Family Advisory Council Application

Please print the following:

Last Name:_____First:_____Middle:_____
Mailing Address: _____
City:_____State:_____Zip Code: _____
Home Telephone Number:_____Cell Telephone: _____
Business Telephone: _____
E-mail Address: _____
Spouse Name: _____
Spouse's Home Phone:_____Spouse's Business Phone: _____
Date of Birth: _____
Social Security Number---------- _____(for background check only)
Foreign Languages Spoken: _____

Name of person to contact in case of an emergency:
Last Name: _____
First Name: _____
Relationship: _____
Telephone Numbers to call: Day:_____Evening: _____

Education (Based on your current level of education):
I have completed: ☐ High School ☐ Some College ☐ College ☐ Graduate School

Employment:
Employer (past and/or present):
_____

Position: (past and/or present):
_____

Volunteer Service:
Organization and purpose of organization (past and/or present):
_____

Position: (past and/or present):
_____

Health Information:
Physician's Name: _____
Telephone Number: _____
Do you have any physical or mental condition that would limit your ability to perform as a volunteer without any supplemental assistance? ☐ Yes ☐ No
If yes, please explain:_____
_____

Please check off the infectious illnesses you have had:

☐ MMR ☐ Chicken Pox ☐ Tetanus ☐ Whooping Cough ☐ Diphtheria ☐ Polio

Please check the infectious illnesses you have been immunized for:

☐ MMR ☐ Chicken Pox ☐ Tetanus ☐ Whooping Cough ☐ Diphtheria ☐ Polio

☐ Influenza (Regular and H1N1) Please specify Date of vaccination_____

References:

Please print the complete mailing addresses of three people we may contact (**excluding relatives and roommates**) who have known you for more than two years. Local references preferred.

Name:_____Relationship:_____
Address:_____
City:_____State:_____Zip: _____
Telephone: (____)_____

Name:_____Relationship:_____
Address:_____
City:_____State:_____Zip: _____
Telephone: (____)_____

Name:_____Relationship:_____
Address:_____
City:_____State:_____Zip: _____
Telephone: (____)_____

Rady Children's Hospital-San Diego reserves the right to conduct state and federal background checks.

Have you ever been arrested for conducting or attempting to conduct a sexual offense?

☐ Yes ☐ No

Have you ever been convicted, plead no contest or plead guilty to a felony or misdemeanor?

☐ Yes ☐ No

If yes, please list the date(s) of the arrest(s) and any facts and circumstances surrounding the arrest(s). Being arrested does not automatically exclude you from consideration. If you meet the requirements, you will be able to explain the circumstances of your arrest. If you are subsequently arrested for conducting or attempting to conduct a sexual offense during the course of your volunteer services at RCHSD, you agree to notify Volunteer Services. Failure to do so may result in termination.

_____
_____
_____
_____

Your Experiences at Rady Children's Hospital

Name(s) of your child or children with health care/experiences at Rady Children's

Child A:_____Child's DOB: _____
Child B:_____Child's DOB: _____

Child A's Primary Diagnosis: _____
Child B's Primary Diagnosis: _____

Do you have other Children? ☐ Yes ☐ No If Yes, how old are they? _____

What Rady Campus location does your family primarily use? _____

Has/have your child ever been admitted as an inpatient? ☐ Yes ☐ No

Has/have your child/children ever been seen in a Rady Outpatient Clinic? ☐ Yes ☐ No

What medical services has your family used? (Check **Past Year** if you have used this service within the past year or **Ever** if you have ever used this service.)

Past Year	Ever		Past Year	Ever	
☐	☐	Emergency Room	☐	☐	General Pediatric Clinic
☐	☐	Urgent Care	☐	☐	Genetics
☐	☐	Neonatal ICU	☐	☐	Home Care or Hospice
☐	☐	Pediatric ICU	☐	☐	Immunology
☐	☐	Surgical Unit	☐	☐	Integrative Medicine
☐	☐	Medical Unit	☐	☐	Lab
☐	☐	Hematology Oncology Unit	☐	☐	Nephrology Clinic
☐	☐	Asthma/Allergy	☐	☐	Neurology Clinic
☐	☐	Audiology	☐	☐	NICU follow up Clinic
☐	☐	Autism	☐	☐	Occupational Therapy
☐	☐	Cardiology Clinic	☐	☐	Orthopedics Clinic
☐	☐	Cath Lab	☐	☐	Pain Team / Palliative Care
☐	☐	Cleft/Craniofacial Clinic	☐	☐	Pharmacy
☐	☐	Cystic Fibrosis Clinic	☐	☐	Physical Therapy
☐	☐	Developmental Clinic	☐	☐	Psychology/Psychiatry
☐	☐	Dermatology Clinic	☐	☐	Pulmonary Clinic
☐	☐	Dialysis Program	☐	☐	Radiology
☐	☐	Down Syndrome Clinic	☐	☐	Rehabilitation Clinic
☐	☐	Ear, Nose, and Throat	☐	☐	Rheumatology Clinic
☐	☐	Endocrine/Diabetes Clinic	☐	☐	Sleep Lab / Clinic
☐	☐	Epilepsy Clinic	☐	☐	Speech/Language Therapy
☐	☐	Feeding Clinic	☐	☐	Urology
☐	☐	Gastroenterology/ GI Clinic	☐	☐	Other:_____

Have you used the following Non-Medical Services? (Check all that apply)

☐ Family Resource Center ☐ Interpretive Services ☐ Chaplaincy
☐ Financial Resources ☐ Ethics Consult ☐ Caring Bridge Web Site
☐ Sibling Play ☐ Social Work ☐ Food Service
☐ Child Life ☐ Children's Web Site

What special perspective or skill do you feel you could bring to the Family Advisory Council?

_____

_____

What do you think the biggest opportunity for improvement is at Rady Children's?

_____

_____

What would you like to accomplish during your term on the Family Advisory Council?

_____

_____

Would you be willing to attend one and a half (1.5) hour monthly meetings? ☐ Yes ☐ No

Would you be willing to make a commitment to serve for one to two years? ☐ Yes ☐ No

Would you be willing as you are able to join other committees and project work groups that are held on various dates and times on an as needed basis? ☐ Yes ☐ No

What is your availability? Please indicate the hours you are available:

Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Weekends
Daytime:						
Evening:						

Comments on your availability?

_____

_____

I acknowledge that I have provided accurate information to the best of my ability.

_____ _____

Applicant Signature **Date**

Please send the completed application to:

Isela Mary Mendoza
Family Advisory Council
Rady Children's Hospital
3020 Children's Way
Mail Code 5071
San Diego, CA 92123-4282

Thank you for taking the time to complete this application. A member of the Family Advisory Council will be contacting you to discuss opportunities for service. All of the information contained on this form will be handled in a confidential manner.

Privacy Information and Release Authorization

Please read the following carefully

Application information

I certify that all information in this application is true and complete.

I understand that any false information or omission may disqualify me from further consideration for volunteer service and may result in my dismissal, if discovered, at a later date.

References

I understand that Rady Children's Hospital-San Diego requires information from me to evaluate my qualifications for volunteer service.

I authorize and release personal references, employers (past and present), and if necessary, other applicable entities to answer questions in regards to volunteer work, employment, ability, character, medical and emotional background and, if applicable, driving history.

Background investigation

I understand, in consideration of my application, a background investigation will be conducted.

I understand this investigation may include, but is not limited to, a criminal background check in the files of any federal, state or local justice agency, driving history, performance of medical examinations, drug screening or reference verification.

I authorized Rady Children's Hospital-San Diego and associated entities (collectively RCHSD) to conduct the background investigation and release RCHSD from responsibility for this investigation.

I understand the requested information is for the sole purpose of gathering accurate information for volunteer services at Rady Children's Hospital-San Diego.

I have read and understand the above, and by my signature consent to these statements.

_____ _____

Applicant Signature **Date**

_____

Print Name

RADY CHILDREN'S HOSPITAL–SAN DIEGO
CONFIDENTIALITY ACKNOWLEDGEMENT & AGREEMENT FORM

PRINT NAME: _____

During the course of your activity at Rady Children's Hospital-San Diego and its affiliates, you may have access to information which is confidential and may not be disclosed except as permitted or required by law and in accord with Rady Children's Hospital–San Diego's policies and procedures. In order for Rady Children's Hospital-San Diego to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information can cause irreparable damage to Rady Children's Hospital-San Diego. Confidential information includes, but is not limited to:

1. Medical and certain other personal information about patients.
2. Medical and certain other personal information about employees.
3. Medical Staff records and committee proceedings.
4. Reports, policies and procedures, marketing or financial information, and other information related to the business of services of Rady Children's Hospital and its affiliates which has not previously been released to the public at large by a duly authorized representative of Rady Children's Hospital.

If you have any questions at any time concerning the confidentiality or disclosure of information, you should contact the Rady Children's Hospital Risk Management Department at 858-495-4980.

By initialing each section and signing this Confidentiality Acknowledgment, you acknowledge and agree that:

_____ 1. I will only access business information for which I have a legitimate business purpose.

_____ 2. Medical Information is confidential and my access is restricted to my legitimate medical need to know for diagnosis, treatment and care of a particular patient.

_____ 3. I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner which is inconsistent with applicable policies and procedures of Rady Children's Hospital - San Diego.

_____ 4. I will print information from any hospital information system only when necessary for a legitimate purpose and I am accountable for this information until it is destroyed. I understand that patient medical information may only be stored in authorized locations such as the hardcopy medical record jacket located in the Health Information Department. Exceptions may be incorporated into departmental policy so long as the exception is approved in writing by RCHSD Risk Manager.

_____ 5. All patient identifiable information must be shredded or disposed of in a designated locked, confidential disposal bin.

_____ 6. Patient medical information available from any hospital information system may not be in final form. Therefore, I will not release printed hardcopy to third parties, including parents/guardians, but will refer them to the Health Information Department for assistance. Exceptions may be incorporated into departmental policy so long as the exception is

approved in writing by Rady Children's Risk Manager.

_____ 7. My access and use of any hospital information system information is subject to routine, random, and undisclosed surveillance by the hospital.

_____ 8. Failure to comply with my confidentiality obligation may result in disciplinary action or termination of my employment/educational affiliation by Rady Children's Hospital and its affiliates, or corrective action in conformance with current medical staff bylaws, rules and regulations.

_____ 9. Impermissible disclosure of confidential information about a person may result in legal action being taken against me by or on behalf of that person.

_____ 10.I understand that licensed health care providers are subject to sanctions for impermissible disclosure under California Business and Professions Code Sec. 2227, including revocation, suspension, probation and public reprimand.

_____ 11.If I am issued a unique user code, it is my responsibility to maintain this code in a confidential manner. This user code is my signature for accessing authorized on line computer systems. My user code will ensure that the data for which I am responsible will not be available to anyone else; therefore, it is mandatory that my user code and access data be kept strictly confidential.

_____ 12. My confidentiality obligation shall continue indefinitely, including at all times after my association with Rady Children's Hospital and its affiliates, such as termination of my employment or affiliation with Rady Children's Hospital and its affiliates.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT, HAVE HAD MY QUESTIONS FULLY ADDRESSD RECEIVED A COPY FOR MY PERMANENT PERSONAL RECORDS.

Applicant Signature_____Date _____

Print Name _____