Application to Serve as a Disaster Volunteer

PART A: Volunteer Information

I am a volunteer, who is making application to assist with a disaster situation. As a volunteer, I affirm that I am not employed by this organization and I am willing to provide services to this organization without the expectation of compensation. I authorize the release of any information as may be necessary to enable the healthcare institution to authorize me to provide services. I understand the healthcare institution may utilize the Wisconsin Disaster Credentialing (WDC) on-line system or obtain information from any hospital, ambulatory surgery center, physician office or other entity with which I have privileges or at which I work to verify my credentials, which will include, but not be limited to, licensure, criminal background check, etc.

Name		
Current Home Address		
City, State, Zip Code		
Social Security Number		
☐ Telephone Number		
☐ Cellular Telephone		
Please check the box above that indicates by which telephone it is best to contact you and at what time: _____ AM ____ PM		
Email Address		
Date of Birth		
Specialty/Area of Expertise		
Current Employer/Retired		
Name of Primary Hospital Affiliation (if applicable)		
Fluent in These Languages:		
Location of Employer		
Employer Telephone Number		
Licensed? ☐ Yes ☐ No	License Number:	State:
Certified? ☐ Yes ☐ No	Certification Number:	State:
Registered? ☐ Yes ☐ No	Registration Number:	State:
Please list other states in which you hold a License, Certification or Registration		
Emergency Contact Person		
Emergency Contact Telephone		

Part B: Please answer the following questions:

1. Do you have any special needs or accommodations that need to be addressed?
   ☐ No
   ☐ Yes (If "Yes", please specify): _____

2. Are there currently pending any challenges against your license, certification or registration or has your license, certification or registration ever been refused, revoked, suspended, terminated, relinquished, reprimanded, probated, monitored, limited, investigated or challenged in any way or otherwise encumbered either voluntarily or involuntarily or while under or in lieu of an investigation?
   ☐ No
   ☐ Yes (If "Yes", please specify): _____
   ☐ Not Applicable

3. Have you ever been convicted of a crime, felony or gross misdemeanor or have any pending charges?
   ☐ No
   ☐ Yes

4. Have you ever been excluded or received sanctions from any state or federal health care program?
   ☐ No
   ☐ Yes

5. Are you free of communicable or contagious diseases?
   ☐ No (If "No", please explain): _____
   ☐ Yes

6. Are you presently experiencing any symptoms or health conditions that may negatively affect your ability to serve as a volunteer?
   ☐ No
   ☐ Yes (If "Yes", please specify: _____

FOR PHYSICIANS and ALLIED HEALTH PRACTITIONERS ONLY:

7. Are there currently pending challenges against your appointment and/or membership or request for any privileges or scope of practice in any hospital or medical facility, medical organization, society, insurance company or HMO, or has your appointment or membership or request for privileges or scope of practice ever been refused, revoked, suspended, reduced, withdrawn, probated, reprimanded, investigated, challenged or not renewed either voluntarily or involuntarily or while under or in lieu of an investigation?
   ☐ No
   ☐ Yes

8. Are there currently pending challenges against your federal or state narcotics license (DEA registration) or has your license ever been refused, revoked, suspended, terminated, relinquished, reprimanded, probated, monitored, limited, investigated or challenged in any way or otherwise encumbered either voluntarily or involuntarily or while under or in lieu of investigation?
☐ No
☐ Yes (If "Yes", please specify): _____
☐ Not Applicable

PART C: Orientation

By checking the following "boxes" I certify that I understand my obligation under each of these categories and commit to abiding by these policies along with all the policies that may be provided to me by my supervisor or any other authorized person at this organization:

☐ **Mission and Values**: (*each organization should include here a brief description of its Mission and Values*)

☐ **Confidentiality**: The state and federal privacy laws require all employees and volunteers to maintain a high level of confidentiality with respect to all information of medical or business nature concerning patients, residents, clinicians or employees. Protected Health Information (confidential information about patients) can be used for treatment, payment or operations. Other uses of Protected Health Information must be cleared through a supervisor. If I improperly disclose or discuss confidential information, it is not only a breach of confidence and a lack of concern for others, but may also involve me in legal proceedings and result in immediate termination of my ability to assist in the disaster operation.

☐ **Infection Control**: Proper hand washing helps to prevent the spread of infections from one person to another. Hand washing products and stations, hand sanitizers or similar materials will be provided. I will not enter any room designated as "isolation" or any sterile area, unless approved by my supervisor. If I will be exposed to blood or other bodily fluids or to airborne contaminants which require the use of protective equipment, I understand that I must wear personal protective equipment (PPE). I understand that I will consult with my supervisor for any instructions about PPE or patient contact.

☐ **On-Site Hazards**. Disaster locations are particularly hazardous locations. I will comply with all safety directions given to me by my supervisor. I understand that the Safety Officer has authority with respect to safety in the disaster zone. I will immediately and without question obey any directions given to me by the Safety Officer. I will wear safety-related clothing and equipment as directed.

☐ **Hazardous Materials**: Potentially hazardous materials and chemicals are used in certain areas as part of the daily operations of the Hospital. Material Safety Data Sheets (MSDS), which describe the hazard and handling instructions for all chemical products

are available. I understand that I should consult with my supervisor for further information.

☐ **General Safety**: I understand that 1) I must report any unsafe conditions or injuries to my supervisor; 2) "Code RED" (*insert appropriate code if different*) indicates that there is a fire and that I am to report to my work area; 3) my supervisor will provide me with the information needed to report a fire and to where I need to report; 4) If there is a severe weather or tornado warning or any other code or alert, my supervisor will direct me .

I understand that I will report to my supervisor or nearest staff person any unsafe condition and/or injury that I sustain while serving as a volunteer. In the event of a called Code or a called Emergency, I will report to my supervisor or the nearest staff person.

☐ **Tobacco Use**: I understand that there is no use of tobacco in the Hospital or on its grounds.

☐ **Health Requirements**: I understand that within 72 hours of being approved to serve as a volunteer, I must complete the required health screenings as so directed by Employee Health.

☐ **Identification**: I understand that I must wear my ID Badge at all times while serving as a volunteer.

☐ **Patient Rights**: I understand that patients deserve care, treatment and services that safeguard their personal dignity and that respect their cultural, psychosocial and spiritual values and that these values often influence the patient's perception and needs.

☐ **Weapons**: I understand that the policy of the Hospital restricts me from bringing any weapons of any kind into the Hospital.

☐ **Code of Conduct**: I will abide by the following standards of conduct:

1. I will treat all individuals served by this Hospital with care and compassion and without any form of discrimination.
2. I am serving without expectation of compensation. I will not seek payment for the care that I render.
3. I will not discuss personal topics such as religious beliefs or political views with staff or patients unless initiated by the patient. Nor will I offer medical advice outside of my role. I will speak professionally about the Hospital, its staff, its volunteers and its facilities.
4. I will not report for service while under the influence of an intoxicant or illegal controlled substance nor will I consume any such illegal controlled substance during my service hours.
5. I shall present myself in a professional manner.
6. I understand that I am responsible for my valuables and personal items.

7. I understand that it is against the policy of this Hospital and is illegal under state and federal law for any volunteer, male or female, to harass a patient, staff member or volunteer.
8. I understand that I must sign in and sign out for each shift and accurately record my time served as a volunteer.

Part D: Identification

I have provided a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following for identification purposes:

☐ A current picture employer ID card that clearly identifies professional/job designation

☐ A current license, certification or registration to practice

☐ Primary source verification of the license

☐ Identification indicating membership on a Disaster Medical Assistance team (DMAT), or Medical Reserve Corps (MRC), Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organization or groups

☐ Identification indicating that I have been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

☐ Identification by current hospital or medical staff member(s), who possesses personal knowledge regarding my ability to act as a volunteer during a disaster.

☐ Other forms of acceptable identification (please specify): _____

_____

Part E: Attestation

I attest that all of the above statements in Parts A, B, C and D are true and accurate.

_____

Signature of Applicant Date Time

_____

Print Name

FOR PHYSICIANS ONLY:

1. I attestation that all information provided is true and accurate;
2. I attest that I have been provided access to and agree to be bound by, as appropriate, Hospital policies and procedures, Medical Staff Bylaws, and directions of the Administrator or designee, Incident Commander, supervising/monitoring physicians, and other administrative and medical staff leaders while acting as a Volunteer and/or providing care during the Disaster;
3. I agree to accurately and legibly complete medical records and other documents associated with providing care, as much as is reasonably possible given the exigencies of the situation, and to cooperate with Hospital as necessary regarding such care.

Signature of Applicant Date Time

Print Name

STOP HERE: The organization will complete the following sections:

PART F: Primary Source Verification and Membership on Medical Staff

A "checkmark" indicates which of the following sources have been queried and that documentation resulting from these queries is attached:

☐ Licensure	☐ Certification	☐ Registration
☐ Office of the Inspector General	☐ Drug Enforcement Agency	☐ NPDB
☐ Criminal Background Check	☐ Employer Verification	☐ SSN Background Check
		☐ National Practitioner Identifier

Date: _____ Time: _____ Verifier: _____

Primary Source Verification was not able to be completed within 72 hours due to (provide explanation):

Date: _____ Time: _____ Verifier: _____

Membership on Medical Staff

The following sources have been queried to document that the physician or allied health practitioner has privileges and is in good standing at a hospital:

☐ Provider Affiliation Report from Wisconsin Disaster Credentialing
☐ Telephone verification
☐ Other attached documentation

Date: _____ Time: _____ Person: _____

PART G: Approval or Disapproval

☐ **Approval:** This Applicant has been approved to provide volunteer services as a

_____ in the specialty or area of expertise

of_____ effective _____. This appointment will remain effective until terminated by the Administrator or Designee. This volunteer has

been assigned to the following supervisor_____.

_____
Signature (Administrator, Human Resources or Designee) Date/Time

☐ **Disapproval**: This Applicant has been denied to serve as a volunteer.

_____
Signature (Administrator, Human Resources or Designee) Date/Time

PART H: Dismissal

Dismissal:

This volunteer was dismissed on _____ because services were no longer needed.

_____
Signature (Administrator, Human Resources or Designee) Date/Time

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