



Appalachian Regional Healthcare

**CHAPLAIN PROFILE  
APPALACHIAN REGIONAL HEALTHCARE**

**Name:** \_\_\_\_\_  
(First) (Middle) (Last)

**Date:** \_\_\_\_\_

**Preferred Mailing Address:**

\_\_\_\_\_  
*Street or P. O. Box Address:*

\_\_\_\_\_  
*City / State / Zip*

**Phone:**  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Church) (Cell Phone)

**Do you receive text on your cellphone?** \_\_\_\_ Yes \_\_\_\_ No

**E-mail Address:**  
\_\_\_\_\_ @ \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Religious or Denominational Affiliation:** \_\_\_\_\_

**I presently serve as an ordained** \_\_\_\_ Pastor \_\_\_\_ Priest \_\_\_\_ Deacon

**Or I serve as a** \_\_\_\_ Layperson \_\_\_\_ Healthcare Provider  
Other – please specify \_\_\_\_\_

**Church Name or Professional Business Name:**

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Street or P.O. Box*

\_\_\_\_\_  
*City / State / Zip*

**Education Background:** (Please list highest grade completed and degrees (if any) received, date and school):

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**Clinical Training:** (Please list any clinical training or certification you have received, date(s) and place(s) :

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**Denominational Reference:** (Please list a denominational authority to whom you are accountable):

*Name and Title:*

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*Street or P.O. Box Address:*

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*City / State / Zip:*

**Personal Reference:** (Please list the name of someone who has known you for 10 years or longer)

*Name:*

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*Street or P. O. Box Address:*

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*City / State / Zip:*

**ARH Chaplaincy Services Reference:** (Please list the name of someone in ARH Chaplaincy Services who knows you personally or professionally)

*Name:*

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*Street or P.O. Box Address:*

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*City / State / Zip:*

**Agreement:**

I WILL ABIDE BY THE POLICY AND PROCEDURES OF ARH CHAPLAINCY SERVICES AND FAITHFULLY DISCHARGE MY RESPONSIBILITIES DURING THE SCHEDULED WEEK OF ON-CALL DUTY.

(Date)

(Signature of Applicant)

**Please Return Profile To:**

Chaplain Sam Stacy  
Hazard ARH System Center  
100 Airport Gardens Road  
Hazard KY 41701

Phone: (606) 487-7781  
Fax: (606)439-6682  
email: [sstacy1@arh.org](mailto:sstacy1@arh.org)  
Cell Phone: 606-438-1259

## DISCLOSURE AND AUTHORIZATION FORM

**Appalachian Regional Healthcare** may request background information about you from a consumer reporting agency in connection with your employment application and for employment purposes. This information may be obtained in the form of consumer reports and/or investigative consumer reports. These reports may be obtained at any time after receipt of your authorization and, if you are hired by the Company, throughout your employment.

HireRight, Inc., or another consumer reporting agency, will obtain the reports for the Company. HireRight, Inc. is located at 5151 California, Irvine, CA 92617, and can be contacted at 800-400-2761. The reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: social security number verifications; credit reports; criminal records checks; public court records checks; driving records checks; educational records checks; employment verifications; personal and professional references checks; licensing and certification records checks; drug testing results; etc. The information contained in the reports will be obtained from private and public record sources, including, as appropriate, personal interviews with sources, such as neighbors, friends and associates.

You may request more information about the nature and scope of any investigative consumer reports by contacting the Company. A summary of your rights under the Fair Credit Reporting Act is also being provided to you.

### ADDITIONAL STATE LAW NOTICES

If you are a California, Maine, New York or Washington applicant, please also note:

**CALIFORNIA:** Under section 1786.22 of the California Civil Code, you may view the file maintained on you by HireRight during normal business hours. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at HireRight's offices in person, during normal business hours and on reasonable notice, or by mail. You may also receive a summary of the file by telephone, upon submitting proper identification. HireRight has trained personnel available to explain your file to you, including any coded information. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification.

**NEW YORK:** You have the right, upon request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

**MAINE:** You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

**WASHINGTON STATE:** If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from us a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

**AUTHORIZATION**

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to the release of consumer reports and investigative consumer reports prepared by a consumer reporting agency, such as HireRight, Inc., to the Company and its designated representatives and agents. I understand that if the Company hires me, my consent will apply, and the Company may obtain reports, throughout my employment.

I also understand that information contained in my job application or otherwise disclosed by me before or during my employment, if any, may be used for the purpose of obtaining consumer reports and/or investigative consumer reports.

By my signature below, I authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requested by the consumer reporting agency.

By my signature below, I certify the information I provided on this form is true and correct. I agree that this Disclosure and Authorization form in original, faxed, photocopied or electronic (including electronically signed) form will be valid for any reports that may be requested by or on behalf of the Company.

**California, Minnesota or Oklahoma applicants only** – You will be provided with a free copy of any consumer reports or investigative consumer reports obtained on you if you check the box below.

I wish to receive a free copy of the report.

Applicant Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth (for ID purposes only) \_\_\_\_\_

**Present 911 Address**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City/State/Zip



Appalachian Regional Healthcare

APPALACHIAN REGIONAL HEALTHCARE  
CHAPLAIN DISCLOSURE FORM

Please complete this form, sign and date it, and return it with your Chaplain Profile. All information is strictly confidential and will be managed under federal statues as mandated by the Health Information Portability and Accountability Act.

Have you ever been convicted of a felony?  No  Yes

Have you ever been convicted of a misdemeanor?  No  Yes

Have you ever been accused in writing of sexual misconduct or child abuse?  No  Yes

If you answered "yes" to any of these questions, please explain.

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If you are required by this disclosure form to disclose any written accusations or convictions for felony, misdemeanor or any incident of sexual misconduct that you dispute or believe should be explained in any way, you have an opportunity at this time to include any additional information that you believe might be helpful or important regarding the disclosure. Any relevant information should be provided in a response statement attached to this form. You may write that information on this form or attach pages. If pages are attached, please indicate on the line below.

\_\_\_\_\_ Pages are attached \_\_\_\_\_  
(Number of pages attached)

I hereby certify that the information provided on this form is true and accurate.

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*Please Print Name*

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*Please Sign Name*

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*Date*



## CONFIDENTIALITY AGREEMENT

As a volunteer chaplain of Appalachian Regional Healthcare, Inc., I understand that I may have access to confidential information including patient, financial or business information obtained through my association with ARH. I understand that one purpose of this agreement is to help me understand my personal obligation regarding confidential information.

Confidential information regardless of media is valuable and sensitive and is protected by law and by strict Company policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Commonwealth of Kentucky state law and other Federal Regulatory laws requires protection of confidential information contained within a health care information system. Inappropriate disclosure of patient data may result in the imposition of fines up to \$250,000 and ten years imprisonment per incident.

Accordingly, as a condition of and in consideration of my access to confidential information, I promise the following:

- ❖ I will not access confidential information for which I have no legitimate need to know to perform my job/function and for which I am not an authorized user.
- ❖ I will not in any way divulge, copy, release, sell, loan, review, gossip or speak in idle talk, alter or destroy any confidential information unless expressly permitted by existing policy except as properly approved in writing by an authorized officer of ARH within the scope of my association with ARH.
- ❖ *I will not utilize another user's password in order to access any system.*
- ❖ If I observe or have knowledge of unauthorized access or divulgence of confidential information I will report it immediately either to my supervisor, the Privacy Officer or the Compliance Hotline.
- ❖ I will not seek personal benefit or permit others to benefit personally by any confidential information that I may access.
- ❖ I will not discuss any information regarding patients in common areas such as elevators and cafeterias, snack bars or smoking areas.
- ❖ *I will respect the ownership of proprietary software and not operate any non-licensed software on any ARH computer.*
- ❖ I agree to abide by all ARH rules and regulations applicable to confidential patient information.
- ❖ I understand that my failure to comply with this Agreement may result in disciplinary action, which might include, but is not limited to, termination of my volunteer staff status with ARH and/or loss of my privileges to provide services outside the scope of my faith community in ARH facilities.

By signing this ARH Agreement, I acknowledge that I have read or have had read to me and understand that ARH has an active on-going program to review records and transactions for inappropriate access and disclosure and I understand that inappropriate access or disclosure of information can result in penalties up to and including termination of visitation rights outside the sphere of my local parish responsibilities, fines, and/or legal action.

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PLEASE PRINT NAME

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SIGNATURE

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DATE

## Chaplaincy Services Ministerial Ethics

Approved 7/21/16

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To all ARH Chaplains.

Reference Number: G-VIII-46

### **PURPOSE:**

To ensure all ARH Chaplains promote positive relationships with area clergy

### **POLICY:**

It is the policy of Appalachian Regional Healthcare, Inc., (ARH) that all Chaplains adhere to the Ministerial Ethics listed below.

### **PROCEDURE:**

I. ARH Chaplains shall abide by the following ethical standards:

- A. Seek to conduct oneself consistently with one's calling and commitment as a servant of God.
- B. Consider a confidential statement made to oneself as a sacred trust not to be divulged without consent of the person making it, or as required by law.
- C. Assist hospital patients in recognizing, when necessary, that Chaplaincy services are provided without fees.
- D. Regard all patients to whom one ministers with equal love and concern and undertake to minister impartially to their needs.
- E. Refrain from performing services in the area of responsibility of another pastor or spiritual leader except upon his/her specific request and/or consent.
- F. To serve patients, their families and ARH staff so as encourage and nourish the patient's relationship with his/her local church or spiritual community.
- G. Upon completion of on duty service as Chaplain of the Week, Chaplains should sever pastoral relations with persons who are associated with a local church or faith community unless by request and/or consent of the patient's pastor, priest, or spiritual care provider.
- H. Demonstrate openness and acceptance of people of all faith communities. When the Chaplain-of-the-Week has a religious, spiritual, or theological conflict of conscience about the beliefs and/or practice of a patient, the chaplain is responsible for securing an individual who can minister to the patient.
- I. Be competent in cultural diversity in regards to culturally specific religious and spiritual traditions, beliefs and practices.
- J. Cooperate with the personnel of Appalachian Regional Healthcare, Inc.
- K. Offer responsible criticism directly to ARH personnel in order that our common concern for the welfare of the patient might be more effective.
- L. Use one's influence to affirm and edify the mission of ARH in providing healthcare and promote well-being in cooperation with churches and spiritual communities.



Appalachian Regional Healthcare

**CHAPLAINCY SERVICES**

**CHAPLAINCY ETHICS AGREEMENT**

I have read the *Chaplaincy Ethics Policy* and agree to abide by the described conduct. I understand that encouraging a positive relationship between patients at ARH Hospitals and their pastors or spiritual care providers is of primary importance in the care of those whom we serve.

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(Name)

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(Date)