New Ulm Medical Center Volunteer Application Form

Allina Health
NEW ULM MEDICAL CENTER

Name:_____
(last) (first) (middle initial)

Address:_____
(street) (city, state) (zip)

Birth Date (year is optional):_____Phone: _____

Email address: _____

In emergency, notify: _____ Relationship: _____Phone: _____

Education/Work Experience

Employer:_____Position: _____How long?_____

Work Phone:_____ May we contact you at work? Y or N

Retired from:_____Position: _____

Level of education completed: _____Degree: _____

If attending college; name of college: _____

Do you have previous experience as a volunteer? _____

Where and what were your responsibilities? _____

_____

Why did you choose the New Ulm Medical Center for volunteer work? _____

_____

Volunteer Availability

Volunteer shifts are typically one time per week or month, scheduled according to department need and volunteer availability. Volunteers are asked to make a minimum commitment of one shift per month for 12 months, or 50 hours for the next year.

Volunteer job(s) you would prefer:

☐ Virginia Piper Cancer Institute ☐ Hospital Front Desk ☐ Clinic Front Desk

☐ Coffee and Gift Shop ☐ Heart of New Ulm ☐ Med/Surg Supplies

☐ Courage Kenny Rehabilitative Institute

Please check all of the times you are available to volunteer:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							

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

_____

How did you learn about 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 Coordinator
1324 5th North Street
New Ulm, MN 56073
507-217-5111

VOLUNTEER/STUDENT - INFECTIOUS DISEASE AND IMMUNIZATION TRACKING

Name: _____ SSN# _____

Work Site: New Ulm Medical Center Department: Volunteer Services

Manager Name: Missy Dreckman, Volunteer Coordinator

___

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
Tuberculosis (TB) _____ I have never had a skin test or blood test for TB (Mantoux) _____ I have had a negative skin test for TB _____ Approximate date of last test (month and year) _____ _____ I have received BCG vaccine (uncommon in U.S.) _____ I have had a positive skin test or blood test for TB _____ not treated _____ treated with isoniazid (INH) or other medication Dates of treatment: _____ Duration of treatment_____ _____ I have or have had TB _____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe: _____ **Current Health Status** ____ I have one or more of the following symptoms ____fever ____cough over 3 weeks _____bloody sputum _____night sweats ____weight loss	QFT test 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 1st step.
Mumps _____ I had Mumps. If yes, have documentation that you had it? yes ☐ no ☐ _____ I have had two Mumps vaccines. If yes, have documentation that you had it yes ☐ no ☐ _____ I have been tested for Mumps antibody. Date _____ Was test: positive ☐ negative ☐ don't know ☐ _____ I don't know if I have had Mumps or been vaccinated	Vaccine Given: Place: _____ Date: _____ Titer Drawn: ___ Yes ___ No Date: _____ Result: Immune Susceptible
Rubella (German Measles) _____ I had German Measles. If yes, have documentation that you had it? yes ☐ no ☐ _____ I had rubella vaccine. If yes, have documentation that you had it? yes ☐ no ☐ _____ I have been tested for rubella antibody. Date _____ Was test: positive ☐ negative ☐ don't know ☐ _____ I don't know if I have had German measles or been vaccinated	Vaccine Given: Place: _____ Date: _____ Titer Drawn: ___ Yes ___ No Date: _____ Result: Immune Susceptible
Measles (Rubeola) (Red Measles) _____ I had Measles. If yes, have documentation that you had it? yes ☐ no ☐ _____ I have had Measles vaccine. If yes, have documentation that you had it yes ☐ no ☐ _____ I have been tested for rubeola antibody. Date _____ Was test: positive ☐ negative ☐ don't know ☐ _____ I don't know if I have had Measles (Rubeola) or been vaccinated	Vaccine Given: Place: _____ Date: _____ Titer Drawn: ___ Yes ___ No Date: _____

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

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	○ MALE ○ FEMALE

STATE DRIVER'S LICENSE NUMBER OR STATE IDENTIFICATION NUMBER →	(PLEASE PRINT CLEARLY)

TELEPHONE				–				–				

Allina Health
NEW ULM MEDICAL CENTER

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 **Human Services**

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.

6a. **If CURRENT background study results in a disqualification that is set aside upon reconsideration:** If you are disqualified as a result your background study, and you request reconsideration and your disqualification is set aside for the program/agency that initiated the current background study, subsequent background studies initiated by other programs/agencies may result in the disqualification being set aside for other programs/agencies when the following criteria are met:

1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
2. the program that initiates the subsequent background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
3. the commissioner has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
4. the previous set aside was not limited to a specific person(s) receiving services.

If the above criteria are met, the notice of disqualification sent to the program/agency that initiates the subsequent background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)

6b. **If a PREVIOUS background study resulted in disqualification that was set aside:** If you were the subject of a previous background study which resulted in your disqualification, and your disqualification was set aside upon reconsideration, DHS will review the information in your record in connection with your current background study and determine whether the following criteria are met:

1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
2. the program that initiated the current background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
3. the commissioner has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
4. the previous set aside was not limited to a specific person(s) receiving services.

If the above criteria are met, the notice of disqualification sent to the program/agency that initiated the current background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)