BENEFITING DESERT **AIDS** PROJECT

REVIVALS

DONATE | CONSIGN | VOLUNTEER | SHOP

STORE **ID #** **NB**

Revivals Volunteer Application

Name: _____Birthday:____ ____
(Last) (First) (Mi) (mo) (day)

Address: _____
(Street) (City) (Zip)

Phone: ( ) _____ ( ) _____ ( ) _____
(Home) (Work) (Cell phone)

E-Mail:_____

EMERGENCY INFORMATION:
Who would we call if you had an emergency? _____
(Name)
Relationship: _____Phone:( )_____

EMPLOYMENT HISTORY:
Are you employed? ___ yes ___ no
Where do you work? _____
What type of work have you done in the past? _____
May we call you at work? ___ yes ___ no
May we leave a message using the name Desert AIDS Project? ___ yes ___ no
Why do you wish to volunteer? _____
_____
How did you hear of our program? _____
Have you ever volunteered before? ___Yes ___No
If so, where? _____

Revivals Resale Store preference: ____Palm Springs ___Cathedral City
____Gallery _____Palm Desert ____Dispatch

PLEASE CHECK THE DAYS AND TIMES YOU WOULD BE AVAILABLE TO WORK:
NOT ALL SHIFTS ARE AVAILABLE IN ALL LOCATIONS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
__AM	__ AM	__AM	__ AM	__ AM	__ AM	__ AM
__PM	__PM	__PM	__PM	__PM	__PM	___PM

Have you ever been convicted of a crime? **(do not include any misdemeanor convictions for marijuana-related offenses more than two years old; convictions that have been sealed, expunged, or legally eradicated; and misdemeanor convictions for which probation was successfully completed or otherwise discharged and the case was judicially dismissed.)** **YES NO if yes, please explain.**

_____

_____

Please check the skills you have from the list below:
COMPUTER SKILLS: ___ Microsoft Word ___ Excel ___ Other_____
OFFICE SKILLS: ___ Typing ___ Filing ___ Telephone/Reception ___ Data Entry

What foreign languages do you speak? _____

As a Desert AIDS Project volunteer:

1) I will attend volunteer meetings as scheduled.

2) I am not eligible for employee benefits including Worker's Compensation Insurance

3) I may not work in or operate a resale business while volunteering at Revivals.

4) I will follow the procedures and guidelines of Revivals.

5)I am aware that the services of any volunteer may be refused or terminated by the Desert AIDS Project at will, and shall be terminated when deemed in the best interest of the Project to do so.

I have read and I understand the foregoing Volunteer application.

_____ _____ _____
Signature Date Witness

REVIVALS MAIN OFFICE
P.O. Box 2890
Palm Springs, CA 92263
Telephone 760-323-2118 Ext 757 or 760 413-6613
REVISED 6/09 HA

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Volunteer Waiver of Liability

Waiver must be signed in order to volunteer.

I wish to volunteer for Desert AIDS Project and/or Revivals. I understand that the nature of volunteer activities that I may perform in my capacity as a volunteer may involve physical activity, contact with unidentified and or unfamiliar persons, objects, machinery, conditions of premises, animals or other unforeseen conditions or events. I understand that such events may pose potential risks of bodily injury or damage to property, or disease.

Knowing this and in consideration of being allowed to volunteer, I hereby assume full and complete responsibility for any personal injury and/or property damage that I sustain or cause during my participation as a volunteer.

I hereby release, hold harmless and covenant not to file suit against Desert AIDS Project, Inc./ Revivals and any of their employees, volunteers, directors, agents, sponsors, board members, and successors from any and all loss, liability or claims I may have arising out of my service as a volunteer to the fullest extent permissible under law.

_____ _____

Signature Date

_____

Name (print)

true hire
get connected

Background Release Form

In connection with this application for employment, I understand that an investigative consumer report may be requested now by True Hire, and in the future as terms of my continued employment. This report may include information pertaining to my character, education, work history, credit history, motor vehicle records, and criminal information contained within any government agency, Federal, State, or Local. This information shall include, but not be limited to, verifying any statements made on my application.

I hereby authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies, military services, and former employers to release information they may have about me to Company or its agents, and do forever release them from any liability or responsibility for doing so to the fullest extent allowed by law from any claims arising from the requested information.

If required, I specifically authorize a credit report to be obtained on myself. If required, I specifically authorize workers compensation claim information to be obtained on myself by True Hire.

I recognize and agree that a copy or facsimile of this document shall be as valid as the original and agree that this release shall be valid for this and any future update reports requested.

According to the Fair Credit Reporting Act, I am entitled to know if employment is denied based on information contained in this report, and to receive, upon written request, a disclosure of the public record information as well as the nature and scope of the investigative report.

Confidential Information Used for Background Checking Purposes

PRINT FIRST NAME	MIDDLE INITIAL	LAST	SOCIAL SECURITY NUMBER	DATE OF BIRTH
DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	EMAIL		
PRESENT ADDRESS		CITY, STATE, ZIP		COUNTY

Please list any previous addresses you have had in the past 7 years:

PREVIOUS ADDRESS	CITY, STATE, ZIP	COUNTY
PREVIOUS ADDRESS	CITY, STATE, ZIP	COUNTY
PREVIOUS ADDRESS	CITY, STATE, ZIP	COUNTY

Please list any former names (I.e. maiden or otherwise) you have used in the past 7 years:

Please list any former felonies or misdemeanors you have been convicted of in the past 7 years (Please list date, charge, location, disposition):

Signature Date

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Desert AIDS Project
care :: prevention :: advocacy

CONFIDENTIALITY AGREEMENT

Applies to all ***Desert AIDS Project*** *"workforce members" including: employees, medical staff and other health care professionals; volunteers; agency temporary and registry personnel; and house staff, students, and interns (regardless of whether they are D.A.P. trainees or rotating through the facility from another institution).*

It is the responsibility of all Desert AIDS Project (D.A.P.) workforce members, as defined above, including employees, medical staff, house staff, students and volunteers, to preserve and protect confidential patient, employee and business information.

The Federal Health Insurance Portability Accountability Act (HIPAA) Privacy Law, the Confidentiality of Medical Information Act (California CivilCode § 56 et seq.) and the Lanterman-Petris-Short Act (California Welfare&InstitutionsCode § 5000 et seq.) govern the release of patient identifiable information by hospitals and other health care providers. The State Information Practices Act (California CivilCode sections 1798 et seq.) governs the acquisition and use of data that pertains to individuals. All of these laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information, . Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Electronic Health Records i.e., ARIES, Greenway, EagleSoft, Financial Edge
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient.

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from D.A.P.'s records which if disclosed, would constitute an unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to D.A.P.

Peer review and risk management activities and information are protected under California Evidence Code section 1157 and the attorney-client privilege.

Effective Date: 4.29.14
Revised Date: 6.4.2015

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to D.A.P. and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of D.A.P. or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of D.A.P. affairs.

4. D.A.P. performs audits and reviews patient records in order to identify inappropriate access.

5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

9. My obligation to safeguard patient confidentiality continues after my termination of employment with D.A.P.

10. If at any time, protected health information or confidential employee or business information is be transmitted over the internet, Voltage, our secure email application must be used at all times.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the D.A.P. may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from D.A.P.

Print Name:	Signature:
Department:	Dated:

Routing: Please complete the form and return it to your hiring department.