

St. Anna Episcopal Church's Medical Mission

IN-STATE VOLUNTEER FORMS

INSTRUCTIONS: Return the attached forms and copies / documentation of the items listed below to –

Diana Meyers
1313 Esplanade Ave.
New Orleans, LA 70116

Or Fax them to: (504) 947-2122

Please allow a minimum of 2 weeks for verification of licensure before we can allow you to work with us. We will contact you as soon as the verification is complete to set dates / times for your work.

To contact Diana with questions, please call (504) 947-2121.

We can't thank you enough for your willingness to work with us to serve the people of New Orleans.

Forms Included in this Packet:

- In-State Volunteer Intake Form
- Volunteer Medical Information Form
- In-State Conditions of Participation Form
- Episcopal Diocese of Louisiana – Volunteer Agreement & Release
- Liability Release and Indemnity Form – St. Anna's Medical Mission
- Confidentiality Form

Other Documentation Required:

- Copy of a government issued photo ID (driver's license or passport)
- Copy of your Health Insurance Cards
- Copy of recent (within 1 year) TB skin test if available
- Copy of your current Medical, Social Worker or Nursing License if applicable
- Proof of current Malpractice Insurance (doctors, nurse, social workers)
- Copy of current CPR card, if available (doctors, nurses)
- Letter of Reference re: your work and appropriateness for this Mission (doctors, nurse, social workers)
- Copy of your DEA number (physician's only)



St. Anna's Medical Mission



IN-STATE VOLUNTEER INTAKE FORM

(PLEASE PRINT):

Name _____
 (first) (middle) (last)

Are You a: ___MD ___Nurse Practitioner ___RN ___Spiritual Counselor ___EMT/Med Tech ___Non-medical

Address _____
 (street) (city) (state) (zip)

Phone: _____
 (with area code) (day) (evening) (cell)

Email Address: _____ **Fax No.** _____

Church/Organization you represent, if any: _____

Clergy Reference, if applicable (PRINT): _____ (Phone) _____

Dates Requesting to Volunteer: (PLEASE NOTE: It is your responsibility to secure your own transportation)

___ I wish to volunteer every _____ between the hours of _____ and _____

___ I wish to volunteer more than once, but will schedule myself monthly with the Coordinator.

___ One-Time Volunteer: Indicate those date(s) you wish to volunteer _____

Any prior work with other associations in disaster relief: _____

If you do not live in the New Orleans area:

Arriving by: Car Van Bus Plane Other: _____

**If not arriving by car/van, it is your responsibility to secure your own transportation while here.

Arrival Date: _____ **Time:** _____ am/pm **Departure Date:** _____ **Time:** _____ am/pm

Housing Needed? YES NO, If NO, where will you be staying?

Name of Hotel/Motel/Person: _____

Address _____
 (street) (city) (state) (zip)

For Use By Parish Nurse/Disaster Relief Coordinator:				accepted	declined
Medical Information Form documented:	Yes	No	Licensure documented:	N/A	Yes No
Copy of Driver's License	Yes	No	Copy of DEA License:	N/A	Yes No
Proof of Certification/Specialty:	N/A	Yes	No	Conditions of Participation signed:	Yes No
Medical/Professional Liability Insurance documented:				Yes	No
Liability and Release of Indemnity x2 signed:				Yes	No
LA DHH Agreement to Provide Volunteer Service signed:				Yes	No
State Board of Nursing Disaster Permit Affidavit				N/A	Yes No



St. Anna's Medical Mission



VOLUNTEER MEDICAL INFORMATION

VOLUNTEER Name: _____
(first) (middle) (last)

EMERGENCY CONTACT #1: Name: _____
(first) (middle) (last)

Phone: _____
(with area code) (day) (evening)

EMERGENCY CONTACT #2: Name: _____
(first) (middle) (last)

Phone: _____
(with area code) (day) (evening)

YOUR PHYSICIAN: Name: _____

Phone: _____
(with area code)

MEDICAL CONDITION:
List any medical conditions you have (asthma, diabetes, epilepsy, etc.): _____

List any allergies or allergic reactions to medications: _____

List any medications you are currently taking: _____

Date of your most recent Tetanus shot: _____

Have you had a complete Hepatitis B Vaccination Series? YES NO**
**If NO, I understand that the lack of the vaccine and contact with potentially infected blood and body fluids will place me at higher risk for contracting Hepatitis B _____(initials)

Other pertinent medical information: _____

MEDICAL INSURANCE: (Bring a copy of your healthcare and pharmacy card with you!!)

Company _____ Policy No. _____

Claims Contact Phone Number _____

In the event of an emergency I give consent for the staff and/or volunteers of St. Anna Episcopal Church, New Orleans or St. Anna's Medical Mission to obtain necessary medical treatment for the person listed above. I further hold harmless St. Anna Episcopal Church, New Orleans, St. Anna's Medical Mission and the Episcopal Diocese of Louisiana from any liability for acting or failing to act in obtaining or consenting to any such medical treatment.

Signature of Participant

Date



In-state Volunteer Conditions of Participation

As a St. Anna's Medical Mission volunteer, I understand that I will be the face of St. Anna's Episcopal Church to those I serve and those I serve with. I have read this page and the attached material carefully in considering my participation in this response.

I am current on the following vaccination:

Tetanus
Hepatitis B vaccination Series OR I have declined to receive the Hepatitis B vaccination series.

I am free of active Tuberculosis.

I understand that I must also demonstrate current medical health insurance coverage before I will be placed.

I understand that I will not be covered for medical liability by St. Anna's Episcopal Church or the Episcopal Diocese of Louisiana and that I must demonstrate current medical malpractice insurance coverage before I will be placed.

I understand that I will not be covered by Worker's Compensation of any type from St. Anna's Episcopal Church or the Episcopal Diocese of Louisiana, as I am a volunteer and not an employee of either entity.

I understand that St. Anna's Episcopal Church, St. Anna's Medical Mission cannot assume liability for my health or safety in a disaster response or rebuilding zone. As part of St. Anna's Medical Mission's volunteer medical response, I understand that I must be prepared and responsible to follow every possible procedure of safety for myself, for the patients I serve, and my fellow volunteers. I understand that basic medical care will be the limitation of services I provide, and that emergent or critically ill patients shall be referred to the nearest available medical facility.

As a St. Anna's Medical Mission volunteer I understand that conditions may vary from modest to primitive – meaning long hours, inclement weather, and inadequate supplies. Food will not be provided. Toilet facilities may include portable toilets.

Working with the St. Anna's Medical Mission may or may not include a doctor on board...a nurse may work alone doing screenings, simple first aid and education. Supplies may be limited. There may also be a compassion minister on board for spiritual guidance.

I understand that many things are outside St. Anna's Medical Mission or St. Anna's Episcopal Church control in a disaster response situation. There may be weeks or even months where conditions/circumstances change daily, or even hourly. I may be working in one location under a certain set of circumstances in the morning and a different place with different challenges by afternoon. OR there may be days on end when I do repetitive tasks with minimal supplies. As in any critical situation, panic only worsens the crisis. I will stay calm, think first, be deliberate and neither rush nor waste valuable time. I understand that as events unfold I may be called upon to wait, to move quickly, to clean up after a day's work, or other tasks as the situation demands. I understand that due to weather or other circumstances, the Medical Mission's schedule may change or be canceled with little or no notice. I AM PREPARED TO BE FLEXIBLE.

I understand that plans for clinic hours may be changed or cancelled with little notice due to weather or circumstances.

I understand the need to approach this experience with a strong sense of humor and a stable sense of self. I understand that I may be dealing with highly stressed individuals (both patients and fellow volunteers); that emotions may vary from intense to flat-line to giddy. I will remain ready to cut everyone plenty of slack.

We all handle stress differently. Add to that unfamiliar and perhaps uncomfortable surroundings and people and the recipe can be volatile. If you believe you can handle these conditions, and can encourage and affirm others in the midst of these conditions, then welcome aboard. If you have doubts as to your performance in this kind of pressure, please don't feel bad about reconsidering your participation.

I, the undersigned, have read, understand and accept the conditions of participation.

Volunteer signature

Date



Episcopal Diocese of Louisiana
The Right Rev. Charles Jenkins, Bishop
Office of Disaster Response
1623 Seventh Street, New Orleans, LA 70115
ph. 504-895-4304 x22 fax 504-895-6637



Archdeacon Dennis McManis, Director dmcmanis@stjamesbr.org
Dr. Courtney Cowart, Co-Director ccowart@edola.org
Susan Foto, Volunteer Coordinator sfoto@edola.org
Darlene Davillier, Volunteer Coordinator ddavillier@edola.org

VOLUNTEER AGREEMENT AND RELEASE

Please read before signing, as this constitutes the agreement as a volunteer and the understanding of your working relationship as a volunteer with the Diocese of the Episcopal Church of Louisiana, including its Office of Disaster Response (hereinafter "the Diocese").

I, _____, acknowledge and state the following:
I have chosen to travel and to perform clean-up, remediation or repair work for damage caused by a disaster.

I understand that this travel and work entails a risk of physical injury and often involves hard physical labor, heavy lifting and other strenuous activity; and that some activities may take place on ladders and building framing other than ground level. I certify that I am in good health and physically able to perform this type of work.

I understand that engaging in this activity involves certain risks, not all of which are foreseen. I am engaging in this project at my own risk. I understand that this is a "grass roots" activity to support individuals adversely affected by hurricane/flood disaster or are receiving assistance to repair or replace substandard housing, and that the conditions might be hazardous to my health. I assume all risk and responsibility for any damage or injury to my property or any personal injury, which I may sustain while involved in this project, and related medical costs and expenses.

In the event that the Diocese or my supervising disaster organization arranges accommodations, I understand that they are not responsible or liable for my personal effects and property and that they will not provide lock up or security for any items. I will hold them harmless in the event of theft or for loss resulting from any source or cause. I further understand that I am to abide by whatever rules and regulations may be in effect for the accommodations at that time.

By my signature, for myself, my estate, and my heirs, I hereby release and discharge, and agree to defend, indemnify and forever hold harmless the Diocese and its officers, directors, agents, volunteers, servants and employees, from any and all causes of action arising from or relating to my participation in this project, and travel or lodging associated therewith, including any damages including but not limited to claims for personal injury, sickness or loss of limb or life, even if said claims arise from injuries or illnesses caused by the sole negligence or fault of those hereby released.

If the any vehicle owned or leased by, or otherwise in the possession of the Diocese or my supervising disaster organization or any of their employees, supervisors or volunteers, is involved in transporting me, I understand that the transportation is being provided at my sole risk and that neither the Diocese or my supervising disaster organization or any of their employees, supervisors or volunteers or the driver of the vehicle is responsible for any accident involving the vehicle or any injury that I might suffer in connection with the transportation.

I understand the need for confidentiality and will not discuss, photograph or otherwise disclose identifying information about the occupants of the house I am working in without prior permission from the Diocese and the occupants, including any reference to names, addresses, or other identifying information.

I may choose to participate in additional activities on multiple or later dates, and this Volunteer Agreement and Release will apply to any activities in which I participate in the future. I hereby certify that I am at least 18 years old.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

EMERGENCY CONTACT: _____

PHONE: _____ WITNESS: _____

ORGANIZATION OR CHURCH NAME: _____

IF WITH GROUP, TEAM LEADER NAME:: _____



St. Anna's Medical Mission



Liability Release and Indemnity Form

MEDICAL MISSION VOLUNTEER

I wish to participate in a short-term relief trip coordinated by St. Anna's Medical Mission, a Louisiana not-for-profit mission of St. Anna's Episcopal Church-New Orleans, in relation to Hurricane Katrina Relief. As a medical volunteer, I understand that St. Anna's Medical Mission has provided an opportunity for me to volunteer my skills to assist victims/ people in need. I understand that I may be working in abnormal and/or subnormal clinical circumstances and that those circumstances may be beyond the control of St. Anna's Medical Mission. I understand that St. Anna's Medical Mission is serving compelling humanitarian needs and is allowing me to perform acts of compassion in cooperation with their larger relief efforts. I understand that St. Anna's Medical Mission may not own or provide the facility in which I will work, but that all possible efforts are being made to secure the medicines, supplies and equipment needed to perform the tasks I am willingly undertaking.

In consideration for providing assistance to me in arranging this trip and for the opportunity afforded me to serve, which, as evidenced by my signing this Liability Release and Indemnity Form, I regard as significant, material, and valuable consideration in exchange for this release and indemnity, I the undersigned medical professional, on behalf of myself and my personal representatives, assigns, heirs, distributes, guardians and next of kin, hereby irrevocably, unconditionally, and forever release, discharge, and covenant not to sue St. Anna's Church, St. Anna's Medical Mission and any other organization(s) with which I work on the trip, and each of their respective divisions, parents, subsidiaries, member organizations, affiliates, chapters, officers, directors, agents, employees, volunteers, insurers, heirs, assigns and successors in interest, and any and all entities who referred me to St. Anna's Medical Mission (collectively the "Releasees"), from any and all claim, demands, liability (under the law of any state or country), fees, expenses and costs of any kind whatsoever that I may have or claim to have on account of or in any way related to or arising from, directly or indirectly, the proposed service opportunity, the cancellation or delay of such opportunity, or the failure to provide future opportunity. Further, I agree to indemnify and hold harmless the Releasees from any and all claims, losses, damage, injuries, damage to property or other costs and/or expenses arising from or caused by me in whole or in part, during my travel to and from and by participation in the trip, including without limitation any of the foregoing related to my professional licensure or lack thereof.

I am fully aware of the risks and other hazards inherent on the trip, and I voluntarily assume the risks and all other risks of loss, damage, or injury that may be sustained by me during my travel to and from and by participation on the trip. I also agree that I bear the sole responsibility for any and all medical expenses which I incur during my travel to and from and by participation in the trip, whether for injury or illness, and whether required as a result of said travel or participation or not.

My release specifically includes, but is not limited to, any and all alleged negligent acts, errors, and omissions of any of the released persons or entities. In addition to economic damages, costs and expenses, this release also specifically covers any and all injuries, deaths, and conditions of health, whether or not immediately apparent following my service through St. Anna's Medical Mission, or which may at any time thereafter develop.

As evidenced by my signing this release, I regard the services, time, skills, transportation, vehicles, medicines, supplies, equipment and other related costs and expenses being furnished to me as significant, material, and valuable consideration in exchange for this release, and I value this consideration as a significant, material factor in fulfilling my compelling desire to serve human needs. I have read and fully understand this document. I understand that I may speak with a St. Anna's Medical Mission staff representative about my questions concerning the proposed opportunity. In connection with any portion of this document that I did not understand, I had and continue to have the right to obtain legal advice from an attorney of my choice.

This agreement shall be binding upon all the heirs at law, assigns, and successors in interest of all parties hereto. This agreement may be enforced by any party hereto and/or by any person or organization released in this agreement. I agree that this agreement shall be governed and interpreted by the laws of the state of Louisiana.

I warrant that I have fully read and understand this Liability Release and Indemnity Form and voluntarily sign the same, and that no oral representations, statements or inducements apart from the foregoing written agreement have been made to me. I further acknowledge and agree that all references to me with regards to my responsibility, waiver, release, and assumption of risk, to the extent allowed by law, apply to minor children for whom I sign this document as legal guardian or parent.

CAUTION: READ BEFORE SIGNING Printed Name: _____

Volunteer Signature _____

Date _____

I hereby authorized St. Anna's Medical Mission to use my name and photographs in any reports of the overall response for which my services have been secured that might appear in newspapers, radio, television, St. Anna's Medical Mission newsletters, or other public relations activities, unless the "no" line at the end of this paragraph is checked. _____NO



St. Anna's Medical Mission



Confidentiality and Security Agreement

I understand that St. Anna's Medical Mission (SAMM) in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice, school) for which I work has a relationship (contractual or otherwise) involving the exchange of health information, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, St. Anna's Church and SAMM must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at SAMM, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with SAMM's Privacy and Security Policies, which are available in the Policies and Procedure Manuals located in the Mobile Unit and SAMM office. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not 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.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with SAMM.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to SAMM.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with SAMM.
8. I will act in the best interest of SAMM.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work at SAMM, in accordance with SAMM's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

If computer accessed or electronic patient records are used:

11. I understand that I should have no expectation of privacy when using SAMM information systems. SAMM may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
 - a. Use only my officially assigned User-ID and password
 - b. Use only approved licensed software
 - c. Use a device with virus protection software.
15. I will never:
 - a. Share/disclose user-IDs or passwords
 - b. Use tools or techniques to break/exploit security measures.
 - c. Connect to unauthorized networks through the systems or devices.
16. I will notify the SAMM Parish Nurse if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to SAMM at the time of each access that I have the requisite patient consent to do so, and SAMM may rely on that representation in granting such access to me.

Signing this document, I, (**PRINT NAME**) _____ acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Volunteer/Student/Worker Signature

Date