



Additional comments, skills, training you feel pertinent to your application: \_\_\_\_\_

How did you learn of the New Ulm Medical Center Volunteer Program? \_\_\_\_\_

**Personal/Professional Reference**

IMPORTANT: Please enclose a letter of recommendation or complete the reference information below. Application without a reference contact will not be considered. (References may not be a relative).

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Volunteer Health Record**

Please fill out attached form for infectious disease and immunization tracking.

Initial here once completed: \_\_\_\_\_

Do you have any disabilities that might limit your volunteer duties? This information will be used to help with appropriate volunteer placement. \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

---

***The information in this application is accurate and correct to the best of your knowledge. Your signature indicates your approval for us to verify references provided.***

***Failure to fully and truthfully complete this application may result in denial of volunteer service or termination from the service.***

***New Ulm Medical Center Volunteer Services IS NOT obligated to provide placement nor are you obligated to accept the position offered.***

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

***New Ulm Medical Center is committed to Equal Opportunity Volunteer Placements***

**Return to:**

New Ulm Medical Center Volunteer Services  
Volunteer Coordinator  
1324 5<sup>th</sup> North Street  
New Ulm, MN 56073  
507-233-1180

# VOLUNTEER/STUDENT - INFECTIOUS DISEASE AND IMMUNIZATION TRACKING

Name: \_\_\_\_\_ SSN# \_\_\_\_\_

Work Site: \_\_\_\_\_ Department: \_\_\_\_\_

Manager Name: \_\_\_\_\_

Phone Number to reach you during day: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Places you have lived outside USA: \_\_\_\_\_

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS. CHECK ALL ANSWERS THAT APPLY TO YOU.	FOR SUPERVISOR
<p><b>Tuberculosis (TB)</b></p> <p>_____ I have never had a skin test or blood test for TB (Mantoux)</p> <p>_____ I have had a negative skin test for TB</p> <p>_____ Approximate date of last test (month and year) _____</p> <p>_____ I have received BCG vaccine (uncommon in U.S.)</p> <p>_____ I have had a positive skin test or blood test for TB</p> <p>_____ not treated _____ treated with isoniazid (INH) or other medication</p> <p>Dates of treatment: _____ Duration of treatment _____</p> <p>_____ I have or have had TB</p> <p>_____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe: _____</p> <p><b>Current Health Status</b></p> <p>_____ I have one or more of the following symptoms</p> <p>_____ fever _____ cough over 3 weeks _____ bloody sputum _____ night sweats _____ weight loss</p>	<p>2 Step TB skin testing or a QFT for all who have patient contact (within 3 feet of patients). If 2 step TB skin testing - a neg test in previous 12 months is used for 1<sup>st</sup> step.</p>
<p><b>Mumps</b></p> <p>_____ I had Mumps. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have had two Mumps vaccines. If yes, have documentation that you had it yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for Mumps antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Mumps or been vaccinated</p>	<p>Vaccine Given: _____</p> <p>Place: _____</p> <p>Date: _____</p> <p>Titer Drawn: ___ Yes ___ No</p> <p>Date: _____</p> <p>Result: Immune Susceptible</p>
<p><b>Rubella (German Measles)</b></p> <p>_____ I had German Measles. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I had rubella vaccine. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for rubella antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had German measles or been vaccinated</p>	<p>Vaccine Given: _____</p> <p>Place: _____</p> <p>Date: _____</p> <p>Titer Drawn: ___ Yes ___ No</p> <p>Date: _____</p> <p>Result: Immune Susceptible</p>
<p><b>Measles (Rubeola) (Red Measles)</b></p> <p>_____ I had Measles. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have had Measles vaccine. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for rubeola antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Measles (Rubeola) or been vaccinated</p>	<p>Vaccine Given: _____</p> <p>Place: _____</p> <p>Date: _____</p> <p>Titer Drawn: ___ Yes ___ No</p> <p>Date: _____</p> <p>Result: Immune Susceptible</p>

<p><b>Chickenpox</b></p> <p>_____ I have had chickenpox. If yes, at what age? _____</p> <p>_____ My children have had chickenpox while living with me</p> <p>_____ I have had Shingles (also called Herpes Zoster)</p> <p>_____ I have had chickenpox vaccine. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for chickenpox antibodies. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>Where tested _____</p> <p>_____ I don't know if I have had Chickenpox or been vaccinated</p>	<p>Vaccine Given: _____</p> <p>Place: _____</p> <p>Date: _____</p> <p>Titer Drawn: ___ Yes ___ No</p> <p>Date: _____</p> <p>Result: Immune Susceptible</p>
<p><b>Tetanus / Diphtheria / Pertussis</b></p> <p>_____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine</p> <p>_____ Date of last tetanus vaccine "booster"</p> <p>_____ Date of last documented DPT vaccine</p> <p>_____ I had a single adult dose of Tdap vaccine</p> <p>_____ Date of documented Tdap vaccine</p> <p>_____ Allergy</p> <p>_____ Unknown</p>	<p>Td booster advised Q 10 yr: _____</p> <p>Tdap (a single adult dose)</p> <p>Vaccine Given: _____</p> <p>Place: _____</p> <p>Date: _____</p>
<p><b>Hepatitis B (required only if your assignments have the potential for blood &amp; body fluid exposure)</b></p> <p>_____ I have had Hepatitis B. If yes, date _____</p> <p>_____ I have had the Hepatitis B vaccine. If yes, approximate dates:</p> <p>Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____</p> <p>Other (describe) _____</p> <p>_____ I have been tested for Hepatitis B antibody. If yes, date _____</p> <p>Where tested _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I have had Hepatitis B surface antigen test. If yes, date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Hepatitis or been vaccinated.</p>	<p>Hep B Series Started: ___</p> <p>Yes ___ No</p> <p>Declination Signed: ___</p> <p>Yes ___ No</p> <p>Other: _____</p>
<p><b>Immune Status:</b> People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. Check if you have had the following:</p> <p>_____ Splenectomy (spleen removed)</p> <p>_____ Organ transplant</p> <p>_____ Chronic steroid use (taking Cortisone, Prednisone, etc.). If yes:</p> <p>Name of medication(s) and dose _____</p> <p>How long have you been on these medications? _____</p> <p>_____ Chemotherapy or radiation</p> <p>_____ Immune deficiency disease: lymphoma <input type="checkbox"/> leukemia <input type="checkbox"/> HIV infection <input type="checkbox"/></p> <p>Other malignancy or condition (list) _____</p>	<p>Places and Dates:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

VOLUNTEER/STUDENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

EHS CLEARANCE: SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

*Complete this form and return to the Volunteer Office.*

## Background Study Form

MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES  
SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY  
EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

**INSTRUCTIONS:**

- **PRINT ALL INFORMATION:** After completing this form, return to the volunteer office. Information will be submitted to the Department of Human Services via NETStudy.
- **OPTIONAL:** Items marked with an asterisk (\*) and below the solid black line are optional. All other information is required.
- **BIRTHDATE:** Enter date of birth in the format MMDDYY (example Dec 31, 1970 would be 12311970)
- **DUAL NAMES:** Separate dual names with a space (example "Mary Louise" or Smith Johnson").
- **TITLES/INDICATORS:** Do not include titles ("D", "Sister", "Father"), or educational ("PhD", "MD", etc), generational ("Jr", "Sr", "II", "IV", etc.) or professional indicators ("LICSW", "LP", etc.)

FIRST NAME			MIDDLE NAME			LAST NAME		
OTHER FIRST NAMES YOU HAVE USED				OTHER LAST NAMES YOU HAVE USED				
ADDRESS								
CITY			STATE			ZIP CODE		
BIRTHDATE						GENDER		
2-Digit Month		2-Digit Day		4-Digit Year		<input type="radio"/> MALE		<input type="radio"/> FEMALE
STATE DRIVER'S LICENSE NUMBER OR STATE IDENTIFICATION NUMBER						(PLEASE PRINT CLEARLY)		
TELEPHONE								



**NEW ULM  
MEDICAL  
CENTER**

*Allina Hospitals & Clinics*

## **Background Study Authorization**

To Whom It May Concern:

I authorize Allina Hospitals & Clinic, including its subsidiary and affiliate corporations ("Allina"), to obtain a background study in connection with my application to volunteer.

Any offer to volunteer is contingent upon a satisfactory background investigation.

I understand that a copy of this background check will be mailed to me at no expense.

A copy of this authorization has the same validity as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES  
SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY  
EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

**BACKGROUND STUDY PRIVACY NOTICE**

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

**1. Purpose and intended use of the information:** Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

**2. Whether you may refuse or are legally required to provide the information:** Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

**3. Known consequences that may arise from supplying the information:** Individuals who have histories with the characteristics identified in Minnesota Statutes, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

**4. Known consequences that will arise from refusing to supply the requested information:** Only items identified as "optional" may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

**5. Identification of other agencies or entities authorized to receive this information:** The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.