Patient & Family Advisory Council
Application for Membership

Application Includes:

1. Applicant Information
2. HIPPA Information
3. Background Check Authorization
4. Confidentiality Agreement
5. Media Release Authorization
6. Liability Waiver

Submit completed application to Justin Siko, Patient Advocate at sikoj@monhealthsys.org or mail to:

Mon Health Medical Center
Attn: Justin Siko, Quality Department
1200 J.D. Anderson Drive
Morgantown, WV 26505

Background Check:

- ✓ Each applicant will be subject to a background check. Permission to run this background verification is provide within the application and must be completed and signed.

References:

- ✓ The contact information for two references must be submitted with the application. The individuals identified as the applicant's references will be contacted via telephone, email, or mail by a Mon Health Medical Center employee. **References may not be relatives of the applicant.**

Orientation:

- ✓ If selected, you will be scheduled for a **mandatory** orientation session. This session will cover the polices, procedures, and necessary volunteer education at Mon Health Medical Center.

Please contact Justin Siko at sikoj@monhealthsys.org with any questions regarding this application.

CONTACT INFORMATION (Please Print)

Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____
STREET CITY STATE ZIP CODE

Phone: _____

Email: _____

EMERGENCY CONTACT INFORATION

Name: _____ Relationship: _____

Phone: _____ Work/Cell: _____

Primary Care Physician: _____ Phone: _____

EMPLOYMENT HISTORY (If applicable)

Most recent / Current Employer: _____

Position: _____ Phone: _____

Contact Name: _____ Phone: _____

Title: _____

PERSONAL REFERENCE 1

All applicants must submit at least two (2) references. Please provide complete information for a personal reference (CANNOT BE RELATED) that has known you for a minimum of two years.

Name: _____

Address: _____

Phone: _____

Email: _____

Relationship to Applicant: _____

PERSONAL REFERENCE 2
All applicants must submit at least two (2) references. Please provide complete information for a personal reference (CANNOT BE RELATED) that has known you for a minimum of two years.

Name:_____

Address:_____

Phone:_____

Email:_____

Relationship to Applicant:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you previously been employed by Mon Health Medical System? (circle one) YES NO

If yes, please give dates and titles_____

Are you related to any Mon Health Employee? (circle one) YES NO

If yes, list employee name:_____

Have you ever been discharged or forced to resign from employment? (circle one) YES NO

If yes, please give details: _____

Have you ever been convicted of a crime other than routine traffic violations? (circle one) YES NO

If yes, please give details:_____

COMMITMENT TERMS

The time commitment required is a two-hour monthly meeting, however, additional time may be required depending on the specific committee or project to which you are assigned or volunteer for. It is a requirement to attend at least 75% of all monthly council meetings.

I certify that all the information provided above is true, complete, and correct to the best of my knowledge. I voluntarily give Mon Health Medical Center permission to make a thorough investigation of my background, education, and criminal records.

Acceptance as a Patient and Family Advisor is contingent upon satisfactory completion or mandatory requirements. I authorize that all employers, schools, or references thus contacted be released from all liability in answering questions related to this application.

My services are donated to Mon Health Medical Center without contemplation of compensation or future employment and given with humanitatian or charitable reasons.

Applicant Signature:_____ Date:_____

PLEASE TELL US ABOUT YOURSELF:

Why would you like to become a Patient & Family Advisory Council member?

What past experience, interests or skills do you have that you could bring to this role? Please include any personal/family, hospital/medical experience, and descriptions.

Areas of special interest to you. (Check all that apply)

- Arts and Asthetics
- Communications
- Development
- Marketing
- Patient Experience
- Quality
- Revenue Cycle
- Safety
- Accessibility
- Other (please specify)_____

Do you know other individuals and/or families who have experienced care at Mon Health Medical Center who might be interested in serving as a Patient & Family Advisor? If yes, please fill in the following information.

Proposed Member Name:_____

Phone Number:_____

Email Address:_____

Mailing Address:_____

_____

Medical Services Used by Member or Family Member:

_____

_____

_____

_____

_____

_____

_____

Confidentiality & Behavior Statement

Access to the health care setting allows non-employees to use or to be exposed to information concerning employees, patients, their families, and hospital business, all of which may be confidential and/or proprietary. Confidential and/or proprietary information includes, but is not limited to, information pertaining to patient care, risk management, the medical staff, quality improvement, utilization review, budgets, revenues, debts, real estate developments, investments, financial statements, medical records, business plans, employee benefit programs, retirement plans, disciplinary actions, human resource issues, physician recruitment, business acquisitions, collaborative activities, mergers and joint ventures activities. This includes, but is not limited to, information that is verbal, written, computerized, faxed, emailed, audio or video taped, observed, or obtained through any other means.

For the purpose of this agreement, "confidential information" shall mean all such confidential and proprietary information that is not in the public domain to which the non-employee has access or exposure during their course of relationship with any entity of the Mon Health Medical Center.

I agree that having been permitted to observe activities at Mon Health Medical Center; I have a legal and moral responsibility to protect the confidentiality of privileged information to which I may be exposed during my observation of patient care and daily facility operations. Accordingly, I agree during my time at Mon Health Medical Center and thereafter that I will not:

- Use, disclose, or discuss any proprietary information or other confidential or patient-related information with any person or entity that does not need to know it.
- In any way divulge, copy release, sell, loan, alter, or destroy any confidential information except as properly authorized.
- Discuss confidential information where others can overhear the conversation. It is not acceptable to discuss confidential information even if the patient's name is not used.
- Attempt to access any computerized information to which I am no authorized
- Encourage any past, present, or future employee of Mon Health to violate the restrictions of this agreement.
- Disclose my password(s) for gaining access to any Mon Health computer system; allow anyone to use the system under my sign on or use anyone else's passwords for access.
- Make any unauthorized transmission, inquires, modifications, or purging of confidential information.
- Access software systems to review patient records when I am not authorized. By accessing a patient's record, I am affirmatively representing to Mon Health that I have the patient's consent to do so, and Mon Health may rely on the representation in granting such access to me.
- Take photographs in any areas of Mon Health entities. Texting, blogging, and posting comments regarding staff, MHS entities or patients on social networking sites are also prohibited.

Further, I will report activity that violates this agreement or any other incident that could pose a risk of non-compliance with Mon Health Corporate Compliance Standards. I will report possible violation or non-compliant activity to management or the Corporate Compliance Officer at 844-536-3273. I understand that Mon Health may take legal action against anyone who does not follow these established guidelines.

I understand that copies of the Bylaws, Policies and Procedures, and Rules and Regulations of Mon Health including those of its Medical Staff are always available in PolicyStat and the Quality Office and furthermore agree to abide by them. I always agree to comply with the standards of conduct of Mon Health and to conduct myself in a professional and positive interpersonal manner. I understand that Mon Health may prohibit me from continuing in my observation, shadowing, or educational-related experience if I do not follow these guidelines or if my personal behavior is disruptive or inappropriate.

Applicant Name (Please Print):_____

Applicant Signature:_____Date:_____