



So good. So caring. So close.

Application For Volunteer

978-683-4000 x2645

Office Use Only

Application Received _____	PIN # _____
Interview _____	Jersey Size _____
Orientation _____	[] SCHEDULED
CORI _____ Flu _____ TB1 _____ TB2 _____	Immunizations _____

PERSONAL INFORMATION

First Name _____ Last Name _____
 Street Address _____ Apartment # _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____ Work phone _____
 Email Address _____ Date of Birth (optional) _____

WORK AND VOLUNTEER EXPERIENCE

I am: Employed Student Retired Eucharistic Minister Other
 Please list current employer or school _____
 Describe current & previous work experience _____
 Describe current & previous volunteer experience _____

BACKGROUND

How did you learn about the volunteer opportunities here? _____
 Have you ever been employed, volunteered or applied previously at this hospital? _____
 List any special skills and interests that you have: _____

INTERN REQUEST - Please complete the Student Application (*students required to provide a certain amount of hours through a school internship*)

JOB SHADOW REQUEST - Please fill out the Job Shadow Application

AVAILABILITY AND INTEREST Patient Care Areas Office Support

View Current Volunteer openings on our Website: www.lawrencegeneral.org and search for Volunteer Opportunities – Select the top 3 places to volunteer:

1. _____ 2. _____ 3. _____

Please circle how many times a week you would like to volunteer? **1 day** **2 days** **3 days**

PREFERRED TIMES: [] mornings 8 or 9am-1pm [] Afternoons 1-3pm [] Evenings 3-7pm (*under 18, you cannot volunteer past 7pm*)

PREFERRED DAYS: [] Sundays [] Mondays [] Tuesdays [] Wednesdays [] Thursdays [] Fridays [] Saturdays

Why do you want to volunteer at Lawrence General? _____

CONTINUED ON BACK

REFERENCES (Please do not include names of relatives)

Name _____ Relationship to you _____
 Phone _____ Email _____

Name _____ Relationship to you _____
 Phone _____ Email _____

STUDENTS – Please Provide the name of your Guidance or School Intern Coordinator:

Name: _____ Phone _____
 Email _____

EMERGENCY CONTACT

Name _____ Relationship to you _____
 Phone _____ (This is a: ___ Home ___ Cell ___ Work number)

SIGNATURE

- The information on this application is true to the best of my knowledge. I understand that false statements made as part of this application will be considered cause for dismissal.
- I understand that if I am accepted as a volunteer/intern, I will not be paid for my services.
- I understand that if I am accepted as a volunteer/intern, I will agree to abide by the guidelines of the Volunteer Services Program.
- I grant authorities of this hospital to investigate my references.
- I understand that Criminal Offender Record Information (CORI) checks are required for all applicants over the age of 18. Acceptance to the volunteer/intern program is contingent upon successful clearance of CORI evaluation.

Applicant Signature _____ Date _____
 *If you are under 18 years of age, the signature of a parent or guardian is required.

Signature _____ Date _____

Mail or deliver completed Application:

Lawrence General Hospital
 Volunteer Department
 1 General Street
 Lawrence, MA 01841



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Health Screening

Name: _____

Date of Birth: _____

Directions: Please take this form to your health care provider for completion. The lab tests needed when immunization records are not available may be costly, and you are responsible for payment. Please be diligent in getting your records from your private physician, school record or previous employer.

For Health Care Provider Completion: For this individual to qualify to volunteer at Lawrence General Hospital, there are minimal infection control standards that need to be met. **A list of the standards is on the back of this form.** Please complete the form below with special consideration to the following: If there is no evidence of measles and/or rubella immunity, please administer MMR or draw titer(s). For questions on form completion, 978-683-4000, ext. 2645. Thank You.

Signature of Health Care Provider: _____ Date: _____

A copy of your immunization records or your school health record is acceptable

Location: _____ Telephone: _____

Measles, Mumps, Rubella:	
For volunteers working in <input type="checkbox"/> Emergency, <input type="checkbox"/> Pediatrics, or <input type="checkbox"/> Maternal Child Health as <input type="checkbox"/> greeters or escorts	MMR #1 Date: _____ MMR #2 Date: _____
TDAP	
For volunteers working in <input type="checkbox"/> Emergency, <input type="checkbox"/> Pediatrics, or <input type="checkbox"/> Maternal Child Health as <input type="checkbox"/> greeters or escorts.	TDAP Date: _____
Chicken Pox/Varicella:	History of Chicken Pox: Yes____ No____
For volunteers working in <input type="checkbox"/> Emergency, <input type="checkbox"/> Pediatrics, or <input type="checkbox"/> Maternal Child Health as <input type="checkbox"/> greeters or escorts.	If No History: Titer: _____ or Vaccination Date: #1 _____ #2 _____
Hepatitis B Vaccine	Hepatitis B Vaccine Date # 1: _____
Required for volunteers with potential exposure to blood borne pathogens. <input type="checkbox"/> Provided by LGH if necessary.	Hepatitis B Vaccine Date # 2: _____ Hepatitis B Vaccine Date # 3: _____ <input type="checkbox"/> Or Declination Signed: _____
Tuberculosis Testing – Please see next page for options	
Flu Vaccine <input type="checkbox"/> Mandatory during Flu Season	Flu Vaccine Date: _____ Place: _____

Infection Control Standards for Health Clearance

Tuberculosis Screening and Chest X-Rays. One of the following is required:

- A. Two (2) PPD Skin tests within the ***past 12 months***; or
- B. For individuals known to be PPD test positive, there needs to be a record of a negative chest x-ray report done by your physician.
- C. Receive the TB Quantiferon Gold blood test.

Measles and Rubella Immunity. The following is required:

- A. Documentation of two MMR vaccines, or
- B. Proof of immunity to measles, mumps and rubella by titer (blood test done by your private Physician. Please note that you will be responsible for payment for this test.)

Hepatitis B Vaccine. For individuals who may be exposed to blood or body fluids during their experience at LGH:

- A. Documentation of the Hepatitis B series, or
- B. Positive antibody test for hepatitis B will be done our Occupational Health Department.

* LGH will provide this vaccine free of charge to individuals who may be exposed to blood or body fluid during their work.

Chicken Pox: Anyone who does not have a history of chicken pox is **strongly recommended** to get the chicken pox (varicella) vaccine from his/her primary care provider. As an adult, chicken pox can be a very serious illness.

Flu Vaccine: 100% compliance during Flu Season, Usually October – April of every year.

* Please refer to LGH Occupational Health Services Infection Control Policy TB Exposure Control Plan (IPC-00012), 3/2019; Influenza Vaccination Program for Health Care Personnel (IPC-00017), 2/2019, Reference: MDPH Adult Immunizations; recommendations & requirements for 2017