Richmond University Medical Center

Volunteer Services Application

DATE:_____

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____

Email Address: _____

Current Address: _____

Zip Code: _____

How long have you been living at above address? _____

Home Phone: _____

Cell Phone: _____

Previous Address:

_____

Country of Birth: _____

If not USA, when did you come to this country? _____

HEALTH:

Do you have any health/physical limitations?

_____

Are you able to work with these limitations? Yes/No/Non-Applicable _____

Are you on medication on a daily basis?

_____

EDUCATION:

Education Background: Name of School: _____

Highest level of education completed: 9th 10th 11th 12th College: 1 2 3 4

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____Relationship _____

Telephone Number_____

References: Please write name and address of your physician and a friend or neighbor (no relatives)

Medical:

_____

_____

Personal:

_____

_____

WORK/VOLUNTEER EXPERIENCE:

Special Skills: (Typing, Computers, Art, etc.)

_____

Where have you worked? (Include Job Description)

_____

Where have you volunteered?

_____

Why would you like to volunteer?

_____

Would you like ___Clerical Work ___Patient Care ___Gift Shop ____Seniors

Time Available: Days _____

Hours _____

Signature:_____ Date:_____

For Office Use Only:

EHU Appointment: _____ Assignment: _____

Start Date: _____

Richmond University Medical Center

Consent Form and Release of Liability

I hereby give permission to release any medical information requested by Richmond University Medical Center for the purpose of gaining a volunteer position.

I hereby give my approval to be photographed by the hospital and to print the photo in the hospital newsletter at the discretion of hospital administration.

I understand that a volunteer position at Richmond University Medical Center may include assisting staff with various tasks/jobs that may involve messenger work, physical exertion, clerical work and other jobs as assigned. I will not hold the hospital liable for any physical harm or injury incurred as a result of volunteering sat the hospital.

I have read the above statements and agree to the terms required to work as a volunteer at Richmond University Medical Center.

_____ _____

Applicant's Name (Print) Date

_____ _____

Applicant's Signature Date

(UNDER 18 YEARS OF AGE)

_____ _____

Parent's Name & Signature Date

_____ _____

Applicant's Name (Print) Date

Richmond University Medical Center

HIPAA CONFIDENTIALITY STATEMENT

Richmond University Medical Center respects the patient's, physicians, employees, and volunteer's rights to privacy and confidentiality.

All information shared by patients and their family during the course of the individual's contact with Richmond University Medical Center, shall be held in the strictest of confidence. This includes, but is not limited to, personal, social and medical information given by the patient. This information is to be discussed only by the professional staff directly involved in the care of the patient and in a manner where privacy and confidentiality are ensured.

Further, all information supplied by the employees of Richmond University Medical Center in relation to their financial, medical or personal status, shall be held in the strictest confidence.

Any volunteer who violates confidentiality will be subject to disciplinary action up to and including discharge.

I acknowledge that I have read this policy and pledge my compliance.

Print Name

_____

Signature:

_____ Date: _____

Richmond University Medical Center

Volunteer Program
Parent Permission Form

Date: _____

I, the undersigned parent/ legal guardian of _____,
Minor's First and Last Name

request and authorize the enrollment of my son/daughter/ward in the Richmond University Medical Center Volunteer Program.

If my son/daughter/ward sustains an injury or accident, which requires emergency medical treatment while he/she is performing volunteer duties in the program, I give my consent for such medical treatment to be given at the Richmond University Center Emergency Room or the closest emergency center.

_____
Signature

_____
Please print name

_____
Number Street

_____
City State

_____
Telephone Number

_____
Relationship

Richmond University Medical Center

Employee Health Services Medical Clearance for Students / Volunteers

Your medical clearance will be delayed if this form is not complete. Please contact your local EHS Office for questions.

Name: _____ Current Hospital/School: _____
Last Name, First Name

DOB: ____ /____ /____ Telephone: ( ) _____ Email: _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

Tuberculosis (TB) Screening: 2-Step Tuberculin Skin Test (TST) or Blood Assay (MUST be within 12 months of starting service)

2-Step Tuberculin Skin Tests

#1 ___/___/___ Date 1st placed ___/___/___ Date Read _____ Result □ Negative □ Positive

#2 ___/___/___ Date 2nd placed ___/___/___ Date Read _____ Result □ Negative □ Positive

OR

Blood Assay: Date Drawn ____/____/_____ Result □ Negative □ Positive

POSITIVE TST History: MUST have a chest x-ray with no active disease & complete the signs/symptoms section below

Chest X-Ray Date: ____/____/_____ Result □ Negative □ Positive TB Treatment Given: ____/____/____

Check all that apply:

□ Night Sweats □ Chronic Cough □ Unexplained Weight Loss □ Bloody Sputum □ Persistent Fever □ Asymptomatic Date: ___/___/___

Vaccination History	Vaccine #1	Vaccine #2	Lab Report Attached
Rubeola	____/____/_____	____/____/_____	□
Mumps	____/____/_____	____/____/_____	□
Rubella	____/____/_____		□
Varicella	____/____/_____	____/____/_____	□

HEPATITIS B Vaccine Documentation

Hepatitis B Series: Dose #1: ____/____/_____ Dose #2: ____/____/_____ Dose #3: ____/____/_____

Date Drawn: ____/_____/_____ HepBsAb □ Positive □ Negative

_____/_____/_____ HepBsAg □ Positive □ Negative

Vaccinations Status

Tdap/DTaP: Pertussis containing vaccine within last 10 years	___/___/____			
Influenza: Vaccinated within the current flu season	___/___/____	□ Refused		
COVID vaccine Date: Type	___/___/____	___/___/___	___/___/____	___/___/___

The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individuals behavior. The office that is completing this form will be responsible for maintaining updated records for the duration of participant's and/or faculty's interactions within the Richmond University Medical Center and provide appropriate supporting documentation upon request.

Health Care Provider or Facility: _____ Phone: _____

Health Care Provider or Facility Signature: _____ Date: _____

Provider/Facility Stamp with Address and Telephone Number:

Office Stamp

For RUMC Use Only:

Department:_____ Program Name:_____

Program Contact Name: _____ Program Contact Phone: _____ Medical Clearance to be sent to (Email address): _____@RUMCSI.org

RUMC Health EHS Reviewer Signature: _____ Date:_____

Revised Jan 2023

Richmond University Medical Center

Requirements for Medical Clearance for Volunteers and Students

Forms to be completed by Primary Care Provider

Annual Physical Exam Form – Completed, stamped and signed by a licensed provider and must include his/her license number.

Tuberculin Skin Test Form – Tuberculin skin test (TST) must be implanted and read within the appropriate time frame and must be within twelve (12) months of starting.

- If positive, TST must have a chest x-ray completed within twelve (12) months and a copy of the radiologist report must be submitted for review.
- We accept the Quantiferon TB test if done within the past (6) months. Official lab report must be provided.

During flu season - Vaccination administration record for Influenza must be provided or a declination submitted.

COVID vaccination – Submit documentation of full vaccination, such as COVID vaccine card with both doses, if applicable.

Note to providers regarding lab reports

Richmond University Medical Center policy requires official lab reports showing titer levels that prove immunity to measles, mumps, rubella, and varicella. All lab results submitted must bear the actual titer value, along with the laboratory's reference range used to determine immunity. All lab reports must have date of collection printed on the report and must be from a U.S. laboratory.

If lab results show negative or equivocal titers, an immunization record must be provided indicating appropriate vaccination.

Forms to be completed by Volunteers & Students

Volunteers and students must fill out a medical questionnaire and Hepatitis B attestation form provided in this medical packet.

Physician Assistant Students

Must have proof of fit testing for type of respiratory mask.

Note: Once fully completed, medical forms and labs are submitted - clearance may take up to two weeks.