). I also understand that it is against EHC policy to ask another employee or provider with access to the EeMR or other EHC Systems to access my PHI and ePHI.
4. I agree to abide by the EHC policies and procedures, as further explained in the EHC “Privacy and Security Awareness Training” handouts.
5. I understand that, by not following EHC policies and procedures, I am subject to disciplinary actions up to and including termination of employment, loss of hospital and clinic privileges, or other affiliations with EHC, loss of access to systems with ePHI, civil action and penalties, and criminal action and penalties.
6. I understand I can call 404-778-2757 if I have questions regarding the training or EHC policies or procedures related to PHI/ePHI I agree to call this number if I have any question regarding the “Privacy and Security Awareness Training. When in doubt reach out!

_____,Volunteer
SIGNATURE and AFFILIATION

DATE

PRINT NAME

Volunteer Services, EJCH

DEPARTMENT/SECTION

Volunteer Name: _____

Date: _____

ANNUAL TUBERCULOSIS SCREENING

ANNUAL TUBERCULOSIS SCREENING	
Temporary or permanent residence (for ≥ 1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe) since last TB test or TB screen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current or planned immunosuppression, including HIV infection, receipt of an organ transplant, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month), or other immunosuppressive medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Close contact with someone who has had infectious TB disease since last TB test or TB Screen	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Tuberculosis testing [TB.SPOT] is recommended if any of the questions are answered "Yes"

TUBERCULOSIS SYMPTOMS QUESTIONNAIRE

Please indicate by check mark if you have had any of the following symptoms in the last 60 days.

Symptom	Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Sputum	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>

Volunteer Signature: _____

Date: _____

If under age 18, must include signature consent of Parent/Guardian:

Print name of Parent/Guardian: _____

Please print

Parent/Guardian Signature: _____

Date: _____

To be completed by Emory Employee Health:

Employee Health Signature: _____

Employee Health Nurse

EMPLOYEE HEALTH SERVICES