GATEWAY BEHAVIORAL HEALTH SERVICES
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 _____

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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)

Gateway BEHAVIORAL HEALTH SERVICES

700 Coastal Village Drive
Brunswick, GA 31520

Confidentiality/Non-Disclosure Agreement

Last Name: _____ First Name: _____ Title: _____

Security and confidentiality are matters of concern for all persons who have access to Gateway Behavioral Health Services (GBHS) information systems. Each person accessing any GBHS 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 GBHS.

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 GBHS, 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 GBHS 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 GBHS.
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 GBHS 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 GBHS 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 GBHS. 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 _____

Gateway BEHAVIORAL HEALTH SERVICES

700 Coastal Village Drive
Brunswick, GA 31520

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 BHS. 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 BHS. I hereby assume the risk of injury, illness, or accident and release, discharge, and indemnify Gateway BHS 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.

_____

Intern/Volunteer signature Date

_____

Witness Signature Date

Gateway
BEHAVIORAL
HEALTH
SERVICES

700 Coastal Village Drive
Brunswick, GA 31520

VOLUNTEER/INTERNSHIP
DRUG-FREE WORKPLACE ACKNOWLEDGEMENT

As an intern/volunteer with Gateway Behavioral Health Services (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.

_____

Intern/Volunteer Signature Date