

## DISCLOSURE FOR CONSUMER REPORTS

In connection with my application for employment (including contract or volunteer services) with Company, I understand consumer reports will be requested by the Company. These reports may include, but are not limited to, address history, criminal records, credit (as allowed by law), motor vehicle records, employment, education, license verification, workers' compensation claims, professional sanctions, civil judgments and other public record information. These records may be obtained from federal, state and other agencies that maintain such records.

In addition, investigative consumer reports (gathered from personal interviews) to gather information regarding my work, character, general reputation, personal characteristics and mode of living (lifestyle) may be obtained.

If I am hired, I understand that the Company can use this disclosure and following authorization to continue to obtain such consumer reports throughout my employment, contract period or volunteer service.

Acknowledged:

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Signature

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Date

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Printed Full Name

### **A Summary of Your Rights Under the Fair Credit Reporting Act**

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identity theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

- The following FCRA right applies with respect to nationwide consumer reporting agencies:

#### **CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE**

**You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization.** The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore).

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:**

TYPE OF BUSINESS:	CONTACT:
<p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552</p> <p>b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Asst. General Counsel for Aviation Enforcement &amp; Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Administration area supervisor</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549</p>
<p>8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>

## AUTHORIZATION

I hereby authorize procurement of consumer report(s) and investigative consumer report(s) by Company and its consumer reporting agency Employment Background Investigations (“EBI”) to obtain information on me from any law enforcement agency, administrator, local, state or federal agency, institution, school or university (public or private), information service bureau, employer, insurance company or the National Records Center to furnish any and all background information including, but not limited to; criminal and public record history, driving and/or motor vehicle records, transcripts, grades and attendance records, employment history, references and workers’ compensation documents (including from the State of Pennsylvania, the Industrial Commission of Arizona and all other states where permissible).

If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for Company to procure such reports at any time during, as permitted by law, my employment, contract, or volunteer period. I authorize without reservation, any person, business or agency contacted by the consumer reporting agency to furnish the above-mentioned information. I further authorize Company to share my report with third parties solely for employment purpose and on an as needed basis.

I understand that I have rights under the Fair Credit Reporting Act. I also acknowledge receipt, and have reviewed, the following documents:

- Disclosure For Consumer Reports
- Additional Information Regarding Your Rights
- A Summary of Your Rights Under the Fair Credit Reporting Act

If you have any questions concerning this background screening content, please contact Employment Background Investigations at 800-324-7700.

**Company/Employer:** TidalHealth

Printed Last Name: \_\_\_\_\_

Printed First Name: \_\_\_\_\_

Printed Middle Name: \_\_\_\_\_

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

E-mail: \_\_\_\_\_ Mobile Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

### For identification purposes:

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Driver’s License: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Other Names Used: \_\_\_\_\_

CANDIDATE INSTRUCTIONS	EMPLOYER INSTRUCTIONS
<p>IMPORTANT: This <i>AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO RELEASE SOCIAL SECURITY NUMBER VERIFICATION FORM</i> must be completed as indicated below and then forwarded to Human Resources:</p> <ul style="list-style-type: none"> <li>• Complete the top line with your name, date of birth and Social Security Number</li> <li>• Ensure that the following items are filled out: (1) the business transaction should be entered as "employment purposes", (2) the reason for using the CBSV should be "background check", (3) the company name and address should be "Employment Background Investigations, Inc., P.O. Box 629 Owings Mills, MD 21117", and (4) the name address of the company's agent should be "Equifax Verification Services, 11432 Lackland Road St. Louis, MO 63146 (888) 749-4411"</li> <li>• If under 18, please have your parent or legal guardian sign, date, list their relationship to you, and fill out their contact information</li> </ul>	<p>IMPORTANT: This <i>AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO RELEASE SOCIAL SECURITY NUMBER VERIFICATION FORM</i> must be completed and signed by the Applicant/Employee or their Parent/Legal Guardian. Copies of the original completed and signed documents are acceptable:</p> <ul style="list-style-type: none"> <li>• The Applicant/Employee should complete the top line with their name, date of birth and Social Security Number</li> <li>• The following items should be filled out: (1) the business transaction should be entered as "employment purposes", (2) the reason for using the CBSV should be "background check", (3) the company name and address should be "Employment Background Investigations, Inc., P.O. Box 629 Owings Mills, MD 21117", and (4) the name address of the company's agent should be "Equifax Verification Services, 11432 Lackland Road St. Louis, MO 63146 (888) 749-4411"</li> <li>• For Applicants / Employees under 18, their parent or legal guardian should sign, date, list their relationship to the Applicant/Employee, and fill out their contact information</li> <li>• Please fax a clear and legible copy of the completed and signed form to 410-413-0263 OR attach to the applicant file in J-One for processing. (EBI will then submit documents to source for processing.)</li> </ul>

## Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:
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Reason for authorizing consent: (Please select one)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> To apply for a mortgage    | <input type="checkbox"/> To apply for a loan          | <input type="checkbox"/> To meet a licensing requirement |
| <input type="checkbox"/> To open a bank account     | <input type="checkbox"/> To open a retirement account | <input checked="" type="checkbox"/> Other                |
| <input type="checkbox"/> To apply for a credit card | <input type="checkbox"/> To apply for a job           | Background Check   |

With the following company ("the Company"):

Company Name: EMPLOYMENT BACKGROUND INVESTIGATIONS, INC.

Company Address: P.O. Box 629 OWINGS MILLS MD 21117

The name and address of the Company's Agent (if applicable):

Agent's Name: Equifax Verification Services

Agent's Address: 11432 Lackland Road, St. Louis, MO 63146

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified. I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

**This consent is valid only for one-time use. This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:**

**This consent is valid for 90 days from the date signed. \_\_\_\_\_ (Please initial.)**

Signature:	Date Signed:
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Relationship (if not the individual to whom the SSN was issued):

### Privacy Act Statement Collection and Use of Personal Information

Sections 205(a) and 1106 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from releasing information to a designated company or company's agent. We will use the information to verify your name and Social Security number (SSN). In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs. A list of routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0058, entitled Master Files of SSN Holders and SSN Applications. Additional information and a full listing of all our SORNs are available on our website at [www.socialsecurity.gov/foia/bluebook](http://www.socialsecurity.gov/foia/bluebook).

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to complete the form. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send to this address only comments relating to our time estimate, not the completed form.**

-----TEAR OFF-----

### NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit <http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf>.

## TidalHealth Volunteers Immunization Record for Volunteers

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ TidalHealth badge #: \_\_\_\_\_

Please provide a copy of your immunization record by either method below:

- Have a licensed provider complete **and** sign this form below  
**OR**
- Attach a copy of your immunization record to this form in lieu of a licensed provider's signature

### Dates of mandatory immunizations

**MMR** (*measles, mumps, rubella*): 1) \_\_\_\_\_ 2) \_\_\_\_\_  
Titer Date: \_\_\_\_\_ Immune: \_\_\_\_\_ **OR** Not Immune: \_\_\_\_\_  
**Varicella** (*Chicken Pox*) Vaccine: 1) \_\_\_\_\_ 2) \_\_\_\_\_  
Titer Date: \_\_\_\_\_ Immune: \_\_\_\_\_ **OR** Not Immune: \_\_\_\_\_  
**Flu shot date:** (*Applies during Flu Season only*): \_\_\_\_\_  
**COVID-19 Vaccination:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

### Tuberculosis questionnaire

Do you persistently have any of the following symptoms of tuberculosis?

Symptom	Yes	No
Persistent cough for > 2 weeks		
Bloody sputum production		
Unexplained weight loss		
Fatigue (unusual)		
Swollen glands		
Poor appetite		
Have you had a positive TB skin test?		

Provider name (print): \_\_\_\_\_

Address: \_\_\_\_\_

Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Cleared for volunteering

Employee Health nurse: \_\_\_\_\_ Date: \_\_\_\_\_

This form and attachments can be returned by:

Email: [volunteers@tidalhealth.org](mailto:volunteers@tidalhealth.org) Fax: 410-677-6644

Mail: TidalHealth Volunteers 100 East Carroll Street, Salisbury, MD 21801



# TidalHealth Volunteers

## Informed Volunteer Consent to Photograph & Record

Photographs, video, film, and audio play an important role in TidalHealth's ability to share its story and provide education to its patients, staff and community. This document provides TidalHealth informed consent to use photographs and other recordings completed while volunteering with TidalHealth for the purpose of marketing, advertising, press, public relations, event promotion or educational purposes.

If at any time, now or in the future, you wish to withdraw this consent, you have the right to do so. Choosing not to participate with photographs or recordings will not affect your ability to volunteer with TidalHealth in any way. This consent has no term limit and remains in effect unless rescinded by the volunteer in writing. To rescind consent, submit your request in writing to: **TidalHealth, c/o Strategic Communications, 100 E. Carroll St., Salisbury, MD 21801**

### Consent Type: Open Publication

I understand that images, videography, film or audio captured by TidalHealth during my time as a volunteer may be used at any time for any of the following purposes:

- Publicly accessible and shareable online platforms including websites, online news channels, email distributions or other social media channels.
- Publication in or by a newspaper, news journal or educational books or journals.
- Marketing and educational publications and materials including as part of a display, brochure, leaflet, or other collateral material produced by or for TidalHealth.
- Other Strategic Communications purposes.

Recordings involving any volunteers will be transparent and performed only with advance notice to the volunteer. This consent has no expiration unless a formal request to rescind consent is received in writing.

Name of volunteer giving consent (*print*): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of volunteer giving consent: \_\_\_\_\_

**NOTE: This section below must be filled out by parent/legal guardian if the above individual is under 18.**

Name of person giving consent (*print*) \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to individual (*circle one*)      Parent      Legal Guardian

Signature of person giving consent : \_\_\_\_\_

TidalHealth Representative: \_\_\_\_\_ *Kelly Novak* \_\_\_\_\_

Date: \_\_\_\_\_ Notes: \_\_\_\_\_ *TidalHealth Volunteers* \_\_\_\_\_

## **TidalHealth Volunteers**

### **Confidentiality of Information Statement**

Name: \_\_\_\_\_ Service Area: Volunteer

As a volunteer, I may have access to confidential information. This information may pertain to patients. It may also pertain to physicians or other staff members. Additionally it may pertain to the hospital, providers or other corporate entities. This information may come in the form of personnel information, medical record data, lab results, etc. I fully understand that I have all the responsibilities listed below.

I am responsible for maintaining the confidentiality of this information. TidalHealth will govern the policies and standards of confidentiality. It will also govern policies on release of information. These policies will detail to whom I may legally disclose information. The policies will also govern under what circumstances I may disclose this information. I will abide by them at all times.

I may obtain access codes to TidalHealth computer systems. I will safeguard the security codes given to me. I will not disclose my security codes to anyone for any reason. This includes my family and friends. It also includes fellow workers, supervisors, and subordinates. I may be required to reveal my security codes to the Information Security Officer. This is the only exception.

I will only use my access security codes to perform my duties. I will not use anyone else's codes to obtain access to any computer system. I will be accountable for all work performed under my security codes. I will also be accountable for changes made to the system or databases under my security codes. I will not allow anyone else access to the computer using my security codes.

TidalHealth reserves the right to monitor or intercept an individual's correspondence, including but not limited to telephone conversations or transmissions, electronic mail or transmissions, and internet access and usage.

Any unauthorized disclosure of information is grounds for immediate termination from TidalHealth. It may also result in legal action. My signature indicates I am aware and do understand this.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
TidalHealth Representative Signature

\_\_\_\_\_  
Date

## **TidalHealth VolunTEEN**

### *Parental Approval for Teen Application*

After completing this application, please read the following carefully:

I understand and agree that submitting this application form does not automatically register me as a TidalHealth volunteer. A clear understanding of your background will aid TidalHealth in considering you for the volunteer position that best meets your qualifications/interests.

1. I give permission to TidalHealth to investigate any and all information concerning my application in order to determine my qualifications. This includes, but is not limited to medical clearance, criminal background checks, employment and personal reference checks. I understand that any misrepresentation of facts contained in this application may be cause for my rejection or dismissal.

2. I hereby acknowledge that I have agreed to become a TidalHealth volunteer. As a volunteer, I understand that I will not be compensated by TidalHealth for my time and/or personal services which I willingly donate. As an ADULT, I agree to serve a minimum of 100 hours within one year. As a TEEN, I agree to serve a minimum of 50 hours during the summer.

3. I agree to be photographed by TidalHealth.

4. I agree that any personal property carried by me from hospital premises, including my packages, briefcase, or any other hand luggage may be inspected by authorized personnel.

5. I agree to abide by all TidalHealth rules and regulations. I understand that this application and any other TidalHealth documents are not contracts of employment, and that any volunteer who is placed may voluntarily leave for any or no reason, at any time and may be terminated by TidalHealth at any time and for no reason.

6. In the event of resignation or termination, I agree to return all TidalHealth property loaned to me such as identification badges, keys, parking cards, etc.

By submitting this form, I attest that the information I have provided on the form is true and accurate. This authorization shall serve as a consent for the hospital to request any information concerning my application.

**Teen Name (PRINTED):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Teen Signature:** \_\_\_\_\_

**Parent/Guardian Name (PRINTED):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

## **TIDALHEALTH**

### **VolunTEEN CODE OF CONDUCT AND DRESS**

*Teens are expected to act as a professional member of our healthcare team!*

#### **DEPENDABILITY**

- I will be punctual and conscientious about coming to volunteer and carrying out my assignment.
- I will call my assigned area if I am unable to come on my assigned day due to illness or emergency.
- I will ensure I have the phone numbers of my department at home to make those call.
- **I WILL NOT USE MY CELL PHONE DURING MY VOLUNTEER SHIFT.**

#### **ANXIOUS TO LEARN – COURTEOUS – CONSCIENTIOUS**

- I will try to learn all I can about the hospital, its careers, and services.
- I will listen, think of and help others.
- I will follow directions and ensure my assigned tasks are completed correctly.

#### **CUSTOMER SERVICE**

- Everyone I come in contact within the hospital is my customer.
- I am the key to good customer service!
- I will practice the Golden Rule: Treat others as I would want to be treated!

#### **QUIET – PLEASANT – CHEERFUL**

- I will work, walk, and talk quietly so I don't disturb the patients or fellow staff.
- I will be tactful and calm with everyone.
- I will keep a smile and a sense of humor.

#### **WORKING IN MY ASSIGNED AREA**

- I will stay in my assigned area except for lunch and when sent on an errand by a member of the staff.
- I will not leave the TidalHealth at any time unless I have **WRITTEN** permission from my parents.

#### **CONFIDENTIALITY**

I will not discuss any information I hear concerning a patient, doctor or a member of the staff.

#### **SUMMER TEEN DRESS CODE**

- I will be well groomed, neat and clean in person and in dress.
- I will always wear the correct uniform and name badge when I am on duty.
  - Khaki slacks
  - TidalHealth polo shirt
  - Soft soled and closed toe shoes
  - Name Badge

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Teen's Signature

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Date

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Parent's Signature

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Date