Allina Health

REGINA HOSPITAL

Volunteer Services

Thank you for your interest in **Regina Hospital's Adult Volunteer Program**.
Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

Here is the process of getting ready to share your talents, time and energy with us.

- Enrollment – Please complete the attached enrollment paperwork. We hope that we can offer you an area of service that is compatible with your interests and availability. Regina Hospital is required to perform a background check, so please thoroughly review the application and complete the attached forms.

- Getting Started – The Volunteer Office will contact you after reviewing your application to discuss next steps and schedule an orientation session.

- Health – Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, and tuberculosis. If you are not sure about some of your vaccinations, a blood test may be required to verify immunizations at no cost to you. Additionally, if any vaccines are needed, they may also be offered to you at no cost.

- General Orientation – We will schedule a time for you to attend a general orientation session to learn what you need to know about Regina Hospital before you get started.

I look forward to meeting with you and pursuing your interest in volunteering at Regina Hospital – Part of Allina Health. Please feel free to contact me if you have any questions.

Sincerely,

Pamela Kochendorfer
651-404-1451
Email: kochendorfer@allina.com

Allina Health
REGINA HOSPITAL

ADULT VOLUNTEER ENROLLMENT FORM

Thank you for your interest in Regina Hospital's Adult Volunteer Program.

Name _____
Address_____ City_____ State _____ Zip_____
Home phone: _____ Cell: _____
Email address: _____
Driver's License #: _____ State _____

WORK STATUS ____ Employed ____ Retired ____ Unemployed
Current or last place of employment _____

INTERESTS, SKILLS, TALENTS (e.g. education, computer, music)

_____

Are you performing this volunteer service because it is required? YES NO (circle one)
If YES: 1) Reason hours are needed _____
2) Number of hours required _____ 3) Completion deadline _____

VOLUNTEER EXPERIENCE
Please list any volunteer experiences that you have. Include where, and how long you did it.

_____

_____

AREA(S) OF INTEREST
Please indicate general area(s) that may interest you, keeping in mind that your choices may change as you discover more about us. Ask about other needs that may not appear on the list below.

- ☐ Escort/wayfinding Services within Hospital
- ☐ Oncology unit volunteer
- ☐ Office/clerical projects (no weekends)
- ☐ Where the need is greatest
- ☐ Eucharist ministries
- ☐ Patient experience cart in Medical Surgical unit
- ☐ Contribute to non-nursing aspect of patient care
- ☐ Gift shop or Country Store
- ☐ Fund raising events (bazaar, garage sale, etc.)
- ☐ Coffee socials
- ☐ Resident Birthday Parties
- ☐ Special events (e.g., serving ice cream socials)
- ☐ Bloodmobile
- ☐ Other _____
- ☐ Resident activities (refer to Senior Living)

AVAILABILITY:

How often would you like to volunteer? 1x week 2x month once a month Other _____

How long would you like your shift to last? 1 – 2 hrs 3 – 4 hours other: _____

Would you prefer a regular or flexible shift? _____ please explain: _____

What day(s) would you prefer? Sun Mon Tues Wed Thurs Fri Sat

What time of day would work best for you: _____

Do you relocate seasonally? YES NO If yes… Leave: _____ Return: _____

ADULT VOLUNTEER REFERENCES

Please list two references – print clearly. Do not use physicians or relatives.

1. Name _____ Phone _____ Best time to call _____
2. Name _____ Phone _____ Best time to call _____

HEALTH INFORMATION

Regina Hospital is required to verify that all prospective volunteers have immunity to measles, mumps, rubella, chicken pox, and tuberculosis. You will be given a referral to speak with Infection Control.

IN AN EMERGENCY PLEASE NOTIFY

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone 1 _____ Phone 2 _____

SIGNATURE

My signature below certifies that all statements made on this enrollment form are true, complete and correct to the best of my knowledge and belief. I understand these statements are subject to verification. I understand that falsification of information can disqualify me from consideration or result in dismissal upon discovery. Furthermore, my signature below provides my authorization to Regina Hospital check my references listed above to determine my suitability for placement.

_____ _____

Signature Date

Return completed application to:	Regina Volunteer Services Attn: Pamela Kochendorpher 1175 Nininger Rd. Hastings, MN 55033	Questions: Call Volunteer Services at: 651-404-1451

Background Check Disclosure for Allina Health Volunteers

Allina Health, including its subsidiary and affiliate corporations, may:

- order a consumer report (a background report) on you in connection with your application to volunteer at Allina Health
- order additional background reports on you for purposes of your volunteer role if you become a volunteer, or if you already volunteer for Allina Health.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and criminal history. Information may be obtained from private and public record sources.

The current consumer reporting agencies (CRAs) are:

Verified Credentials, Inc. 20890 Kenbridge Court Lakeville, MN 55044 952-985-7200 Toll free:1-800-473-4934	Bureau of Criminal Apprehension BCA Headquarters – St. Paul 1430 Maryland Avenue East St. Paul, MN 55106-2802 651-793-2400

You have the right in most circumstances to submit a written report to the CRAs for a complete and accurate disclosure of the nature and scope of any consumer report Allina Health ordered about you. The CRAs must provide you with this disclosure form within five business days after its receipt of your request or the report was requested by Allina Health, whichever date is later.

Background Check Authorization for Allina Health Volunteers

By signing below, I authorize Allina Health, including its subsidiary and affiliate corporations, to obtain a consumer report in connection with my application for a volunteer role, or, as allowed by law, at any time during my volunteer role and from a consumer reporting agency (CRA) other than Verified Credentials, Inc.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, and subject to all laws protecting my information and individual privacy, I also authorize that the following information may be disclosed to the CRA as needed to compile the report: my past and present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed to the CRA, if and only as allowed by law, includes information related to my criminal background, motor vehicle history, employment and earnings history, education, personal references, character, mode of living, credit background, civil judgments or liens, military service, and professional credentials and licenses.

A volunteer opportunity with Allina Health is contingent upon a satisfactory background investigation. If I become a volunteer, I authorize Allina Health to order additional background reports while volunteering with Allina Health related to any of the above issues without asking me for my authorization again.

I may receive a copy of any consumer report obtained by Allina Health at no expense to me. I understand that I may request additional information on the nature of the report upon written request to the CRA. These searches will be conducted by: Verified Credentials, Inc., 20890 Kenbridge Court, Lakeville, MN 55044, 800-473-4934, www.verifiedcredentials.com. Check this box if you would like a free copy of your background report: ☐ Yes ☐ No

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

Identity Information and Address History		
First Name	**Middle Name**	**Last Name**
Former name(s) or alias you have used in the past (including maiden name):		
Date of Birth*	**Social Security Number***	
Phone	**Email Address**	
Please list ALL the of the addresses where you have lived during the **last 7 years**		
Current:		
Previous:		
Previous:		
Previous:		
Signature:		**Date:**

***** *This information is used for identification purposes only*

Regina Hospital and Regina Auxiliary
Infectious Disease and Immunization Tracking

Name: _____ SSN# _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number to reach you at during the day: _____

Places you have lived outside USA: _____

Work Site: _____ Department: _____

Manager Name: _____

- Submit the completed form and documentation of all vaccinations to Employee Occupational Health (EOH), or call 612-262-4490 for further instruction.

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 – Any current symptoms such as:** ____fever____cough over 3 weeks_____bloody sputum_____night sweats____weight loss ____no current symptoms	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 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	
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	
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	

Regina Hospital and Regina Auxiliary
Infectious Disease and Immunization Tracking

Chickenpox
_____ I have had chickenpox/and or shingles (also called Herpes Zoster).
If yes, do you have MD documentation of having the disease? yes ☐ no ☐
_____ I have had chickenpox (Varicella) vaccine.
If yes, do you have documentation of two vaccinations? yes ☐ no ☐
_____ I have been tested for chickenpox immunity.
If yes, do you have documentation of lab titer results? yes ☐ no ☐
_____ I don't know if I have had Chickenpox/and or shingles or been vaccinated

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

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.

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)_____

Regina Hospital and Regina Auxiliary
Infectious Disease and Immunization Tracking

CONSENT:

VOLUNTEER NAME (Please Print):
_____

VOLUNTER SIGNATURE _____ DATE: _____

☐ By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

PARENTAL CONSENT **required if applicant under 18 years old:**

_____ DATE:
_____
(*parent/guardian signature*)

By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.

Please include copies of all prior immunization records and/or lab titers for:

- **TB skin test or QFT (TB blood test)**
- **Chest x-ray only if positive TB history**
- **MMR (Measles, Mumps, Rubella)**
- **Hepatitis B**
- **Tdap or TD**
- **Influenza**
- **Chicken Pox (Varicella)**

Choose the lab you would like to go to. Wait 3 days to allow your order to be received and set up. You can report to the lab within 3 to 14 business days after you submit your request.

Blood tests that may be ordered are:

1. **Tuberculosis screening (QFT-Quantiferon Gold Test)**
2. **Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox**

Lab Locations to choose from are:

☐ **Hastings Allina Health Clinic**
1880 N. Frontage Road
Hastings, MN 55033
Hours: Monday-Friday 8am-3:30pm

For Questions: Please contact Heidi Willhite, Occupational Health Tech. ***Phone:*** 651-241-5481; ***Email:*** heidi.willhite@allina.com

OFFICE USE ONLY:

EOH CLEARANCE SIGNATURE:_____ Date:_____