

# Contra Costa Regional Medical Center

## Spiritual Care Application

**Personal Information:**

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

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Telephone: (    ) \_\_\_\_\_ Street \_\_\_\_\_ city \_\_\_\_\_ Zip \_\_\_\_\_  
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: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Street \_\_\_\_\_ city \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address: \_\_\_\_\_

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

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

Telephone: (    ) \_\_\_\_\_ Street \_\_\_\_\_ city \_\_\_\_\_ Zip \_\_\_\_\_  
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: \_\_\_\_\_