Rady Children's Hospital San Diego

UNIVERSITY of CALIFORNIA, SAN DIEGO
SCHOOL OF MEDICINE

Advancing the future of pediatric healthcare…together.

Rady Children's Hospital Cardiac Family Advisory Council Application

Basic Information

Last Name: _____ First: _____

Mailing Address:
_____

City: _____ State: _____ Zip Code: _____ County: _____

Telephone Number: _____ Cell / Home / Office (Circle One)

E-mail Address:
_____

Your Experience at Rady Children's Hospital Heart Institute

Patient's Name: _____ Patient's DOB: _____

Medical Condition(s):
_____
_____

Approximate Dates of Surgeries/Hospitalizations:
_____
_____

Rady Children's Hospital Cardiac Family Advisory Council

Our mission is to integrate the patient and family perspective into the vital work of Rady Children's Heart Institute. Through advocacy and collaboration, we will advance the knowledge of, and optimal care for, people with congenital or acquired heart disease.

Please provide a brief description of why you are interested in joining and being a part of the Rady Cardiac Family Advisory Council.
_____
_____
_____
_____

_____
_____

As a member of the council, are there any specific topics that you would like to see the Cardiac Family Advisory Council address?

_____
_____
_____
_____
_____

Do you have any professional or volunteer experiences that would be relevant to your position on the Cardiac Family Advisory Council?

_____
_____
_____

Is there anything else that you would like the Rady Cardiac Family Advisory Council to know as they are considering your application for membership?

_____
_____
_____
_____
_____

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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

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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 online 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 _____