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

VOLUNTEER APPLICATION

Name: _____
First Middle Last

Previous last name(s): _____ Other first name(s): _____

Address: _____
Street or Mailing Address City State Zip Code

Phone: _____ Email address: _____
Circle one: Cell / Home

Date of birth: _____ Social Security Number: _____
mm/dd/yyyy

_____ I authorize Providence St. Joseph Medical Center to initiate a required background check using
initial my social security number and date of birth supplied above.

Emergency Contact: _____
Name Phone Number Relationship

Please describe special skills, education, experience, interests, and hobbies:

_____

_____

Why are you interested in becoming a volunteer with Providence St. Joseph Medical Center?

_____

Are you interested in a specific service or hospital department? _____

Are you a student? Y / N School & Year: _____ Major: _____

Please circle preferred hours: Su M Tu W Th F Sa ☐ Morning ☐ Afternoon ☐ Evening

Reference 1: _____
Name Phone Number Title/Relationship

Reference 2: _____
Name Phone Number Title/Relationship

_____
Applicant Signature Date

Please return completed form to Anna Steinhoff: anna.steinhoff@providence.org; 406.883.8933.

revised JUN-2024

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Name: _____
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ADMINISTRATIVE USE ONLY

Photo Identification Verification (to be completed by Volunteer Services Staff only):

_____
Document Title Document Number Expiration Date

I attest that I have examined the document presented by the above named applicant. The above-listed document appears to be genuine and to relate to the applicant named.

_____
Staff Signature Date

Additional Forms:

___ Disclosure & Authorization ___ Other Disclosures

Additional Requirements:

___ Background Check ___Orientation ___ Badge ___ HIPAA ___ Dress Code

___ 2 TB Tests ___ MMR ___ Flu ___ OIG

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Parental Consent

Student's Name:_____ Date_____

Parental Consent if volunteer is less than 18 years of age.

I hereby grant permission for my child to participate in the Providence St. Joseph Medical Center Volunteer Program. I further release the Hospital from any legal or other responsibilities for any injuries, act, or incidents involving my child's participation in the volunteer program.

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.

Providence

Providence SWEDISH | PROVIDENCE Health Services | CovenantHealth | KADLEC | Providence Medical Institute

TB RISK ASSESSMENT AND SYMPTOM SCREENING QUESTIONNAIRE

Name: _____ Preferred Name: _____
Last First Middle

Date of Birth: _____ Caregiver ID #: _____

Dept: _____ Home/Cell Phone #: _____

☐Caregiver/Applicant ☐Volunteer ☐Other: _____

DO YOU HAVE SYMPTOMS OF		If yes, please explain
1. Persistent and/or productive cough for more than three weeks? (Exceptions: Cough due to asthma, allergies, COPD, or residual cough from recent Covid-19 infection)	☐Yes ☐ No	
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	
CURRENT 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: diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipient, 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? (*)	☐Yes ☐ No	
HISTORY		**If yes, please explain**
15. Have you lived or visited (more than one month) in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand and those in northern Europe or Western Europe). (*)	☐Yes ☐ No	
16. Have you had unprotected close contact with someone who has had infectious TB disease during your lifetime or since your last TB test? (*) (Exception: Not including any close exposure in the last 8 weeks)	☐Yes ☐ No	Relationship:
17. Have you received the BCG vaccination?	☐Yes ☐ No	
18. Have you ever had a positive TB skin or blood test?	☐Yes ☐ No	Date:
19. 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

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment 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.

Applicant/Caregiver Signature: _____ **Date:** _____

For Clinic Use Only

(*) Risks: if any one question is marked yes, refer back to TB algorithm.

(!) **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

Caregiver Health Nurse Name (Printed): _____ Signature: _____ Date: _____

4/25/2024

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:_____

Revised 10/2017 AD