volunteers of st. vincent's medical center

We are delighted to hear of your interest in becoming a part of a very special group of people, the volunteers of St. Vincent's Medical Center.

Most of our volunteers serve 4 hours per day, once or twice a week in various capacities throughout the Medical Center. Volunteer applicants are required to commit to a minimum of 60 hours of service within one year. We hope you will consider joining the group of volunteers who have been with us for many years.

In order to volunteer at St. Vincent's Medical Center you will need to provide us with the following completed forms:

- **Application**
- **Assessment & Immunization**
- **Signed Drug Screening Consent**
- **Signed Background Check Release**

As soon as we receive your completed and signed forms, we will contact you for a personal interview and next steps. You will need to bring a form of picture identification for verification.

Volunteering is an extremely rewarding, interesting and fulfilling experience. Please know that we look forward to meeting with you to discuss the many opportunities available.

Sincerely,

Volunteer Services Department

please note!

All volunteers of St. Vincent's Medical Center must successfully pass the following:

- A health assessment
- Drug screening
- Seasonal/annual flu vaccine
- Criminal background check

send your completed forms to:

volunteers@stvincents.org
or mail to:
St. Vincent's Medical Center
Attn: Volunteer Services Dept.
2800 Main Street
Bridgeport, CT 06606

junior volunteer application

(16-17 years old)

DATE:_____

NAME:_____
(Please print)

SCHOOL: _____ GRADE: _____

ADDRESS: _____ CITY: _____

ZIP: _____ HOME PHONE: _____ CELL PHONE:_____

E-MAIL ADDRESS: _____ BIRTH DATE: _____ AGE: _____

CONSENT:

My child _____has my consent to serve as a Volunteer at St. Vincent's Medical Center. I also give my consent for drug screening, criminal background check, PPD test and flu vaccine (during flu season.)

SIGNATURE: _____ RELATIONSHIP: _____

DO YOU HAVE RELATIVES OR FRIENDS AT THE HOSPITAL IN ANY CAPACITY? ___ YES___NO

IF YES, PLEASE EXPLAIN_____

WHY DO YOU WANT TO VOLUNTEER? _____

HOW DID YOU HEAR OF THE VOLUNTEER PROGRAM? _____

PLEASE TELL US ABOUT YOUR AREAS OF INTEREST _____

_____

_____

DAYS AND TIMES WHEN AVAILABLE: _____

ANY SPECIAL SKILLS (COMPUTER, FOREIGN LANGUAGE): _____

ANY WORK EXPERIENCE: _____

PLEASE LIST **TWO** REFERENCES TO CALL. ONE SHOULD BE FROM A TEACHER OR GUIDANCE COUNSELOR.

REFERENCES: 1) _____

NAME ADDRESS PHONE

2) _____

NAME ADDRESS PHONE

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN CASE OF ILLNESS ON DUTY OR EMERGENCY:

NAME _____ RELATIONSHIP_____

HOME PHONE:_____ WORK: _____ CELL: _____

HAVE YOU EVER BEEN CONVICTED OF A VIOLATION OF A NARCOTIC LAW OR LAWS RELATED TO SEXUAL OFFENSES?

YES_____ NO _____ IF YES, PLEASE PROVIDE DETAILS: _____

_____

PLEASE USE THIS SPACE TO TELL US ANYTHING ELSE YOU WOULD LIKE US TO KNOW.

I GIVE MY CONSENT FOR A DRUG SCREENING AND CRIMINAL BACKGROUND CHECK.
SIGNATURE:_____ DATE: _____

send your completed forms to:

volunteers@stvincents.org
or mail to:
St. Vincent's Medical Center
Attn: Volunteer Services Dept.
2800 Main Street
Bridgeport, CT 06606

junior volunteer health assessment

NAME:_____ DATE OF BIRTH: _____

(Please print)

ADDRESS: _____ CITY: _____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

E-MAIL ADDRESS: _____

1) DO YOU OR A MEMBER OF YOUR FAMILY HAVE A CONTAGIOUS DISEASE NOW? YES _____ NO _____

IF YES, SPECIFY: _____

2) DO YOU HAVE A MEDICAL CONDITION OR DO YOU TAKE MEDICATIONS THAT WOULD MAKE YOU PARTICULARLY SUSCEPTIBLE TO INFECTION? YES _____ NO _____ IF YES, SPECIFY: _____

3) DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WOULD INTERFERE WITH YOUR ABILITY TO LIFT, PUSH OR PULL PATIENTS/SUPPLIES, OR INTERFERE WITH EXTENDED STANDING? YES _____ NO _____ IF YES, SPECIFY

_____

You will need to provide Employee Occupational Health Center documentation of all your vaccinations including measles, mumps, rubella, chickenpox, tetanus and tuberculin skin testing. Please take the accompanying form, "Proof of Immunization/Immunity", to your physician or health care provider for completion. You will need to have a **2-step PPD tuberculin skin test** performed. This involves a small injection of fluid into your forearm. It is imperative to return 48 to 72 hours later, for the skin test to be read. After that, the test is only required once a year. If unable to complete immunization documentation, blood work can be done at Employee Occupational Health.

Upon completion, submit the medical form with your application, and all required forms to Volunteer Services.

I authorize Occupational Health to place a PPD tuberculin test and a flu vaccine (seasonally or annually.)

SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

immunization requirements for volunteers

St. Vincent's Health Services requests that all volunteers provide, from their physician, any proof of immunity or vaccination for the following diseases that may be available. St. Vincent's may provide any additional testing or vaccination at no cost to you.

PATIENT NAME:_____DOB: _____
(Please print)

1) **GERMAN MEASLES**
RUBELLA VACCINE: DATE _____
OR
RUBELLA TITER: DATE _____ RESULT _____

2) **MEASLES**
MEASLES VACCINE:
1ST DOSE DATE (AFTER 1/1/69) _____
2ND DOSE DATE (AFTER 1/1/80) _____
OR
MEASLES TITER: DATE _____ RESULT _____

3) **MUMPS**
MUMPS VACCINE:
1ST DOSE DATE (AFTER 1/1/69) _____
2ND DOSE DATE (AFTER 1/1/80) _____
OR
MUMPS TITER: DATE _____ RESULT _____

4) **HEPATITIS B**
If you have potential blood or body fluid contact
1ST DOSE DATE _____
2ND DOSE DATE _____
3RD DOSE DATE _____
ANTIBODY TITER: DATE _____ RESULT _____

5) **TUBERCULOSIS**
Two step tuberculin skin test (Mantoux PPD only) 1ST DATE (WITHIN 12 MONTHS) _____

RESULT N P _____ MM
2ND DATE (WITHIN 6 MONTHS) _____
RESULT N P _____ MM

IF PPD + CXR: DATE _____
RESULT _____
PROPHYLACTIC THERAPY
MEDICATION _____
LENGTH OF TIME _____

6) **CHICKENPOX**
VARICELLA TITER:
DATE_____ RESULT_____
____
OR
VARICELLA VACCINE: DATE_____
VARICELLA VACCINE: DATE_____

7) **FLU VACCINE:** DATE_____
8) **DECLINATION:** DATE_____

I ACKNOWLEDGE COMPLETING THE ABOVE REQUIRED IMMUNIZATION/IMMUNITY TESTING ON _____

Health Care Provider's signature _____
Health Care Provider's name _____
Address _____ Phone _____
Date:_____

OFFICE SEAL OR STAMP

drug screening consent for volunteer applicants

INFORMATION CONCERNING THE DRUG SCREENING PROCESS

St. Vincent's Medical Center has a firm commitment to providing a safe work environment. The health and safety of our patients, employees and volunteers requires that stringent safety standards be met. Therefore, it is our intention to maintain a drug and alcohol-free environment.

Drug screening is a very important part of a volunteer's initial assessment. Anyone refusing to be tested, or anyone submitting a urine specimen that establishes the use of an illegal substance or the use of a prescribed drug without a valid prescription, will be denied a volunteering opportunity at the Medical Center.

During the drug screening process, you will be asked to divulge any medications prescribed for you by a physician. Any falsification or omission of this information will also result in your volunteer experience being denied.

I understand that the results of this test will not be released to anyone except the staff of Employee Occupational Health Center.

I have read and understand the above notice as it relates to my application as a volunteer with St. Vincent's Medical Center.

SIGNATURE _____

PARENT OR GUARDIAN _____ (if applicant is under the age of 18)

DATE _____

OFFICE USE

_____ PICTURE IDENTIFICATION VERIFIED BY _____

WITNESS_____

BACKGROUND CHECK RELEASE FORM

I. I _____understand that in conjunction with my application for employment a consumer report and/or investigative consumer report may be generated on me that may include information as to my character, work habits, performance and experience, along with reasons for termination of past employment, financial/credit history, criminal history records from any criminal justice agency in any or all federal, state, city and county jurisdictions, state Department of Motor Vehicle/Drivers' License Records to include traffic citations and registration, military records from the National Personnel Record Center, education records including transcripts, and requests for records and information from any individual, company, firm, corporation, present and/or past employers and public agencies (including the Social Security Administration and the U.S. Citizenship and Immigration Services). I acknowledge that to the extent an investigative consumer report is procured, I have the right to ask in writing for additional information regarding the nature and scope of any investigation requested. Such request must be submitted to: Evolution Consulting, 49 Court Street, Binghamton, NY 13901

Please Initial:

II. ___ I fully understand that Ascension Health and/or their agent Evolution Consulting LLC, may be requesting information from public and private sources about any of the information described in Section 1, and I freely give my consent for Ascension Health and Evolution Consulting LLC to do so.

III. ___ I hereby authorize, without reservation, any one contacted by Ascension Health and/or their agent Evolution Consulting LLC, to furnish the information described in Section I.

IV. ___ I hereby authorize, without reservation, Ascension Health and/or their agent, Evolution Consulting LLC, to contact my former employer/employers for employment verification/references.

V. ___This disclosure further serves as a request that any present or former employer, police department, educational or financial institution or other person having personal knowledge about me furnish Evolution Consulting LLC and its affiliates or representative any and all information in their possession regarding me in connection with my application for employment.

VI. ___ The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

VII. ___ I agree that a photocopy or telephonic facsimile of this authorization shall be valid as the original with the same authority as the original and I specifically waive any written notice from any present or former employer who may provide information based upon this authorized request.

VIII. ___ I hereby release Ascension Health, Evolution Consulting LLC, their agents and all persons, agencies and entities providing information or reports about me, from any liability arising out of the request for or release of any of the above mentioned information or reports.

IX. California Residents Only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please indicate if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by Ascension Health. ___ Yes ____ No

X. New York Residents Only: I acknowledge receipt of a copy of the New York Correction Law Article 23-A.

APPLICANT: PLEASE COMPLETE THE FOLLOWING:

_____ _____ _____
Signed Today's Date Gender

_____ _____
Printed Name (As it appears on your Drivers License) Drivers License # State

_____-_____-_____ ___/___/___ _____
Social Security Number Date of Birth Email Address

_____ _____
Current Street Address City State Zip Phone Number

_____
Parent or Guardian signature if worker is under 18 years of age