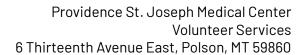


Providence St. Joseph Medical Center Volunteer Services 6 Thirteenth Avenue East, Polson, MT 59860

### **VOLUNTEER APPLICATION**

Name:	 Middle	 Last
Previous last name(s):	Other first name(s): _	
Address:		
Street or Mailing Address	City	State Zip Code
Phone:Circle one: Cell / Home	Email address:	
Date of birth: mm/dd/yyyy	Social Security Number:	
	Joseph Medical Center to initiate a requi and date of birth supplied above.	red background check using
Emergency Contact: Name	Phone Number	Relationship
Please describe special skills, ed	lucation, experience, interests, and h	obbies:
	ning a volunteer with Providence St. J	
Are you interested in a specific s	ervice or hospital department?	
	ol & Year:	
	Su M Tu W Th F Sa ☐ Morni	
Name	Phone Number	Title/Relationship
Reference 2: Name	Phone Number	Title/Relationship
Applicant Signature		 Date

Please return completed form to Anna Steinhoff: <a href="mailto:anna.steinhoff@providence.org">anna.steinhoff@providence.org</a>; 406.883.8933.





### **VOLUNTEER APPLICATION**

First	Middle	Last			
	ADMINISTRATIVE USE ONLY				
Photo Identification Verification (to be completed by Volunteer Services Staff only):					
Document Title	 Document Number	 Expiration Date			
Lattest that I have examine	ed the document presented by the above name	ed applicant. The above-listed			
	enuine and to relate to the applicant named.	а арриовии инс восто песов			
Staff Signature		Date			
Additional Forms:					
Disclosure & Authoriza	ation Other Disclosures				
Additional Requirements:					
•	· _Orientation Badge HIPAA Dress (	Code			
2 TB Tests MMR	·				

Please return completed form to Anna Steinhoff: <a href="mailto:anna.steinhoff@providence.org">anna.steinhoff@providence.org</a>; 406.883.8933.



Providence St. Joseph Medical Center Volunteer Services 6 Thirteenth Avenue East, Polson, MT 59860

# **Parental Consent**

Student's Name:	Date
Parental Consent if volunteer is less t	han 18 years of age.
I hereby grant permission for my child to participate in Volunteer Program. I further release the Hospital from act, or incidents involving my child's participation in the	any legal or other responsibilities for any injuries,
Parent name (printed)	
Parent Signature:	

After you have completed the paperwork, please contact Caregiver Health to set-up an appointment for your volunteer immunization & health check. This is required before you can begin volunteering.

A parent or legal guardian must accompany the new hire candidate to their health screen appointment if they are under 18 years of age.

#### **Immunization and Titer records**

Please bring as much documentation as possible regarding the tests and immunizations listed below. This will prevent the duplication of testing and/or vaccinations. If you do not have documentation, the tests or vaccines can be provided free of charge.

#### Tuberculosis screening -

- We will accept laboratory documentation of a current (within the last 90 days)
   Interferon Gamma Release Assay (IGRA), which is a blood test for TB, Quantiferon TB
   Gold or T Spot.
- Positive TB history (TST or IGRA), please bring: Positive test result, chest X-Ray report, documentation of any treatment regimen, and/or any medical provider records.

Measles, Mumps, and Rubella (MMR) – Documentation of two MMR vaccines at least 4 weeks apart and after one year of age and/or positive laboratory titers. (Rubella is required in Alaska)

**Chickenpox (Varicella)** – Documentation of two Varicella vaccines 4 weeks apart and after one year of age and/or positive titer

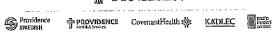
**Hepatitis B (Hep B)** – Documentation of completed vaccine series (either the 2-dose or 3-dose versions) and a positive laboratory titer or signed declination in applicable states. (Hepatitis B vaccination is required in Alaska).

**Tetanus, Diphtheria and Pertussis (Tdap)** – Documentation of vaccination or signed declination of vaccine

Annual Influenza vaccine – Documentation of acceptance or signed declination of the vaccine

**COVID-19 vaccine** – Documentation of all Covid-19 vaccinations received.

**Caregiver Health:** Call Cindy Hagen at 406-883-7488 to set-up an appointment. Testing is free of charge from Caregiver Health for Volunteers at St. Joseph Medical Center, 6 Thirteenth Ave East, Polson, MT 59860.











#### TB RISK ASSESSMENT AND SYMPTOM SCREENING QUESTIONNAIRE

Name	e: Preferred Name:					
	Last First Middle					
Date	of Birth: Caregiver ID #:					
Dept:		Phone #:				
	aregiver/Applicant   Volunteer   Other:					
	YOU HAVE SYMPTOMS OF		If yes, please explain			
1.	Persistent and/or productive cough for more than three weeks? (Exceptions: Cou	gh □Yes □No				
	due to asthma, allergies, COPD, or residual cough from recent Covid-19 infectior	i)				
2.	Cough for more than one week following confirmed TB exposure?	□Yes □ No	□ N/A			
3.	Prolonged low-grade fever (98.9) associated with cough for more than 1 week?	□Yes □ No				
4.	Blood present in sputum?	☐Yes ☐ No				
5.	Unexplained night sweats (unrelated to menopause)?	□ Yes □ No				
6.	Unusual fatigue for more than two weeks?	□Yes □ No				
7.	Loss of appetite for more than two weeks?	□Yes □ No				
8.	Unexplained weight loss of five pounds or more?	□Yes □ No				
9.	Do you have unexplained shortness of breath lasting more than two weeks?	☐ Yes ☐ No				
10.	Do you have unexplained pain in your chest lasting more than two weeks?	☐ Yes ☐ No				
11.	Do you have unexplained hoarseness lasting more than two weeks?	□Yes □ No				
CUI	RRENT HEALTH STATUS		If yes, please explain			
12.	Do you have an acute viral infection or febrile illness?	□ Yes □ No				
13.	Have you had a live-virus vaccine in the past four weeks?	□ Yes □ No				
14.	Are you on or planning to begin immunosuppressive therapy or treatment for:	□Yes □ No				
	diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipie	nt,				
	undergoing radiation therapy, chemotherapy, treatment with a TNF-alpha					
	antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of					
	prednisone >15 mg/day for >1 month) or other immunosuppression medication? (	*)				
HIS	TORY		If yes, please explain			
15.	Have you lived or visited (more than one month) in a country with a high TB rate?	Yes □ No	'			
]	(Any country other than the United States, Canada, Australia, New Zealand					
	and those in northern Europe or Western Europe). (*)	ش 	•			
16.	Have you had unprotected close contact with someone who has had infectious T	B □Yes □No	Relationship:			
ĺ	disease during your lifetime or since your last TB test? (*) (Exception: Not					
	including any close exposure in the last 8 weeks)					
17.	Have you received the BCG vaccination?	□Yes □ No				
18.	Have you ever had a positive TB skin or blood test?	□Yes □ No	Date:			
	Have you had a chest x-ray related to TB?	□Yes □ No	Date:			
20.	Have you ever been treated with TB medications?	□Yes □ No				
Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.						
To my knowledge, the above information is correct. I consent for an IGRA (TB) blood test, and/or chest x-ray, if applicable.  ELECTRONIC SIGNATURE ACKNOWLEDGMENT AND CONSENT FORM						
1	, agree and understand that by signing the Ele	ectronic Signature Ackr	nowledgment and Consent Form.			
that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.						
For Clinic Use Only						
(*) Risks: if any one question is marked yes, refer back to TB algorithm.  (i) Any questions 1-11 marked positive refer to TBQ Scoring Grid Standard Work.						
Caregiver Health Nurse Review: Based on current TB algorithm, I have reviewed the above and recommend:  ☐ IGRA ☐ TST ☐ Symptom review only						
Care	giver Health Nurse Name (Printed): Signature:	·	Date:			



# imMTrax Consent Form for Adults

Name:	Sex: M	F	Date of Birth:				
I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.							
Signature:							
Date:			27				

Revised 10/2017 AD