**Getting Ahead Mentor Application**

**Please print**

First Name Last Name

Address City/State/Zip.

Telephone Social Security #

Date of Birth Spouse’s Name

Email Address ……………………………………………. Gender ………………………………………

**Physical Limitations:** No Yes (Please Explain)

**Work/occupation** **Most recent employer (optional)**

**List previous/current mentoring and/or training experience** …………………………………………

**Skills (List your related mentoring skills and indicate proficiency leve**l) Skilled Can Teach Amateur

1.

2

3

**Languages** Fluent Read Write

1

2

**Mentoring is a big responsibility and can change the lives of both the mentor and the mentee. What do you hope to gain from the experience? What do you hope the mentee will gain?**

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**In an emergency, notify:**

First Name Last Name

Address

City/State/Zip Telephone

CONFIDENTIALITY STATEMENT

I acknowledge that this statement applies to all members of the workforce, including but not limited to, employees, volunteers, students, physicians, resident physicians, and third parties, whether temporary or permanent, paid or not paid, visiting, or designated as associates, who are employed by, contracted to, or under the direct control of [Organization name].

I acknowledge that [Organization] has formally stated its commitment to preserving the confidentiality and security of health information, whether it is maintained or distributed in paper, electronic, video, verbal, or any other medium or format. I understand that I am required, if I have access to such health information, to maintain its confidentiality and security.

I understand that access to health information created, received, or maintained by [organization] is limited to those who have a valid business or medical need for the information or otherwise have a right to know the information. I understand that there are many administrative, physical and technical safeguards in place to protect the privacy and security of this health information, and that any attempt to bypass or override these safeguards is a violation of federal and state laws and the privacy and security policies of the [organization].

I understand that anyone who is authorized to access electronic health information within [organization] will be issued a unique user identification and password, and that any person who knowingly discloses their user ID or password to others, uses or discloses another individual’s user ID or password, or accesses any electronic protected health information without authorization is subject to disciplinary action, up to and including dismissal. In addition, I understand that all [organization] and affiliate workforce members must comply with applicable information technology security policies.

I further understand that, with the exception of purposes related to treatment, access to, uses and disclosures of, and requests for an individual’s health information must, to the extent practicable, be limited to the minimum necessary to accomplish the intended purpose of the approved use, disclosure or request.

I understand that any known or suspected violation of the confidentiality or security of health information must be reported to my immediate supervisor immediately.

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Signature Date

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AUTHORIZATION TO OBTAIN CRIMINAL BACKGROUND REPORTS

I authorize [organization] to obtain criminal background reports and/or investigative criminal background reports

for background investigation. I understand that these reports might include, but are not limited to, a search of my criminal background, reference checks, driving record checks, and verification of my identification and Social Security Number. I agree that this Disclosure/Authorization, in original or copy form, is valid for all current and future criminal background reports.

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Signature Date

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