



Project Compassion, Inc.

St. Scholastica Retreat Center P: (479) 783-2273 F: (479) 783-1849 1205 South Albert Pike Ave. Email: director@projectcompassioninc.com

Fort Smith, AR 72903

www.projectcompassioninc.com

Volunteer Application

Last Name: _____ First Name: _____ Middle: _____

Other Name(s)(maiden, etc): _____ Social Security Number: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip: _____ Birthday: ____/____/____

Phone: Main: (____) ____ - ____ Cell: (____) ____ - ____ Email: _____

Employer: _____ Position: _____

Emergency Contact: _____ Relation: _____

Phone: Home: (____) ____ - ____ Cell: (____) ____ - ____ Work: (____) ____ - ____ Email: _____

How did you hear about Project Compassion? _____

References:

Name: _____ Relation: _____ Phone: (____) ____ - ____

Name: _____ Relation: _____ Phone: (____) ____ - ____

Areas of Interest (check all that apply):

____ Visiting a Resident in the Nursing Home _____ Events (Luncheons, Tennis Tournament, etc.)

____ Hearts of Gold Campaign (Nov-Dec) _____ Office or Administrative Work

____ Other: _____

What activities do you enjoy? _____

What do you hope to get out of your volunteering? _____

Please list your availability: _____

Do you authorize Project Compassion, Inc. to perform a background check? (check one) Yes No

Do you authorize Project Compassion, Inc. to use your name and photo for publicity in print/TV/online regarding your volunteer work at Project Compassion? (check one) Yes No

Signature: _____ Date: _____

(By typing your name you are agreeing to terms)

For Office Use Only:

Name Pin Ordered: ____ Date Given to Volunteer: _____ Nursing Home Preference: _____

Key Volunteer Notified: ____ Orientation Date: _____ By: _____ RSVP app: _____

Project Compassion, Inc. is a 501 (c)(3) organization and proud United Way Community Partner.



CONFIDENTIALITY PLEDGE FOR PROJECT COMPASSION VOLUNTEERS

I understand that while I am visiting in this capacity, I may be exposed to "protected health information," as that term is defined and used in the nursing home policies and in the federal HIPAA privacy regulations (the "Privacy Regulations"), and other information deemed to be confidential by other laws. Protected health information is information about a person's health or treatment that identifies the person. I also understand that while I am visiting in this capacity I may be treated as a temporary member of the nursing home's "workforce" for purposes of the Privacy Regulations only.

I pledge and agree not to use or disclose any of this protected health information, and any other confidential information.

I understand that I may direct to the nursing home Privacy Officer any questions I have about my obligations under this Confidentiality Pledge or under any of the nursing home policies and procedures and applicable laws and regulations related to confidentiality.

Printed Name of Project Compassion Volunteer

Address of Volunteer (Street, City, St, Zip)

Telephone of Volunteer

Email Address of Volunteer

Signature of Volunteer

(By typing your name you are agreeing to terms)

Date

For Office Use Only

I, as sponsor of the above-named Volunteer, have reviewed this pledge with the volunteer and certify that the volunteer is in the nursing home for one-to-one visitation with the residents only.

Printed Name of Party at Project Compassion Responsible for Volunteer

Responsible Party Signature

Date