REHABILITATION & Performance Center
PHYSICAL THERAPY

117 Harmony Crossing, Suite 4
Eatonton, GA 31024-9549
706-454-1811

VOLUNTEER / STUDENT INTERNSHIP APPLICATION

Date: _____

Name Date of Birth last 4 digits of SS#

Address: _____

Phone: _____ Cell: _____ Email: _____

Emergency Contact name Relation Phone

EDUCATION: Highest level of education completed: ☐ High School/grade: _____ ☐ College/year _____ G.P.A. _____

SKILLS / EXPERIENCE: CPR Certified ☐ YES ☐ NO Special Training / Hobbies: _____

Prior Volunteer Experience (include organization & dates): _____

_____

List any experiences that have prepared you for volunteer work in physical therapy _____

_____

Do your future plans include work in physical therapy? ☐ YES ☐ NO What do you hope to gain from this experience?

_____

_____

Have you ever been convicted of a crime? ☐ YES ☐ NO If yes, please explain: _____

_____****Conviction of a crime is not an automatic disqualification for volunteer work**

Availability: ☐ Mon ☐Tue ☐ Wed ☐ Thur ☐ Fri ☐Sat ☐ Sun Daily Hours available: 2 3 4 5 6 7 8

REFERENCES: List three people, not related, who can attest to your character, skills, and dependability.

NAME	YEARS KNOWN	CONTACT NUMBER OR EMAIL

READ CAREFULLY BEFORE SIGNING: I understand that this application is NOT a guarantee, promise, or implied commitment of a volunteer opportunity. I understand this information will be verified and I certify that the information provided is true and complete to the best of my knowledge and that any falsification, omission, or misrepresentation will void this application and any offer of a volunteer position or termination of a current volunteer position with Lake Oconee Rehabilitation and Performance Center, LLC.

Applicant signature Date

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Eff 9/15/2013

Business Associate Agreement Provisions

Definition

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use. For purposes of this agreement, Protected Health Information will be represented as "PHI" throughout the agreement.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose PHI other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) If applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available PHI in a designated record set to the individual or the individual's designee as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to PHI in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

(j) In the event of a request for PHI, amendment, an accounting disclosure, etc. that the business associate receives directly from the individual, the business associate will forward the individual's request(s) to the covered entity.

Permitted Uses and Disclosures by Business Associate

(a) Business associate may only use or disclose PHI where permitted by law or under direction of the covered entity.

(b) Business associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity.

(c) Business associate may disclose PHI for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of PHI.

Permissible Requests by Covered Entity

(a) Covered entity shall not request business associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity. [Include an exception if the business associate will use or disclose PHI for, and the agreement includes provisions for, data aggregation or management and administration and legal responsibilities of the business associate.]

Term and Termination

(a) Term. The Term of this Agreement shall be effective as of the said date of this agreement, and shall terminate on the date covered entity terminates the agreement either due to the agreement ending or for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate shall return to covered entity [or, if agreed to by covered entity, destroy] all PHI received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the PHI. This includes any keys, access codes, computer user names and/or passwords, etc.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(b) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

ACKNOWLEDGEMENT: READ ENTIRE AGREEMENT BEFORE SIGNING

I acknowledge that I have received a copy of Lake Oconee Rehabilitation and Performance Center, LLC Business Associate Agreement and that I agree to the provisions within.

Business Associate name (PRINT) Business Associate signature Date

REHABILITATION & Performance Center
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POSITION TITLE: **Volunteer**

REPORTS TO: **Clinic Director, directly & therapists & technicians/aides, indirectly**

CLASSIFICATION: **Non- Paid**

FUNCTION: **Assist the clinic and business office staff with routine patient set up duties and clinic maintenance**

ESSENTIAL JOB FUNCTIONS: Comply with the Facility's Comprehensive Compliance Plan (CCP) which includes but is not limited to: Business & Clinical Operations, Environmental Health & Safety, HIPAA, Human Resources and Code of Conduct as well as all facility policies and procedures and educational requirements associated the CCP. Comply with all local, state and federal regulations training and instruction requirements as well as any other standards that govern healthcare services provision

- **Class I Volunteer duties include, but are not limited to:**
  - Basic patient set ups
  - Patient room and equipment preparation
  - General clinic and laundry maintenance duties
  - Basic clerical duties
  - Legislative or association support functions
  - Carry out EHS duties as designated by the Director of Clinical Services

- **Class II Volunteer duties are limited to:**
  - Patient care observation
  - Basic clerical duties
  - Legislative or association support functions
  - Comply with EHS policies and procedures

PHYSICAL DEMAND CAPACITY: Consistent with published industry PDC norms; minimally:

QUALIFICATIONS: A person who has an interest in pursuing a career in Physical or Occupational Therapy or a related healthcare profession and who can meet the physical demand level of the position.

EDUCATION / EXPERIENCE: High school or equivalent skills & aptitude required, Health Occupations Courses in High School and College level basic science courses are desirable. No experience is required but healthcare observation and/or volunteer hours desirable.

HIPAA STATUS: Has been determined as eligible for access to/use of PHI & EPHI based on work duties and responsibilities in compliance with 'minimal necessary' standards

My signature indicates that I understand and agree to fulfill the position description as reflected above and that I have been given the opportunity to discuss and request clarification of any duties and/or responsibilities noted. I understand this job description is not an all-inclusive list of duties and that responsibilities can change as business needs permit.

Employee name (printed)	Employee's signature	Date

Authorized representative (printed)	Authorized representative's signature	Date