Contra Costa Regional Medical Center

Spiritual Care Application

Personal Information: Date: _____

Applicant's Name: _____ Date of Birth: _____

Home Address: _____
Street city Zip

Telephone: ( ) _____ Email Address: _____

Your Preferred Faith Group: _____

Your Congregation's Name: _____

Address: _____
Street city Zip

Phone Number: ( ) _____ Fax Number: ( ) _____

Email Address: _____ Website: _____

Are you an ordained or licensed Clergy Member? ☐ Yes ☐ No Availability?_____

I am interested in the Spiritual Care Partnership Council ☐ Community Clergy Partner ☐

If so, what is your denomination or faith group? _____

Do you speak another language besides English? _____

References: (Please provide the contact information of two references that are not relatives.)

Name: _____

Address: _____
Street city Zip

Telephone: ( ) _____ Email Address: _____

Name: _____

Address: _____
Street city Zip

Telephone: ( ) _____ Email Address: _____

The above information is accurate and correct to the best of my knowledge.

Signature: _____ Date: _____

Contra Costa Regional Medical Center
Spiritual Care Partnership

Confidentiality Agreement

I understand that Contra Costa Regional Medical Center ("CCRMC") has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their private health information. In the course of my participation as a **Spiritual Care Partner**, I may see, hear, come into possession of, or use "protected health information." "Protected Health Information" ("PHI") is defined as individually identifiable information regarding a patient's identity, health, condition, diagnosis, treatment, treatment outcomes and any other private health information, regardless of form, including but not limited to electronic, written, and oral information.

Accordingly, **I AGREE** to abide by the following confidentiality practices during my participation as a Spiritual Care Partner described above.

1. **I AGREE** that I will only access and utilize the minimum amount of PHI needed for my effective participation as a Spiritual Care Partner.

2. **I AGREE NOT** to talk with **anyone**, including my family/relatives, friends, acquaintances, and members of the press, about any PHI, including but not limited to my observations, acquired by me during my participation as a Spiritual Care Partner.

3. **I AGREE NOT** to duplicate, download, or otherwise remove any PHI information from the premises of CCRMC.

4. At the conclusion of my participation as a Spiritual Care Partner, **I AGREE** to appropriately destroy any PHI that I acquired and/or used in the course of my participation as a Spiritual Care Partner, including but not limited to the shredding of any and all written documents.

5. **I AGREE NOT** to take any photographs, videos, or audio recordings of PHI, patients, family members of patients, or the working staff of CCRMC.

6. I shall at all times uphold the philosophy and standards of Contra Costa Regional Medical Center.

7. I have read and agree to each of the above conditions:

Signature: _____ Date: _____

Print Name: _____