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 Intern 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

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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 ______________

<u>Mail or deliver completed Application</u>:

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

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:	MMR #1 Date: ______________ MMR #2 Date: ______________
For volunteers working in ▢Emergency, ▢Pediatrics, or ▢Maternal Child Health as ▢greeters or escorts	
TDAP	TDAP Date: ________________
For volunteers working in ▢Emergency, ▢Pediatrics, or▢ Maternal Child Health as ▢greeters or escorts.	
Chicken Pox/Varicella:	History of Chicken Pox: Yes____ No____ If No History: Titer: _________ or Vaccination Date: #1 ______________ #2 ______________
For volunteers working in ▢Emergency, ▢Pediatrics, or ▢Maternal Child Health as ▢greeters or escorts.	
Hepatitis B Vaccine	Hepatitis B Vaccine Date # 1:________________ Hepatitis B Vaccine Date # 2:________________ Hepatitis B Vaccine Date # 3:________________ ▢Or Declination Signed: ________________________
Required for volunteers with potential exposure to blood borne pathogens. ▢Provided by LGH if necessary.	
PPD/Tuberculosis Skin Test & Assessment Form	Date Planted:__________ Date Read:____________ Result in MM:__________ Date TB Assessment Risk Form Received __________ Date Q-GOLD TB Blood Test completed___________
Please see options, next page.	
Flu Vaccine Mandatory during Flu Season	Flu Vaccine Date:_________________

☐ **Occupational Health**, 2nd Floor, 25 Marston Street, Suite 204
Lawrence, MA Monday – Friday, 8:30am – 4:00pm

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Volunteer Health Screening

Infection Control Standards for Health Clearance

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

A. One (1) PPD Skin test within the *past 12 months and complete a TB Risk Assessment Form*.
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 IGRA blood test such as the TB QuantiFERON – TB 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.

Reference: MDPH Adult Immunizations; recommendations & requirements for 2017

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ASSESSMENT OF SYMPTOMS FOR TUBERCULOSIS

Complete this questionnaire:

Annually for any individual working as a volunteer for Lawrence General Hospital
Prior to the start of service for any new volunteer with a past history of positive skin testing or reported history of tuberculosis disease.

Below I indicate if I have any symptoms related to a possible TB infection. Should I now or at any time in the future have these symptoms I will contact the Occupational Health staff. I understand that I may ask Occupational Health staff or my personal physician for any additional information regarding TB.

Symptoms of TB always include a persistent cough and one or more of the following symptoms. I have indicated below if I have any of the following:

YES	NO	
____	____	Persistent cough
____	____	Unexplained weight loss
____	____	Night sweats
____	____	Bloody sputum
____	____	Loss of appetite
____	____	Fever

___________________________ ____________________________ ___________
Signature (Print your name) Date

If you are under 18 years of age, the signature of a parent or guardian is required:

____________________________ ____________________________ ___________
Parent / Guardian Signature (Print your name) Date