

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

volunteer application

DATE: _____

NAME: _____
(Please print)

ADDRESS: _____ CITY: _____

ZIP: _____ HOME PHONE: _____ CELL PHONE: _____

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

EMPLOYEE HISTORY (Last 5 years or resume): _____

WORK PHONE: _____

SPECIAL INTERESTS: _____

VOLUNTEER EXPERIENCE: _____

HOSPITAL EXPERIENCE (As patient, employee or volunteer): _____

IN WHAT COMMUNITY ORGANIZATIONS ARE YOU ACTIVE? _____

HAVE YOU HELD ANY OFFICE? _____

ANY SPECIAL SKILLS (COMPUTER, FOREIGN LANGUAGE): _____

HAVE YOU BEEN EMPLOYED BY THE HOSPITAL? ____ YES ____ NO. IF YES, PLEASE PROVIDE DATES OF EMPLOYMENT AND JOB TITLE: _____

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: _____

PLEASE LIST **TWO** REFERENCES TO CALL:

REFERENCES: 1) _____

NAME

ADDRESS

PHONE

2) _____

NAME

ADDRESS

PHONE

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN CASE OF 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: _____

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VOLUNTEERS



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

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 skin test and a flu vaccine (seasonally or annually).

SIGNATURE: _____ DATE: _____

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

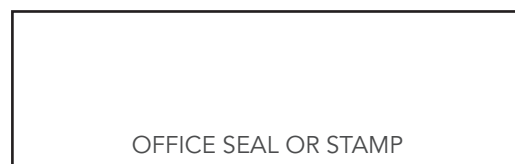
VARICELLA TITER: DATE _____
RESULT _____
OR
VARICELLA VACCINE: DATE _____
VARICELLA VACCINE: DATE _____

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 _____



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 _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Ascension (“the Company”) may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. These searches will be conducted by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature

Date

Parent/Guardian Signature (If under the age of 18)

Date

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by Ascension ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, Inc., Post Office Box 5920, Scottsdale, AZ 85261, 1-877-263-8033, www.universalbackground.com, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: 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.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.

- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards.

Please check this box 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 the Company whenever you have a right to receive such a copy under California law.

Full Legal Name (Printed)

Applicant Signature

Date of Birth

Social Security Number

Current Address

City, State, and Zip Code

Driver License State/Number

Parent/Guardian Signature (If under the age of 18)
