



Volunteer Application

Please answer all questions. All information provided is considered confidential and held in strictest confidence.

Name: _____

When you are free to volunteer

Address: _____

Morning Afternoon Evening

City: _____ St: _____ Zip: _____

Monday _____

Date of Birth: (optional) _____ SSN: _____

Tuesday _____

Home Phone: () _____

Wednesday _____

Work Phone: () _____

Thursday _____

Cell Phone: () _____

Friday _____

Best time for calls:

Saturday _____

Home _____ AM _____ PM _____ Eve (5:00+)

How many hours per week are

Work _____ AM _____ PM _____ Eve (5:00+)

you available? _____

May message be left at home? _____ at work? _____

Occupation: _____

Where: _____

Are you a student: No: ___ Yes: ___

Where: _____

Full or Part-time? _____

Past/Present work experience: _____

Special Training/Skills/Hobbies: _____

Second Language? No: ___ Yes: _____

School District: _____

Current/Previous volunteerism (please specify)

Political: _____

School: _____

Religious: _____

Hospital: _____

Civic: _____

Other: _____

Do you have your own transportation? Yes: _____ No: _____ A current IN drivers license? Yes: _____ No: _____

Auto liability? Yes: _____ No: _____ (Proof will be required of license and liability if transporting volunteers.)

Have you ever worked with Planned Parenthood before? When/Where? _____

How did you hear about Planned Parenthood? _____

Why are you interested in volunteering for Planned Parenthood of Indiana? _____

(Please circle your choice.)

Prefer to volunteer on a: Regular Basis Weekly Bi-Weekly Monthly As Requested

Work preferred: Escort Library Mailings Clinic _____ Fairs/Exhibits Speaker Marketing

Public Policy Project Assistant Fund Raising Environment Other _____

Other comments: _____

In case of an emergency, call:

Name: _____

Telephone: _____

Physician: _____

Telephone: _____

Three References (not relatives):

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Complete all pages of this application and send to Samantha Gray via fax, email, postal mail:

Fax- 317-637-4375

Email- samantha.gray@ppin.org

Address: Planned Parenthood, Attn: Samantha Gray, 200 South Meridian, Suite 400, Indianapolis, IN 46225

For office use only:

Comments:

Assigned to: _____

Date: _____

Assigned to: _____

Date: _____

**PLANNED PARENTHOOD OF INDIANA
CONFIDENTIALITY POLICY**

All information obtained from or concerning patients is a privileged communication. Neither employees nor volunteers should divulge any information concerning a patient to outside sources without written permission of the patient.

Confidentiality means:

- At no time is the name of a patient or client used unless it is necessary for the service being delivered to that person. (Patients and clients include: clinic patients, pregnancy test clients, and people who walk in or call for information).
- Patients seen in other places should not be recognized unless they make the first move.

We must avoid being trapped by these or any other pitfalls:

- Talking over “cases” by name with other personnel.
- Mentioning, even in strictest confidence, to a close friend or family member or anyone else, the name of a patient.
- Using patients’ full names in a place where they can be overheard.
- Discussing confidential matters (e.g., abortion) with a patient where you can be overheard.
- Using specific case histories, even without using names, to illustrate a story about Planned Parenthood to your daily contacts or at social gatherings.

It is the patient’s privacy that we are preserving.

I understand the policy on confidentiality of Planned Parenthood and agree to respect the confidentiality of all patient/client information which I gain either directly or indirectly from my work. I further understand that any breach of the agreement constitutes grounds for immediate dismissal.

Employee/Volunteer Signature

Date

PRIVACY STATEMENT

As an employee, officer, volunteer or individual who is part of the workforce of PPIN, you may have access to Health Information. To ensure that Health Information is used and disclosed in compliance with the HIPAA Privacy Regulation and our Privacy Policies and Procedures, you are required to read and sign this document. This Statement, along without the Privacy Policies and Procedures, describe your duties and obligations with regard to Health Information. Full compliance with this PRIVACY STATEMENT and our Privacy Policies and Procedures are a condition of your employment or volunteering. A copy of your signed Statement will be kept on file.

A. Restrictions on the Use and Disclosure of Health Information

As a general matter, an individual's Health Information may not be used or disclosed without proper permission. The use of and disclosure of Health Information is subject to the restrictions in the HIPAA Privacy Regulation and our Privacy Policies and Procedures. The use or disclosure of Health Information may be limited by Business Associate contracts between PPGI and third parties. The Privacy Regulation requires these contracts. Please refer to our Privacy Policies and Procedures or ask the Privacy Official for further guidance.

B. Penalties and Fines

Penalties and fines can be imposed by HIPAA on anyone who improperly uses or discloses Health Information. In addition to penalties and fines, any improper use or disclosure of Health Information may subject you to disciplinary action up to and including termination.

C. Certification Of Understanding And Compliance

I hereby certify that I have carefully read and understand this Privacy Statement and the Privacy Policies and Procedures and agree to abide by their provisions. All of my questions, if any, about these documents have been answered and copies have been made available to me. I agree to abide by all of the requirements and provisions set forth in this Statement and the Privacy Policies and Procedures.

Personnel *(please print)*

Human Resources Manager

Signature

Date