



Have you ever pled guilty or been convicted of a crime?  Yes  No  
 If yes, when did the offense occur? \_\_\_\_\_ Nature of crime:  
 \_\_\_\_\_

Are you required to volunteer?  Yes  No. If yes, by whom? \_\_\_\_\_

How did you hear about our Volunteer Program? \_\_\_\_\_

**Volunteer – Please Read and Sign:**

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief, and hereby grant Mount Nittany Medical Center permission to verify such answers and investigate references.

Believing that the Medical Center has a real need for my services as a volunteer worker,

- I will be punctual and conscientious in the fulfillment of my duties and accept supervision gracefully;
- I will conduct myself with dignity, courtesy, and consideration;
- I will consider as CONFIDENTIAL all information which I may hear directly or indirectly concerning a patient, doctor, or any of the personnel, and will not seek information in regard to a patient;
- I will take any problems, criticisms, or suggestions to the Director of Volunteers;
- I will endeavor to make my work of the highest quality, and I will uphold the traditions and standards of the Medical Center and interpret them to the community at large.
- I understand that a Tuberculin skin test is required for volunteers with patient contact, and that the test will be provided to me free of charge at the Medical Center.

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**For Junior Volunteers Only:**

Parent or Guardian: Please acknowledge the above consent form by signing below.

Signed \_\_\_\_\_

DATE \_\_\_\_\_

**ORIENTATION CHECKLIST**

Mission & Vision Statements		Emergency Announcements	
Confidentiality Statement		Infection Control	
HIPAA		Customer Service	
Sign-In Books		National Patient Safety Goals	
Schedules and Call-Offs		Uniforms and Dress Code	
Assignment Guides and Checklists		Benefits	

## Health Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

E-mail address: \_\_\_\_\_ Local Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Allergies: \_\_\_\_\_

Must be completed prior to volunteer service

### **TUBERCULOSIS:**

Tuberculin screening (tuberculin skin test or blood assay for *M. tuberculosis*) is required unless you have had a positive test or are deferred from testing for other reasons. Only results of testing performed within the past one (1) year will be accepted.

Exempt from testing: ( ) NO ( ) YES

If yes, reason: \_\_\_\_\_

Date of tuberculin screening: \_\_\_\_\_ Result: \_\_\_\_\_

If tuberculin screening is/was positive, attach a copy of a chest x-ray report done within the past one (1) year.

### **VARICELLA (CHICKEN POX):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody),
- \_\_\_ proof of vaccination with one/two doses varicella zoster vaccine, or
- \_\_\_ history of herpes zoster (shingles) based on healthcare provider diagnosis.

### **RUBELLA (GERMAN MEASLES):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody), or
- \_\_\_ proof of vaccination (one dose on or after age one).

### **RUBEOLA (MEASLES):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody),
- \_\_\_ proof of vaccination (two doses on or after age one or one dose if born before 1957), or
- \_\_\_ documented physician-diagnosed infection.

### **MUMPS:** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity,
- \_\_\_ proof of vaccination (two doses on or after age one or one dose if born before 1957), or
- \_\_\_ documented physician-diagnosed infection.

PRINTED NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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

If you cannot provide evidence of immunity as described above, a blood test (titre/s) will be performed by the Medical Center to determine your immunity status. If you have any questions contact the Volunteer Services Department office at 814.234.6170.

## Reference Form

This form is to be completed by the applicant's reference.

\_\_\_\_\_ has applied to be a volunteer at Mount Nittany Medical Center and has given your name as a reference. Because we strive to provide our patients with quality care, it would be helpful to have your comments on whether you consider this person well-suited to healthcare volunteer service.

Please return this completed form to the address provided below. Your prompt and frank reply will be greatly appreciated, and will be considered confidential. Volunteers cannot begin their assignments until a reference is returned.

Sincerely,

Vickie A. Morgan, CAVS  
Director of Volunteer Services

\_\_\_\_\_  
Name of Applicant: \_\_\_\_\_

Name of Reference: \_\_\_\_\_

How do you know Applicant: \_\_\_\_\_

Reference Address: \_\_\_\_\_

Reference Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Comments: \_\_\_\_\_

### Please return to:

Mount Nittany Medical Center  
Volunteer Services Department  
1800 East Park Avenue  
State College, PA 16803  
814.234.6170



**Consent for Tuberculin Skin Test for Volunteers under age 18:**

All volunteers who have been interviewed must have a tuberculin skin test before starting volunteer activities. The test will be provided, at no charge to the volunteer, during the orientation process.

If you are under 18, your parent or guardian must sign this letter before you receive the tuberculin skin test. Please bring the signed letter with you when you come to the Medical Center for your appointment.

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For Parents/Guardians of Junior Volunteers (volunteers under age 18):

I have read this letter, and I give my permission for \_\_\_\_\_(Name) to receive a tuberculin skin test at Mount Nittany Medical Center.

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Signature of Parent or Guardian

Date