



## VOLUNTEER/INTERNSHIP APPLICATION

### PERSONAL INFORMATION

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_

RELATIONSHIP TO INTERN/VOLUNTEER \_\_\_\_\_ TELEPHONE \_\_\_\_\_

HAVE YOU EVER PLED "GUILTY" OR "NO CONTEST" TO OR BEEN CONVICTED OF A CRIME?

YES  NO IF YES, PLEASE PROVIDE DATE(S) AND DETAILS \_\_\_\_\_

### VOLUNTEER INFORMATION

WHAT SPECIAL TALENTS AND/OR SKILLS DO YOU HAVE THAT YOU WISH TO SHARE?

DO YOU WISH TO WORK WITH:  CHILDREN  ADULTS  
 DEVELOPMENTAL DISABILITIES  MENTAL HEALTH  ADDICTIVE DISEASES  
 ANY OF THE ABOVE

DAYS AND TIMES YOU ARE AVAILABLE \_\_\_\_\_

### SCHOOL INFORMATION

NAME OF SCHOOL \_\_\_\_\_

NAME OF ADVISOR \_\_\_\_\_

YEAR IN SCHOOL \_\_\_\_\_ EXPECTED GRADUATION DATE \_\_\_\_\_

NEED INTERNSHIP TO BEGIN \_\_\_\_\_

LEVEL OF SUPERVISION NEEDED \_\_\_\_\_

TIMES AVAILABLE FOR INTERNSHIP \_\_\_\_\_



## VOLUNTEER/INTERNSHIP APPLICATION

### EMPLOYMENT HISTORY

CURRENT OR MOST RECENT EMPLOYER \_\_\_\_\_

POSITION HELD \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

RESPONSIBILITIES \_\_\_\_\_

REASON FOR LEAVING \_\_\_\_\_

SUPERVISOR'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

PREVIOUS EMPLOYER \_\_\_\_\_

POSITION HELD \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

RESPONSIBILITIES \_\_\_\_\_

REASON FOR LEAVING \_\_\_\_\_

SUPERVISOR'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

PREVIOUS EMPLOYER \_\_\_\_\_

POSITION HELD \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

RESPONSIBILITIES \_\_\_\_\_

REASON FOR LEAVING \_\_\_\_\_

SUPERVISOR'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

I certify that all information on this form is correct. I authorize Gateway to verify this information. I further certify that either:  
1) I have not been convicted of a drug-related criminal offense; or, 2) If I have been convicted of a drug-related offense, it has been more than two (2) years since my first conviction, or more than five (5) years since a second or subsequent conviction.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Applicant)



7395 Hodgson Memorial Drive  
Savannah GA 31406

### Confidentiality/Non-Disclosure Agreement

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Title: \_\_\_\_\_

Security and confidentiality are matters of concern for all persons who have access to Gateway Community Service Board (Gateway) information systems. Each person accessing any Gateway Network data source, including, but not limited to, patient, provider, administration, and financial information (The Confidential Information) holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, all persons who are authorized to access data and resources must read and comply with all Confidentiality Policies of Gateway.

As a condition to receiving access to information, I, the undersigned, agree to comply with the following terms:

1. I will not, at any time during or after my affiliation with Gateway, disclose information to which I have access in any form (i.e., electronic media, paper, microfilm, etc.) to any unauthorized individuals.
2. My computer access code is equivalent to my LEGAL SIGNATURE and I will not share or disclose this code to anyone or allow anyone to access any Gateway application using my access code.
3. I am responsible and accountable for all entries made and retrievals accessed under my access code.
4. I am acquainted with the HIPPA Privacy Rules and I will utilize and access "protected health information" only where such information is necessary for performance of "treatment, payment and operations" purposes of a "covered entity," as such terms are defined in the Privacy Rule, and that I will access only the minimum amount of protected health information necessary for such tasks. I further warrant and represent that I will only access protected health information when I am acting in the capacity of a covered entity, a member of a covered entity's "workforce" or a "business associate" of a covered entity.
5. I will not attempt to learn or use another's log-in code or password.
6. I will not access any on-line workstation using a log-in code other than my own.
7. I will not access or request data on consumers for whom I have no relationship. In addition, I will not access any other confidential information, including financial or private information.
8. If I have reason to believe that the confidentiality of my user log-in and/or password has been compromised, I will immediately ensure that the password is changed by the approved procedure for password name change.
9. I understand that information accessed via any data source contains sensitive and confidential patient care, business, financial, and employee information, which should only be disclosed to those authorized to receive it.
10. I will respect the confidentiality of any reports and handle, store, and dispose of these reports appropriately.
11. I will not install or operate any non-licensed software on any computer within Gateway.
12. I will log off or suspend access when leaving the workstations.
13. I will comply with all policies and procedures and other rules of Gateway with relation to confidentiality of information and log -in codes.

I have read and understand the above Confidentiality and Non-Disclosure Agreement. I understand that my use of Gateway information will be monitored to ensure compliance with this agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action including discharge, civil, or criminal action being taken against me, loss of privileges to access information, termination of employment, volunteer or internship, or any other legal remedy available to Gateway. I accept my obligation to maintain the confidentiality of consumer and provider information and agree to abide by the terms of the agreement.

Signature: \_\_\_\_\_ Date \_\_\_\_\_



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**HOLD HARMLESS AGREEMENT**

I, \_\_\_\_\_, acknowledge that all information provided on the *Volunteer/Internship Application* is accurate and true. I understand that I am to complete an orientation process and agree to follow all Policies and Procedures of Gateway Community Service Board (Gateway). I further understand that failure to follow said policies will result in immediate dismissal from my internship/volunteer program and my student advisor will be notified. I understand that the internship/volunteer program is a **Non-Paying** position. I also acknowledge the fact that the completion of the internship/volunteer program does not guarantee my hiring or transfer to any paid position at Gateway. I hereby assume the risk of injury, illness, or accident and release, discharge, and indemnify Gateway and its respective officers and employees from any and all claims for injuries, illness, or accident arising from my participation in the internship/volunteer program.

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Intern/Volunteer signature

Date

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Witness Signature

Date



7395 Hodgson Memorial Drive  
Savannah GA 31406

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**VOLUNTEER/INTERNSHIP  
DRUG-FREE WORKPLACE ACKNOWLEDGEMENT**

As an intern/volunteer with Gateway Community Service Board (Gateway), I hereby certify that I have been notified concerning Gateway's policy to maintain a drug-free workplace. I understand that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and violation of this policy can result in disciplinary action up to and including dismissal from Gateway. I understand that consuming illegal drugs and/or alcohol on state property owned, leased, or otherwise operated by Gateway is strictly prohibited. I further realize that as a condition of interning/volunteering, I will notify my supervisor of any criminal drug arrest or conviction no later than five (5) days after such event occurs.

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Intern/Volunteer Signature

Date

Please fill out and sign above. Once completed, click the button below.