

New Milford Hospital

AFFILIATED WITH DANBURY HOSPITAL

21 Elm Street New Milford, CT 06776 Phone: 860-210-5287 Email: catherine.gabianelli@wchn.org

Date:					
CONT	TACT INFORMATI	ON:			
Name	:				
Home	Address:				
Email	Address:				
Home	Phone:	Cell	#:		
Please What t	LABILITY: Circle Day(s) of the vitime of day you are av Year Round	railable to volunteer	r	a.m	
1.	KGROUND: Have you ever been What is your highest		•		
	LS/QUALIFICATIO Please list any comp		ng you have comp	oleted:	
4.	Do you have a partic	ular area you are in	iterested in volun	teering at the hospit	tal?

5. Other volunteer activities in which you have participated (present or past):							
EMERGENCY CONTACT:							
Emergency Contact:	Relationship:						
Emergency Contact's Home Phone #	Cell #						
JUNIOR VOLUNTEER PROGRAM (age 16-1) Junior Volunteer (16 - 18 years of age)	YesNo						
Student Status:							
School Attending & last year completed:							
SIGNATURES (required):							
Volunteer Signature:	Date:						
**Parent/Gaurdian Signature: ** (All JR Volunteers Ages 16 – 18 – "MUST" have a	Date: Parent/Guardian Signature Granting Permission to Volunteer).						
	RVIEW WITH THE DIRECTOR OF VOLUNTEER PLETE THE APPLICATION PROCESS						
I understand that my placement as a volunteer is dependent upon satisfactory completion of the application, interview and orientation process, and training for the volunteer position to which I will be assigned. I hereby give New Milford Hospital my permission to contact the individual(s) whose name is provided as a reference above. I understand that I am expected to inform the Director of Volunteer Services of any significant change in my health status that would negatively impact my ability to perform the tasks to which I am assigned. I also understand that any falsification of the statements provided in this application will result in the cancellation of my application or discharge from the hospital service if I have already been placed.							

PERSONAL REFERENCE(s	s) (please list two not related to	you):
Name		
Address		
Daytime Phone #		
Name		
Address		
Daytime Phone #		
How did you hear of the opportunity?	e volunteer	
2. Do You Have Friends of YES or NO	or Relatives Employed or Volur	nteering at New Milford Hospital?
If yes, please indicate n	name, relationship and depart	tment:
**********	*********	*******
POST ACCEPTANCE INFORM FOR COMPLETION BY DIRECTOR		
Assignment:	Days:	Times:

INFECTION CONTROL/EMPLOYEE HEALTH

Volunteer Health Screening Consent Form

Name of Volunteer:	
Please Print	
Signature:	
Date of Birth:	

All volunteers, especially those who work in patient contact areas of the Hospital, may be put at risk of exposure to infectious disease. For this reason, we consider volunteers as employees of the Hospital in regard to certain requirements of Infection Control and Employee Health Programs.

All volunteers are required to complete self-learning modules prior to the start of their service. Important information concerning Infection Control and Employee Health is contained in these modules. In addition, Employee Health Programs will be given annually on OSHA Standards, including blood borne diseases, AIDS and Hepatitis B, the pulmonary disease Tuberculosis and Standard Precautions. Attendance is required for all employees and volunteers who work in patient contact areas.

Our policy on Tuberculosis screening requires all employees and volunteers to have TB skin testing done upon joining the Volunteer Services Program (some high risk volunteers are tested more frequently). TB skin testing will only be done on those with negative results in the past. Any exemptions from skin testing or medical evidence of recent skin testing (within three months) must be documented by a physician and sent to the Employee Health Coordinator.

The hospital also offers vaccination against the blood borne virus infection, Hepatitis B, free of charge to volunteers who work in patient care areas. A blood test to determine immunity is done prior to offering the vaccine and one month after completion of the Hepatitis B vaccine series. Parental consent is necessary for all health screenings and/or vaccinations of those volunteers under the age of 18 years. Please read the reverse side of this form and sign the appropriate consents. The signed consent form should be presented to the Employee Health Coordinator prior to receiving any screening.

Any questions are to be directed to Judy Pilch, RN, Employee Health Coordinator at ext,5286.

See Next Page for Required Parental Consent Signatures for Volunteers under the age of 18.

Parental Consent(s)

I grant permission for my son/daughter to receive the TB skin testing.

Signature/Date

I grant permission for my son/daughter to receive the Hepatitis B vaccine and the associated blood testing for immunity.

Signature/Date

Refusal of Parental Consent for Hepatitis B

I understand that due to my son/daughter's possible occupational exposure to blood or other potentially infectious materials, he/she may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity for my child to be vaccinated with Hepatitis B vaccine at no charge to myself. However, I decline for my child to receive the Hepatitis B vaccination at this time. I understand that by declining this vaccine, my son/daughter may continue to be at risk of acquiring Hepatitis B, a serious disease, If, in the future, my son/daughter continues to have possible occupational exposure to blood or other potentially infectious materials and I want him/her to be vaccinated with Hepatitis B vaccine, I can have my son/daughter receive the vaccination series at no charge to me.

Parent/Guardian Signature/Date

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