TEEN

ST. MARY'S GENERAL HOSPITAL

Volunteer Application 14 -17 yrs. old

Please fill out completely and return to:
SMGH Volunteer Dept., 350 Boulevard, Passaic, NJ 07055

Volunteer Application Process

Application Rec'd: _____
Orientation: _____
Medical Clearance: _____
PPD/TB vaccination: _____

First Assignment: _____

Name: _____
(Last Name) (First Name) (Middle Initial)

Address _____
(Number & Street) (City, State) (Zip Code)

Email Address: _____

Home Phone #: _____ Date of Birth: _____/_____/_____

Cell Phone # : _____ Social Security #:_____

Emergency Use Only _____
(Name, Relationship, Phone #)

Family Doctor: _____

*(Give the Doctor's full name and address)*_____

Physical Restrictions _____

School currently attending: _____

Grade: _____ Grade Average: _____

Career Ambition: _____

Foreign languages spoken: _____

Hobbies, talents & skills: (Photography, Computer Skills, Crafts, Etc.): _____

_____

Why are you interested in volunteering? _____

_____

Day(s) Preferred: _____ Time Preferred: _____

Signature _____ Date _____

ST. MARY'S
GENERAL HOSPITAL

350 Boulevard, Passaic, NJ 07055 ▪ 973-365-4300 ▪ www.smh-nj.org

Employee Health Services
Volunteer: Tuberculosis, Measles, Rubella, Varicella and Hepatitis B Screening

Dear Applicant,

Please note that the form Health Certificate must be presented to your physician for the physical exam. It requests an evaluation for i**mmunity** status for Measles, Rubella, Varicella and Hepatitis B. Proof of Hepatitis B immunity may be established via a titer or date of when 3 vaccine doses where given.

NJDHSS, NJHA, CDC require all hospital healthcare workers and volunteers to be screened for Tuberculosis and other diseases.

The initial **two-step** (two doses, one week apart) PPD/Tuberculin Skin Test for Tuberculosis may be done with your private physician, or at St. Mary's General Hospital Nursing HUB Department, Monday – Friday, 9:00 a.m. – 6:30 p.m. and Saturday – Sunday, 9:00 a.m. – 5:00 p.m. The HUB is located on the 2nd floor of the Main Building, (turn left when exiting the elevator on the 2nd floor). **Please bring this form and your entire Volunteer Application with you when reporting to the HUB for this TB skin test.** There is no fee for this PPD test.

**** Parent or legal guardian of minors must be present for placement of TB skin test ****

The skin test will be placed /injected on the forearm just under the first layer of skin (intradermal) and must be read 48 hours - 72 hours after. Tuberculin skin tests may be read by a registered nurse in the HUB, a school nurse or a private physician. If the test is administered by St. Mary's, we will provide the form for documentation of off- site readings.

Allergy to eggs or taking large doses of Prednisone must be reported to the HUB.

If the applicant has had a negative PPD/Mantoux/Tuberculin skin test within the last 12 months then please submit the documentation for review. The second one may be given at the St. Mary's Nursing HUB. .

If the applicant has a ***past history*** of a positive skin test (that of an induration greater than 10mm), documentation of a medical evaluation and ***treatment plan*** will be requested. A copy of a current chest-x-ray report by a radiologist should also be submitted for review but is not enough by itself. The treatment plan must be documented regardless of declining or accepting treatment. Please bring any past documentation for review to the HUB and/or submit it with your Volunteer Application.

New positives will be followed up as per St. Mary's General Hospital Policy.

I hereby give permission for Tuberculosis skin testing/ screening for:
Parent or legal guardian must be present for placement of Tb skin test

Volunteer's Name: _____

Name of parent /legal Guardian (Print): _____

Signature of parent/legal guardian _____ Date____/____/____

Any questions about this test, may be directed to HUB nursing personnel at 973-365-4379.

BRING THIS FORM TO YOUR DOCTOR

ST. MARY'S GENERAL HOSPITAL

350 Boulevard, Passaic, NJ 07055 • 973-365-4300 • www.smh-nj.org

Volunteer Department

HEALTH CERTIFICATE

Volunteer Applicant Name: _____ **SS#:**_____
(Last, First, MI)

Address: _____
(Street, City, State, Zip)

Telephone Number: (_____) _____ **DOB:** _____/_____/_____

1. **Measles, Mumps, Rubella, and Varicella:** The CDC defines immunity to these viruses as one of the following: (1) Appropriate immunization*, (2) positive titer, diagnosed case of the illness. Given the above definition of immunity, please complete the following information for this individual.

   VACCINE: Dates of each injection or exposure.

   Measles: Yes_____ No_____ Mumps: Yes_____ No_____

   Rubella: Yes_____ No_____ Varicella: Yes_____ No_____

*Measles, Mumps, and Rubella Vaccine (MMR): Two doses of live measles (or MMR) vaccine, at least one month apart, on or after his/her first birthday. Varicella Vaccine: Individuals who receive the vaccine between 12 months and 12 years of age are required to only receive one dose of the vaccine. Individuals over the age of 13 should receive two doses of the vaccine 4 to 8 weeks apart. If unsure of immune status, please have titers done.

2. **Hepatitis B Vaccine:** If you have given this patient the Hepatitis B vaccine, please record the dates that it was given.

   1st dose _____/_____/_____ 2nd dose_____/_____/_____ 3rd dose_____/_____/_____

3. **Tuberculosis Testing:** If you have ever placed a Mantoux Test (PPD) on this patient, please record the two most current test dates and results. If positive, please provide documentation of a chest x-ray.

   Date: mo/date/yr Amount Result (mm)

   1._____

   2._____

4. **Health Status:** To my knowledge this applicant:

   a. Is free from contagious disease and capable of performing all volunteer assignments.

      Yes_____ **No**_____

   b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in her or his activities: _____

      _____

5. Doctor's Name:_____ Doctor's signature:_____

6. Doctor's Address:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

DATE: _____NAME OF PATIENT: _____

DATE OF BIRTH: _____

I hereby authorize ***MY DOCTOR*** to release protected health information of the above-named patient to:

VOLUNTEER SERVICES
ST. MARY'S GENERAL HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055

The purpose of such release is _____

The type and amount of information requested is as follows:

☐ Discharge Summary from (date)_____ to (date)_____
☐ H&P from (date)_____ to (date)_____
☐ Consultation Record from (date)_____ to (date)_____
☐ Lab Reports from (date)_____ to (date)_____
☐ Radiology Reports from (date)_____ to (date)_____
☐ Abstract from (date)_____ to (date)_____
☐ Entire Record from (date)_____ to (date)_____
☐ Other_____

I understand that Federal law protects the confidentiality of health information contained in alcohol/drug abuse related patient records; these regulations (42 CFR, Part 2) prohibits the further disclosure of health information without the specific written consent of the patient or as otherwise permitted by such regulations. A general authorization for; the release of information ("any and all") is NOT sufficient for this purpose.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right or contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ Date

If I fail to specify an expiration date, event or condition, this authorization will expire within 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization I need not sign this form in order to assure treatment or payment I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
If Signed by Representative, Relationship to Patient Signature of Witness

7910-05B IH Rev. 9/11

IF UNDER 18 PARENT MUST SIGN