

**County of Los Angeles – ValleyCare
OLIVE VIEW-UCLA MEDICAL CENTER
Volunteer Services Division**

ORIENTATION & REQUIRED TRAINING RELEASE

Medical Student/Field Placement Name (PRINT): → _____

Assigned Area: Department of Medicine Area Extension: 3205

As a matter of record, all non-compensated adults undergoing medical training/field placement at ValleyCare/OliveView-UCLA Medical Center must have a volunteer application and job description on file in the Volunteer Office. To meet Joint Commission (JCAHO) standards, proof of required training, health screening and competency assessment performance evaluations must be on file for all employees and volunteers. **Medical students not attending UCLA must attach letter of acceptance to OV-UCLA program.**

Area Supervisors Are Responsible for Obtaining and Maintaining the Following:

- EVERY 4 YEARS: Fire & Life Safety Training (Formal Session)
- ANNUAL Code of Safe Practices Training
 - -Safe Work Practices
 - -Emergency Fire Procedures
 - -Fire Extinguisher
- ANNUAL Hazard Communications Training
- ANNUAL Radiation Safety Training
- ANNUAL Bloodborne Pathogen Training
- ANNUAL Tuberculosis (TB) Training
- ANNUAL Tuberculosis (TB) Skin Test
- ANNUAL Competency Assessment Performance Evaluation

GENERAL INFORMATION

All volunteers are required to turn in a time sheet to the Volunteer Office. Time sheets are used for County insurance records as well as tracking volunteer hours. Volunteers are not permitted to perform invasive treatments/procedures. Volunteer identification badges and uniforms are to be returned upon termination. Validine cards and parking permits are not available through the Volunteer Office.

CERTIFICATION

I verify compliance with the above. This volunteer is not a graduate medical physician (U.S. or foreign country). The Volunteer Office will be notified in the event that the volunteer receives compensation for services.

Area Supervisor's Signature:  Date: _____

Print Supervisor's Name: Soma Wali, M.D. Title: Program Director

Please note: For convenience, a time sheet for an entire year is attached. Please indicate the total estimated number of hours (and rotation) for each month. These forms and a "job description: must be attached to the Volunteer Application.

County of Los Angeles – ValleyCare
OLIVE VIEW-UCLA MEDICAL CENTER

Instructions: Please complete this form entirely. Indicate the rotation and total estimated number of hours for each month. Place and “X” through the months you will NOT be at Olive view-UCLA Medical Center. Please return this timesheet with your application **and** Orientation & Required Training Release forms. Thank you!

PRINT Last Name: → _____ **PRINT** First Name: → _____

Calendar Year: → 2011-2012 School Attending: → _____

January	February	March	April
Rotation:	Rotation:	Rotation:	Rotation:
Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:
May	June	July	August
Rotation:	Rotation:	Rotation:	Rotation:
Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:
September	October	November	December
Rotation:	Rotation:	Rotation:	Rotation:
Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:	Total Monthly Hours:

CERTIFICATION: I verify above hours and will comply with the policies, practices and procedures as stated on reverse of this timesheet.

Signature: → _____ Date: → _____

REVIEW AND VERIFICATION OF REQUIRED INFORMATION

The following are policies of the Department of Health Services and other required information, which must be reviewed and verified annually with each Volunteer (hereafter referred to as "employee") by his/her supervisor.

I understand and will adhere to all policies and procedures, including (but not limited to):

CAPPING: Employees of the Department will not engage in capping activities on or off County property. Capping is an employee's referral of County clients to a specific law office or attorney and is illegal under Section 6151, 6152, and 6153 of the Business and Professions Code of the State of California. Employees are required to report to their Supervisor any observation and knowledge they may have of capping activities.

SOLICITATION: County ordinance No. 2292 prohibits solicitation in any building or on any property of the County of Los Angeles. Solicitation may be interpreted to include the act of selling or attempting to sell goods or services, the request for contributions, and the solicitation of a person to sign or distribute political petitions on county premises.

CONFLICT OF INTEREST: It is the employee's responsibility to disclose and report all potential conflict of interest situations, document the circumstances and secure for the head of the division appropriate consultation and approval of the procedures to be followed which will be designated to protect the Department, the employee, and the public. Additionally, employees of the Department will not engage in or have any interest in any business or transaction that conflicts, or appears to conflict, with performing their duties, nor will they accept money, favors, or other considerations for work performed. Employees will not accept gifts, gratuities, or favors from patients, persons, or vendors doing business with the County.

NEPOTISM: All employees of the Department are required to identify any person who is a close relative and who is also employed by the Department. Close relatives should not be assigned within the same organizational unit or supervised by the same person. An employee may not supervise any close relative wither as in immediate supervisor or as a higher level supervisor. Close relative is defined as mother, father, stepmother, stepfather, father-in-law, mother-in-law, brother, sister, husband, wife, child, and any other genealogical or marital relationship.

OUTSIDE EMPLOYMENT: A full time employee may work in non-conflicting outside employment to a limit of 24 hours in any one work week provided that the employee's effectiveness in their county assignment is not impaired. Employees will not use County time, facilities, tools, equipment, or supplies for other than County purposes, nor will confidential or other non-public information gathered by used in connection with outside employment. Employees are to notify their supervisor prior to engagement in outside employment, including self-employment. The employee is responsible for keeping the information updated and observing the limitations on outside employment. Forms are available in Human Resources.

POLITICAL ACTIVITIES: Employees may not participate in political activities of any kind during work hours or while in uniform. Employees must also refrain from political activities that would impair the efficiency, integrity, or morale of the Department or its employees. Employees on items funded in whole or in part by the Federal government are subject to further restrictions by the Hatch Act. Employees who engage in improper political activities will be subject to immediate disciplinary action. Questions regarding the appropriateness of any planned political activity should be directed to Human Resources.

CHOICE OF PHYSICIAN FOR INDUSTRIAL INJURY/ILLNESS – EMPLOYEE OPTION: State law allows employees to be treated by their own personal physician immediately after injury/illness providing the employee has previously submitted written notice to their employer of this choice. Employees who wish to be treated by their own physician in case of industrial injury/illness must complete the STATEMENT ON WORKER'S COMPENSATION LAW REGARDING CHOICE OF PHYSICIAN. Unless an employee has completed this form, all medical referrals for industrial injury/illness will be made from the county Medical Directory. Forms are available in Human Resources.

CONFIDENTIAL INFORMATION: The confidentiality of all patient information and personnel/employee information is protected by law. Such confidential information will not be released without prior authorization by the Division head of Administration. Unauthorized release of any confidential information to any person on or off the job is strictly prohibited and subject to severe disciplinary action which could include discharge from county Service and/or legal action against all parties involved in such unlawful acts.

TIMECARD/TIMEKEEPING POLICY: Each employee will accurately record time worked and time off. Each Supervisor will verify those recordings. Employees who falsify any timekeeping records or make any unauthorized changes in timecard recordings after the supervisor has signed the timecard will be subject to disciplinary action, which could result in discharge from County service. Employees are responsible for observance the ValleyCare timecard/Timekeeping Policy and are responsible for maintaining an accurate record of their own hours balances.

SEXUAL HARASSMENT: It is the policy of Department of Health Services and ValleyCare to afford equal employment to all persons and to maintain an Affirmative Action Program necessary to achieve and maintain a workforce that is balanced for ethnic minority groups, women, and the handicapped based on their representation in the County's population and their availability.

CHILD/ELDER/DEPENDENT ADULT ABUSE REPORTING: All Department of Health Services employees have the responsibility to participate in identifying and reporting cases of suspect child/elder/dependent adult abuse. Health care professionals, including medical and non-medical practitioners, shall report all cases of suspect child/elder/dependent adult abuse as required by law. Reporting: Health care professionals shall report suspected child/elder/dependent adult abuse to the appropriate agencies designated to receive such reports by telephone immediately and in writing within 36 hours of making the observation. The agency designated to receive such reports is the appropriate Protective Services Office of the Department of Public Social Services. The report shall include identifying information which will enable the Department of Public Social Services to make an evaluation of the report. (Ref: DHS Policy No. 293 & 295).

UNIVERSAL BLOOD/BODY FLUID PRECAUTIONS: The Occupational Safety and health Administration (OSHA) requires that all staff observe Universal Blood and Body Fluid Precautions when dealing with ALL patients. Please familiarize yourself with the procedures and make sure that they are observed at all times.

DEPARTMENT OF HEALTH SERVICES MISSION STATEMENT:

The mission of the Los Angeles County Department of health services is to protect, maintain, and improve the health of the community.

ValleyCare Strategic Plan

Mission: To improve the health of our patients and community.

Vision: To establish an integrated, community based health care delivery system emphasizing excellence in service, education, partnership, and academics.

Values: Compassion, Communication, Integrity, Improvement.

Goals: Access: To assure access to necessary health care. Service: To provide services which satisfy our customers. Community involvement: To establish priorities through community involvement. Patient empowerment: To empower patients through education and shared decision making. Job satisfaction: To enhance job satisfaction and growth for our employees. Learning and teaching: To promote discovery and sharing of the best approaches to healthcare delivery. Resources: To help coordinate and optimize the use of public and private healthcare resources for our community. Outcomes: To continuously improve health outcomes.

Certification:

During my orientation, I became familiar with Safety police procedure, terrorism awareness, Risk Management, Quality Improvement, Advance Directives, Infection Control (updated annually), including Universal Blood and Body Fluid Precautions, hospital building systems operations,, Sexual harassment, Patient and Employee Confidentiality, fire and Life Safety Training (updated annually), Hazardous Waste Training (updated annually). I further understand that to meet compliance with the Joint Commission on the Accreditation of Hospitals Organization (JCAHO), I will be reviewed for my performance and will cooperate in completion of the probationary and annual competency Assessment Performance Evaluation(s). I will complete an annual Tuberculosis Test (skin test or chest X-ray) as required by government standards.

My Signature on reverse of this document verifies my understanding and compliance of the above.

County of Los Angeles – ValleyCare OLIVE VIEW-UCLA MEDICAL CENTER

MEDICAL STUDENT/VOLUNTEER APPLICATION

Have you been at Olive View on rotation before? ___ Yes ___ No
If yes: When: _____ Department: _____

PRINT Last Name: _____ PRINT First Name: _____ MI: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Work/School: (____) _____

Emergency Contact Person: _____

Telephone: (____) _____ Relationship: _____

Any limitations? Do you take medications? Please explain:

Rotation: _____ How many hours? _____ By when? _____

Program Instructor: _____ Phone (____) _____

OV-UCLA Supervisor: **Mark DeVany** Phone (____) **X3205**

RULES: As a medical student/volunteer at Olive View-UCLA Medical Center I will be loyal, dependable and punctual. I will follow the rules of this facility and will keep in strict confidence all matters learned or observed in the course of my service. I agree to complete orientation and any required training courses. I agree to accept release for any reason deemed sufficient by the Director of Volunteers, Department Chief or designated agent. I agree to pay for any uniforms that I fail to return. I understand that I must follow the hospital dress code.

MEDICAL WAIVER: The undersigned hereby consents to, authorizes and request the Department of Health Services of Los Angeles County, its physicians, surgeons, dentists and its medical personnel to administer and perform any and all medical examinations and treatments, dental examinations and treatments, diagnostic procedures, vaccinations, and immunizations against disease which may now or during the course of volunteerism be deemed advisable or necessary.

PLEASE NOTE: Medical Students *other than UCLA* must attach a letter of acceptance.

Your signature is required FOUR times on this application.

Signature of Applicant: → _____ Date: → _____

Volunteer Liability and Insurance Statement

If you are a person who is duly enrolled as an individual or as a group member in a volunteer program sponsored by a department of Los Angeles County, the following information will answer your concerns about insurance and your liability for your actions while serving as a volunteer:

What happens if you are injured in the course of a volunteer assignment?

County volunteer workers accident insurance reimburses the volunteer accident victim for medical expenses resulting from an accident sustained in the course of rendering volunteer services to the County. If the volunteer has personal medical insurance coverage, *this must be utilized as a primary resource before claiming reimbursement* from the Los Angeles County insurance program. Volunteer coverage provides up to a total of \$5,000 for injuries and provides accidental death benefits in the amount of \$3,000. Medical expenses benefits are on a reimbursement basis, therefore, it is not necessary that the volunteer be referred to any specific hospital or facility. All injuries should be reported to the Volunteer Office and to your area supervisor WITHIN 24 hours or on the next regular workday, even though you use your own personal insurance to cover expenses involved. If you are injured on the job in the hospital, report the injuries immediately to the Volunteer Director and departmental supervisor. A claim must be submitted on the proper claim form(s) through the Volunteer Office.

What happens if a client that you are serving or someone else is injured in activities while you are acting as a volunteer?

County ordinance allows the same liability protection for volunteers as for regular employees. The ordinance provides liability protection from suits by third parties for volunteers while they are performing assigned tasks unless the volunteer acts or fails to act because of actual fraud, corruption, or actual malice or outside the scope of their assigned tasks. Additionally, the volunteer cannot be indemnified against any judgement against them for punitive damages. Therefore, it is very important that you have a clear understanding of the procedures you may need to follow. Please contact the Volunteer Office during regular working hours if you need additional information.

If you drive a car as part of your volunteer assignment, do you need car insurance?

The County liability protection does not excuse you from observing California state laws regarding auto insurance nor from maintaining a valid driver's license. The volunteer Office will require information regarding your auto insurance and verification of a valid driver's license before giving you an assignment involving transportation of clients/patients or times for use in the course of Volunteer Services Programs.

In case of emergency or accident involving a patient/client of a County agency while away from the hospital:

1. Assist client/patient to nearest medical facility.
2. Notify the responsible family member.
3. During working hours, notify the Volunteer office.
4. Evenings and weekends notify the Assistant Nursing Director.
5. Evenings and weekends notify the Volunteer Director the next workday.
6. Should the situation warrant emergency care, call 911.

If necessary, the client will be transported to the nearest emergency hospital. Ambulance charges can be covered by Medi-Cal. You may need to make a police report.

For your protection: If your assignment with a minor will involve you in an activity without the presence of their parents or guardian, remember to always have in your possession a participation/medical consent form properly completed by parent, guardian or probation officer.

Remember...As a volunteer, you are a non-compensated County employee. Report on-the-job injuries to your area supervisor and Director of Volunteers at (818) 364-3074 immediately. You must complete insurance claim forms on the next working day; otherwise, the County of Los Angeles may not assume any responsibility or liability expenses.

I have read the above statement and have a clear understanding of the Los Angeles County Accident Insurance Program for Volunteers.

→

Volunteer Signature

→

Date

Subject: Capping, Gift & Gratuities, Solicitation

Any individual employed by the county, on a voluntary basis, who is simultaneously engaged in professional or vocational activities outside County control, shall not either directly or indirectly benefit from such relationships.

CAPPING: Capping is soliciting business for attorneys. It is illegal for employees or volunteers to solicit any business for attorneys, both on or off County property, or act as a runner or capper for an attorney in the solicitation of business. All know violations must be reported to Administration.

GIFT AND GRATUITIES: Volunteers shall not accept gifts or gratuities from patients, vendors, or other persons with whom the County does business, or with whom they may come in contact with while conducting County business.

SOLICITATION: No volunteer shall solicit for a private vendor, nor refer any County patients or clients for treatment or services. Solicitation may be interpreted to include the act of selling or attempting to sell goods or services, the request for contributions, and the solicitation of persons to sign or distribute petitions on County premises.

I hereby acknowledge that I have reviewed and fully understand the above.

Volunteer Signature → _____ Date → _____

Subject: Confidentiality of Information

This organization acknowledges both a legal and ethical responsibility to protect the privacy of patients and employees. Consequently, the indiscriminate or unauthorized review, use, or disclosure of personal information, medical or otherwise, regarding a patient or employee is expressly prohibited. Except when required in the regular course of business, the disclosure of patient information is strictly forbidden. Individuals who have access to employee information or business information designated as confidential by administrators or managers are expected to respect and treat the confidentiality by administrators or managers are expected to respect and treat the confidentiality of such information in the same manner as that of patient information.

This is to certify that I have read, understand and acknowledge the significance of this policy. A single violation of this policy will result in immediate discipline, up to and including discharge from the volunteer program.

Volunteer Signature → _____ Date → _____

Subject: General Information

DRESS CODE STANDARDS: Hats, short-shorts, tank tops, bare midriiffs, mini-skirts, open toe shoes/sandals, long/dangling earrings or sunglasses are not permitted. Shirrtails must be tucked in. Longer (Bermuda length) shorts may be permitted in some areas: check with your area supervisor or the Volunteer Office. Various uniforms may be required depending on the service to which you are assigned: check with your supervisor for any area specific dress code requirements. Generally, clean, preferably white pants or skirts with clean white tennis shoes and white socks are appropriate for all areas. **Identification badge is worn on upper left quadrant of the body AT ALL TIMES.**

HYGIENE: Good hygiene practices are necessary not only to decrease the infection rate, but also for the comfort of the patients we serve. **To avoid unpleasant situations, please: Bathe before your shift.** Use a deodorant. Brush your teeth. Be sure your clothes/uniform are clean. Hair should be neatly styled: long hair must be secured at the neckline (or above) with a non-decorative fastener. Fingernails must be clean and neatly manicured.

BREAKS/LUNCH: A 15 minute break is allowed after two hours of volunteer time; inform your supervisor before leaving your assigned area for break or lunch (lunch is ½ hour). Ordinarily, two volunteers on the same unit will not be allowed to break together due to service needs.

MEAL TICKETS: A free meal is provided after a minimum of four hours of service, with a maximum of one meal per day. Cafeteria hours are 6:30 am to 7:30 pm. You may obtain your meal ticket in the Volunteer Office (or in Nursing Administration, room 2C197). Be sure to **sign the back of your meal ticket before you reach the cashier**. Please do not use your meal ticket for snacks or beverages, only for a full breakfast or lunch. Remember, there are always cookies, coffee and other beverages available in the Volunteer Office free of charge. **Please do not eat or drink in your work area.** Please use the cafeteria, Volunteer Office or designated lounge areas.

Volunteer Signature → _____ Date → _____

OLIVE VIEW-UCLA MEDICAL CENTER
Medical Administration

INTEROFFICE MEMORANDUM

DATE: _____

TO: Medical Staff Office

FROM: MARK DEVANY

RE: MEDICAL STUDENT APPLICATION

The attached MEDICAL STUDENT APPLICATION is for:

LAST	FIRST	M.I.
Department:		
Dates of Medical School:		
START DATE:	EXPECTED END DATE:	

OLIVE VIEW-UCLA MEDICAL CENTER

MEDICAL STUDENT

INFORMATION SHEET

Last,	First,	Middle
Print or type full name, including suffix (e.g., Jr., Sr.) and maiden name if applicable		
Home Address		
City	State	Zip
Telephone Number ()	Beeper/Pager Number ()	E-mail address:
<ul style="list-style-type: none">• Please indicate: Male Female• My Date of Birth is: ____ / ____ / ____		

MEDICAL SCHOOL

Name of Medical School:			
Mailing Address:		City:	
State:	ZIP:	From: (mm/yy)	To: (mm/yy)

**VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER AND HEALTH CENTERS**

**STATEMENT OF CONFIDENTIALITY
OF PEER REVIEW/QUALITY IMPROVEMENT ACTIVITIES
OF THE PROFESSIONAL STAFF ASSOCIATION,
COMMITTEES, DEPARTMENTS AND DIVISIONS**

All information discussed, distributed, and prepared for peer review/quality improvement activities shall be deemed confidential, including but not limited to all material related to the performance of medical review, participation in a risk prevention program, or investigation/discussion of any safety or quality of care issues.

The Medical Director shall determine the persons or entities outside the respective committees or activities that are legally entitled to access this information. All minutes, files, and correspondence shall be kept secured in a designated area and distributed only as directed by the Medical Director.

CONFIDENTIALITY AGREEMENT:

As a member or a guest of peer review/quality improvement activities at ValleyCare Olive View-UCLA Medical Center, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it by the Medical Director.

I further understand that the organization is entitled to undertake action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

Print full name _____

Signature _____

Date _____