Volunteer Information & Application Packet

|  |  |
| --- | --- |
| Director of Volunteer ServicesPhoneE-MailMailing AddressWebsite for Skagit Regional Health | Steve Schultz(360) 814-2142sschultz@skagitvalleyhospital.orgSkagit Regional Health 1415 East KincaidP.O. Box 1376Mount Vernon, WA 98273www.skagitregionalhealth.org |

Thank you for your interest in volunteering at Skagit Regional Health. We are looking for responsible, dependable volunteers. We’re sure you will enjoy participating in one or more of the many volunteer positions here at Skagit Regional Health.

# **Application and Interview Process**

To start the volunteer process, please submit these items:

1. Completed application form & health questionnaire.
2. Parental consent form (volunteers under age 18)
3. Two reference forms
4. Disclosure Statement

You’ll find these forms at the end of this packet. If your application packet is missing any of these forms, please call the Volunteer Services office: (360) 814-2142. After Volunteer Services receives the above forms, we will contact you for an interview. Additional interviews may be scheduled with department managers.

# **Additional Requirements**

# The following additional requirements must be met before placement can be made:

1. Washington State Patrol Background Request
2. TB Test
3. Signed Statement of Confidentiality
4. Identification Badge
5. Competency Assesment
6. Minimum age for volunteering is 16 years.

Skagit Regional Health will provide you with all the appropriate forms.

# **Volunteer Commitment**

We ask all volunteers for a minimum commitment of 100 hours.

|  |
| --- |
| FOR STUDENTS AND JOB SEEKERSWhile volunteering can be a great way to explore job opportunities, network or get required school credits, we do ask volunteers to complete a minimum of 100 hours before requesting recommendations or receiving credit for hours volunteered. As the number of positions is limited, prospective volunteers should apply at least a year in advance of any school deadlines that may be applicable. High school students seeking course or club credit should apply and begin volunteering before their senior year. |

###### ****Professional Liability****

If a patient should incur an injury caused by a volunteer's actions(s), the hospital insurance will protect the volunteer. The volunteer must sign in on their time sheet to prove that they are functioning within their volunteer positions.

**Parking**

Parking though not always easy, is available. Please don’t park in spaces that would deter patients and/or patients' families from easy access to the hospital.

**Uniforms**

Uniforms are provided by Volunteer Services.

**Just Say “No”**

Always know that volunteers do not have to substitute or accept any responsibilities if they do not want to.

# **Placement**

After you complete the application intake requirements, you are matched with departments based on your interests, skills, and availability. Placement may take 3-4 weeks after you meet all the application requirements.

# **Orientation**

Volunteer orientation and training involves three parts and is designed to instill not only job knowledge, but confidence as well. The three parts are:

1. Volunteer basics (interview)
2. SRH orientation
3. Department/unit orientation

# **Evaluation**

# After 30 days of volunteering you will meet with Volunteer Services to evaluate your volunteering experience.

Photo ID Badge

Skagit Regional Health issues you a photo ID badge that is to be worn at all times you are on duty.

## **VOLUNTEER SERVICE OPPORTUNITIES**

**Information Desk**

Our information desk volunteers stay very busy. When they’re not answering questions or escorting patients to destinations throughout our facilities, they’re providing wheelchair transport, delivering flowers and complimentary papers, responding to courier requests, and assisting with projects. The information desks are truly the “hubs” of our customer service activities.

#### **Clerical and Office Support**

A variety of opportunities exist throughout Skagit Regional Health to assist the staff with clerical and office duties in clinical and administrative departments. Opportunities are open to volunteers who would like to gain office experience and learn new skills in a medical center environment. Duties may include computer work, answering phones, assisting patients, filing and collating, operating office machines, and running errands.

#### **Skagit Valley Hospital Gift Shop**

The gift shop volunteers serve the many customers who purchase gifts for patients and family members. All proceeds generated by the shop are donated back to Skagit Regional Health.

#### **Special Projects**

A variety of short-term projects and events require a variety of skills throughout the year. Many events are fun, festive and include the community. Projects include educational programs, mailing parties, health fairs, and special office projects.

**Patient Care Areas**

(Endoscopy, Orthopedic and Surgical Care, Progressive and Critical Care, Medical and Pediatric Care, Acute Care and Emergency)

While volunteers may not give direct patient care, they may assist with clerical tasks, stocking of supplies, creation of start kits, patient transport, room change-overs and other supportive tasks. These are excellent positions for students and others desiring to learn about employment in the medical field.

## **Junior Medical Volunteers**

## The Junior Medical Volunteer program is for students age 16-18. The program allows young people an excellent opportunity to explore the culture of a health care organization while giving service to their community. Junior Medical Volunteers work in many areas of Skagit Regional Health. Each year, Skagit Regional Health awards scholarships to outstanding Junior Medical Volunteers. For more information or to become a member please call 360-814-2142.

Desired Volunteer Location: \_\_\_\_\_ Skagit Valley Hospital, Mount Vernon

 \_\_\_\_\_ Cascade Valley Hospital, Arlington

 \_\_\_\_\_ Clinic Location (Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Four Social Security Number: \_\_ \_\_ \_\_ \_\_

Name You Prefer To Go By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

###### Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Why do you wish to volunteer at SRH? |
|  |
|  |
| What type of volunteer work do you hope to do? |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Education | School name | Dates Attended | Years Completed | Degree |
| College |  |  |  |  |
| High School |  |  |  |  |
| Other |  |  |  |  |
|  |  |  |  |  |

### **Current Employment / Volunteer Obligations**

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer / School, if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior experiences (to help Volunteer Services identify skill areas)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | City, State | Company | Dates from-to | Job title |
| **Work** |  |  |  |  |
| **Work** |  |  |  |  |
| Volunteer |  |  |  |  |
| **Volunteer** |  |  |  |  |

**Availability** (Please list the hours that you are available to volunteer)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mon. | Tues. | Wed. | Thur. | Fri. |
| Volunteer shifts fall between 7am and 8pm Mon – Fri. |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

I understand that volunteers are asked to complete a minimum of 100 hours before requesting recommendations or receiving credit for hours volunteered. As the number of positions is limited, prospective volunteers should apply at least a year in advance of any school deadlines that may be applicable. High school students seeking course or club credit should apply and begin volunteering before their senior year.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature

Have you been convicted of ANY criminal offense within the last 10 years (including Juvenile convictions)? No Yes. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Note: A criminal conviction does not necessarily bar you from service with SRH.

I will consider as confidential all information that I may hear directly or indirectly concerning a patient, doctor or staff member. I hereby certify that there are no willful misrepresentations or falsifications of any of the statements or answers to questions on this application.

Signature Date

**PARENTAL CONSENT (Teens 16 through 17)**

Your signature indicates your approval for your child's participation in the Junior Medical Volunteer Program at Skagit Regional Health. You also acknowledge that Skagit Regional Health is not liable for any accidents or injury incurred by the student while engaged in the voluntary service.

Teen applicant’s name Birth date

Parent/Guardian Name

Address City/ Zip

Phone Relationship to Volunteer

**IMMUNIZATIONS**

I hereby grant permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be screened for the presence of Tuberculosis by means of a skin test (referred to as a Mantoux Test). I understand that if my child has never been tested for Tuberculosis in the past a second test will need to be administered within one month of the first test. If the test should produce a positive result either his/her family physician or the County Health Department should evaluate the child.

**In addition, before acceptance into the Junior Medical Volunteer Program, all applicants (under age 18) will be required to provide proof of immunity to Measles, Mumps and Rubella. A valid vaccination record showing two MMR vaccinations or blood work that shows immunity evidences proof.**

**Parent or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I give my permission for to become a teen volunteer at Skagit Regional Health.

I give my permission for the required tuberculosis test as required by Skagit Regional Health. If my son/daughter reacts positive to the test, I give my permission to conduct a chest x-ray at no charge.

I also give my permission for any necessary treatment to be given in the event of illness or injury.

In the event of illness, injury, or emergency, please contact:

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

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

I have read the volunteer requirements. I agree to support my son/daughter in meeting these requirements.

Signature of parent/guardian: Date:

DISCLOSURE STATEMENT

Pursuant to the requirements of RCW 43.43.830.840, we must ask you to complete the following disclosure statement. This information will be kept confidential.

**Have you EVER been convicted of any of the following crimes against children or other persons (including juvenile offenses) or, any of these crimes as they may have been renamed?**

|  |  |
| --- | --- |
| YES NO Aggravated Murder Arson 1st degree Assault in 1st degree Assault in 2nd degree Assault in 3rd degree Assault in 4th degree Burglary 1st degree Child abandonment Child abuse or neglect as defined in RCW 26.44.020 Child buying or selling Child molestation 1st degree Child molestation 2nd degree Child molestation 3rd degree Communication with a minor for immoral purposes Criminal abandonment Criminal mistreatment 1st degree Criminal mistreatment 2nd degree Custodial assault Custodial interference 1st degree Custodial interference 2nd degree Extortion 1st degree Extortion 2nd degree Extortion 3rd degree Felony indecent exposure Forgery (5 or more years) Incest Indecent liberties Kidnapping 1st degree Kidnapping 2nd degree | YES NO Malicious harassment Manslaughter 1st degree Manslaughter 2nd degree Murder 1st degree Murder 2nd degree Patronizing a juvenile prostitute Promoting pornography Promoting prostitution 1st degree Prostitution (3 or more years) Rape 1st degree Rape 2nd degree Rape 3rd degree Rape of a child 1st degree Rape of a child 2nd degree Rape of a child 3rd degree Robbery 1st degree Robbery 2nd degree Selling or distributing erotic material to a minor Sexual exploitation of minors Sexual misconduct with a minor 1st degree Sexual misconduct with a minor 2nd degree Theft 1st degree Theft 2nd degree (5 or more years) Theft 3rd degree (3 or more years) Unlawful imprisonment Vehicular homicide (negligent  homicide) Violation of a child abuse restraining order |

**If your answer is “yes” to any of the above, please describe and provide the date(s) of the conviction(s) and sentence(s) imposed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been convicted of the following crimes relating to financial exploitation of a person 60 years of age or older, who has a functional, mental, or physical inability to care for him/herself or is a patient in a state hospital:**

|  |  |
| --- | --- |
| YES NO 1st, 2nd, or 3rd degree extortion 1st or 2nd degree robbery 1st, 2nd, or 3rd degree theft | YES NO1. Forgery

 Or any of these crimes as they may have been renamed |

**If your answer is “yes” to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor? YES NO

2. Have you ever been found in a court in a domestic relations proceeding to have physically abused or exploited any minor? YES NO

3. Have you ever been found in a court in a domestic relations proceeding to have physically abused or exploited any developmentally disabled person? YES NO

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited any person 60 years of age or older who has a functional, mental, or physical inability to care for him/herself or who is a patient in a state hospital? YES NO

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability to care for him/herself or who is a patient in a state hospital? YES NO

If your answer is “yes” to any of questions 1 through 5 above, please describe and provide the date(s) of the finding(s) and the penalty(ies) imposed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am placed I can be discharged for any misrepresentation or omission in the above statement. I also understand that if I am placed my service is conditioned on your receipt of a satisfactory report from the Washington Sate Patrol.

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

# Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of criminal convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. If you are placed before that report is available, YOUR SERVICE WILL BE CONDITIONED UPON THE RECEIPT OF A SATISFACTORY REPORT.

**You will be notified of the State Patrol’s response within ten days after we receive the report. We will make a copy of the report available to you upon your request.**

|  |
| --- |
| **REFERENCE FORM****Skagit Regional Health’s Vision: *“****Each of us will contribute to making Skagit Regional Health the best regional integrated health system in the Northwest, dedicated to understanding and exceeding our patients’ expectations.”* |

Our volunteers play a large role in delivering quality services by providing a variety of patient services. Our volunteers must possess self-motivation and maturity. We appreciate your completing this form so that we may make a decision on the applicant’s ability to fulfill the responsibilities involved in our volunteer program.

Applicant’s name:

How long have you known the applicant?

In what capacity have you known the applicant?

Please evaluate the applicant in the following areas:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Outstanding | Very Good | Fair | Needs Improvement |
| 1. Displays courtesy, tact, and patience.
 |  |  |  |  |
| 1. Works well with a diverse population.
 |  |  |  |  |
| 1. Exhibits interest and enthusiasm for a volunteer position.
 |  |  |  |  |
| 1. Accepts supervision in a positive way.
 |  |  |  |  |
| 1. Seeks opportunity to improve and advance.
 |  |  |  |  |
| 1. Accepts responsibility and commitment.
 |  |  |  |  |
| 1. Is dependable and punctual.
 |  |  |  |  |

Other comments:

Signature: Date:

Printed name: Phone:

Address:

|  |
| --- |
|  **REFERENCE FORM****Skagit Regional Health’s Vision: *“****Each of us will contribute to making Skagit Regional Health the best regional integrated health system in the Northwest, dedicated to understanding and exceeding our patients’ expectations.”* |

Our volunteers play a large role in delivering quality services by providing a variety of patient services. Our volunteers must possess self-motivation and maturity. We appreciate your completing this form so that we may make a decision on the applicant’s ability to fulfill the responsibilities involved in our volunteer program.

Applicant’s name:

How long have you known the applicant?

In what capacity have you known the applicant?

Please evaluate the applicant in the following areas:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Outstanding | Very Good | Fair | Needs Improvement |
| 1. Displays courtesy, tact, and patience.
 |  |  |  |  |
| 1. Works well with a diverse population.
 |  |  |  |  |
| 1. Exhibits interest and enthusiasm for a volunteer position.
 |  |  |  |  |
| 1. Accepts supervision in a positive way.
 |  |  |  |  |
| 1. Seeks opportunity to improve and advance.
 |  |  |  |  |
| 1. Accepts responsibility and commitment.
 |  |  |  |  |
| 1. Is dependable and punctual.
 |  |  |  |  |

Other comments:

Signature: Date:

Printed name: Phone:

Address:

SKAGIT REGIONAL HEALTH/CASCADE VALLEY HOSPITAL

EMPLOYEE HEALTH SERVICES

VOLUNTEER HEALTH QUESTIONAIRE

|  |  |
| --- | --- |
| Name | **Last Name First Name Middle** |
| Address | **Address City Zip Code** |
| Date of Birth |  |
| Home Phone |  |
| Social Security Number | **ONLY last four digits \_\_ \_\_ \_\_ \_\_** |

 Allergies and Sensitivities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Food, Medicine, Environmental etc**

Tuberculosis

**Date of most recent TB skin test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of taking BCG\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of positive TB skin test?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Medication?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date of most recent Chest X-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle if you have had any of the following symptoms which were unexplained in the last year:**

 **Fever, Cough, Bloody Sputum, Weakness, Loss of Appetite, Night Sweats, Weight Loss, Fatigue**

Dermatological Conditions

 **Are you allergic to latex?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Do you have skin conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Immune System Y/N

**\_\_\_\_ Spleenectomy**

**\_\_\_\_ Kidney, heart, lung, bone marrow or pancreas transplant**

**\_\_\_\_ Currently taking Steroid medication**

**\_\_\_\_ Current or recent chemotherapy or radiation therapy**

**\_\_\_\_ HIV Infection**

Health History Y/N

 **\_\_\_\_ Asthma/Wheezing/Chronic Respiratory Problems**

 **\_\_\_\_ Blurred Vision/Vision Problems**

 **\_\_\_\_ Carpal Tunnel**

 **\_\_\_\_ Chest Pain**

 **\_\_\_\_ Closed Head Injury**

 **\_\_\_\_ Depression/mental health problems/psychiatric problems**

 **\_\_\_\_ Diabetes**

 **\_\_\_\_ Fainting Spells/Dizziness**

 **\_\_\_\_ Eczema/Skin Problems**

 **\_\_\_\_ Frequent headaches**

 **\_\_\_\_ Hearing Loss/Hearing Problems**

 **\_\_\_\_ Heart Problems**

 **\_\_\_\_ Hepatitis**

 **Type A\_\_Type B\_\_Type C\_\_**

 **\_\_\_\_ Liver Problems**

 **\_\_\_\_ Loss of Memory/Difficulty with Mental Functioning**

 **\_\_\_\_ Numbness**

 **\_\_\_\_ Oral Herpes/Cold Sores**

 **\_\_\_\_ Weakness**

 **\_\_\_\_ Seizures/Loss of consciousness**

 **\_\_\_\_ Tendonitis**

 **\_\_\_\_ Tuberculosis**

**Employee Health Services Health Questionnaire pg. 2**

|  |
| --- |
| **Current Medications or treatments:** |
| **Current medical problems/chronic illness not listed above:** |
| **Surgeries:** |

|  |
| --- |
| Neck/Back/Shoulder Assessment Y/N |
|  | **Do you have neck, back or shoulder pain?** |
|  | **Do you have chronic pain in your back or neck or shoulders?** |
|  | **Have you seen a physician, chiropractor or therapist for these problems in the last two years?** |
|  | **Have you ever had restrictions on your work due to these problems? If yes what were they?** |
|  | **Do you have any current restrictions or limitations?** |
| Arm Wrist Hand Assessment Y/N |
|  | **Do you have arm, wrist or hand pain?** |
|  | **Do you have chronic pain in your arms, wrists or hands?** |
|  | **Have you seen a physician, chiropractor or therapist for these problems in the last two years?** |
|  | **Have you ever had restrictions on your work due to these problems? If yes, what were they?** |
|  | **Do you have any current restrictions or limitations?** |

|  |
| --- |
| Immunity Profile |
| Tetanus **Date of last tetanus booster Tdap?** |
| MMR and Varicella **MMR Vaccine #1 Date: \_\_\_\_\_\_\_\_ Vaccine #2 Date \_\_\_\_\_\_\_\_**  **Varicella Vaccine #1 Date: \_\_\_\_\_\_\_\_ Vaccine #2 Date \_\_\_\_\_\_\_\_** **Laboratory Confirmation of Immunity Rubella \_\_\_\_ Rubeola \_\_\_\_ Mumps \_\_\_\_ Varicella** \_\_\_\_ |
| Hepatitis B  **Vaccine #1 \_\_\_\_ Vaccine #2 \_\_\_\_ Vaccine #3 \_\_\_\_** **Hepatitis B antibody test date\_\_\_\_ Result \_\_\_\_** |
| Hepatitis A **Vaccine #1 \_\_\_\_ Vaccine #2 \_\_\_\_** |

HEPATITIS B ELECTION AND DECLINATION STATEMENT:

**I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself.**

 **\_\_\_\_I elect to receive the Hepatitis B vaccine. I will contact the Employee Health**

**Service at my convenience to have it administered within the next 10 days.**

**\_\_\_\_ I decline Hepatitis B vaccine at this time due to having completed the series**.

**Patient Care Staff (Nursing, PT, OT, RT, etc.) and others with exposure opportunities:**

**\_\_\_\_ I decline hepatitis B vaccine at this time. I understand that by declining this**

**vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receivethe vaccination series at no charge to me.**

**Staff without expected exposure opportunities:**

**\_\_\_\_ I decline hepatitis B vaccine at this time. If in the future I have occupational**

**exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series *at no charge* to me.**

***Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***07-20-10***