VOLUNTEER APPLICATION

Name ____________________ Date of Birth ___________________ SS # ______________________________

Address ____________________ City ______________ State _______ Zip ______________________________

Home Phone ___________________ Work ___________________ Cell ______________________________

E-Mail Address ____

Education (circle highest completed) High School: 1 2 3 4 College: 1 2 3 4 Graduate: 1 2 3 4

If you are currently a student, where are you enrolled? ______________________________

Have you previously volunteered at Weiss? ____ Yes ____ No If yes, dates: _____/_____ to _____/_____

Do you speak a language other than English? If, so, which language? ______________________

Emergency Contact ____

Name Relationship Telephone #

Days & Hours you would like to volunteer:

	SUN	MON	TUES	WED	THURS	FRI	SAT
AM							
PM							

Volunteer Experience

Name of Agency	Dates	Duties

Work Experience

Name of Employer	Dates	Title/Duties

Have you ever pleaded guilty to or been convicted of a misdemeanor or felony? Yes ____ No ____

If yes, please explain: ____

Please list two references, including their mailing addresses and telephone numbers:

1. ____

2. ____

Signature ____ Date _____/_____/_____

Parent/Guardian Signature (if under 18) ______________________________ Date _____/_____/_____

For office use only:

ID Badge _____ HIPAA _____

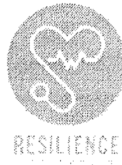
Corporate Compliance _____

Background Check _____ Jacket _____

Influenza Vaccine _________ TB Test _________

Placement ____________________

Duration ____________________



Employee Health Requirements for Resilience Healthcare Volunteers

PLEASE BRING YOUR IMMUNIZATION RECORD WITH YOU TO YOUR SCREENING (childhood record).

If you are unable to locate your copy you can obtain this from your high school. In the state of Illinois these records must be kept for 30 years after graduation. Providing this information will facilitate your screening process with Employee Health and allow you to attend your scheduled orientation.

* If you have worked/volunteered in healthcare before or been in school studying something in the healthcare field, your current/previous employer/school/place of volunteering will have this information. Please request this information promptly so that you can bring it with you to your health screening.

THE FOLLOWING ARE REQUIRED TO BE CLEARED PRIOR TO ATTENDING NEW VOLUNTEER ORIENTATION

TB: A 2-Step TB screening/Quantiferon is required. If you have received a TB test within one year of your screening, this can be accepted as step one.

If you have a history of a positive TB skin test, documentation of the positive reading is required and a copy of your most recent chest x-ray. If you took medication, please bring those records as well.

Rubella, Rubeola and Mumps required: proof of immunity in one of the following:

- immunity by titer
- proof of 2 MMR vaccines
  (If you do not have these, testing by blood draw will be provided at the screening; if you haven't been fully immunized this will be done at the screening if you are 18 years or older.

Varicella (chicken pox) required: proof of immunity in one of the following:

- immunity by titer
- proof of 2 Varicella vaccines
  (If you do not have either of these, testing by blood draw will be provided at the screening; if you are incompletely immunized, this will be done at the screening if you are 18 years or older.

WEISS

RESILIENCE

West Suburban Medical Center

Hepatitis B: documentation is required in the following ways:

- proof of vaccination with 3 doses of Hepatitis B vaccine. This information will be on your immunization record. This series of shots has been mandatory in the Illinois public school systems since 1997-if you attended an Illinois public school in 1997 or later, they will have proof of your vaccination.
- Positive hepatitis B Antibody titer*
- If you refuse vaccination you will be required to sign a declination form.

** Please note, new guidelines from the CDC state "health care personnel lacking documentation of Hepatitis B vaccination should be considered unvaccinated or incompletely vaccinated and should receive additional doses to complete a documented Hepatitis B series". Even if you have a positive titer for Hep B, you should attempt to locate documentation of the Hepatitis B vaccines that you received. If you are unable to locate this, based upon the CDC statement above, you should be vaccinated to complete a documented Hepatitis B series. The Hepatitis B vaccines are available to you,* ***free of charge****, in Employee Health if you are 18 years or older.*

TDaP vaccine: if you have not received a TDaP vaccine since the age of 18, this will be given at the screening if you are 18 years or older. If you have received one already, you must bring proof of immunization with you to your screening.

Flu vaccine: required annually. If you have been vaccinated elsewhere bring documentation with to your screening. If you have not received a current seasonal flu vaccine one will be administered at the volunteer screening if you are 18 years or older (approximately/seasonally September 1-April 1, subject to availability of vaccine)

NOTE: WE DO NOT VACCINATE VOLUNTEERS UNDER THE AGE OF 18. IT WILL BE YOUR RESPONSIBILITY TO RECEIVE ALL REQUIRED IMMUNIZATIONS FROM YOUR MD, CVS, WALGREENS, ETC.

You will not be cleared to begin volunteering until all requirements have been met.

IMMUNIZATION INFORMATION FORM
RESILIENCE HEALTHCARE

Name: ______________________________
Email Address: ______________________
Date of Birth: ______________________ Department: ______________________

Requirements must be met no later than two weeks prior to start date.

Resilience Healthcare requires students to show proof of surveillance for **Tuberculosis infection within 3 months** of their scheduled clinical rotation and proof of immunization against **Measles, Mumps, Rubella, Varicella, Hepatitis B*, and Tetanus, Diphtheria & Pertussis (TDAP Vaccine)**, including tithers. **Proof of annual influenza immunization is required for rotations between November 1 and April 30**. A healthcare professional must verify all information on this form and date and sign it in the space provided at the bottom. ** *Records of vaccines, titers, and Tuberculosis screenings must be attached to this form to meet the requirements.*

	Live attenuated virus vaccine dates	OR	Seroiogy date (attach copy of titer results)	OR	EXEMPTION
MEASLES (RUBEOLA)	DOSE 1 ______ DOSE 2 ______		______		______
MUMPS	DOSE 1 ______ DOSE 2 ______		______		______
RUBELLA	DOSE 1 ______ DOSE 2 ______		______		______
TDAP	DOSE 1 ______ (recommended to be within last 10 years)				______
CHICKEN POX (VARICELLA)	DOSE 1 ______ DOSE 2 ______		______		______

TB SCREEN *(Within past 3 months* 2 STEP PPD/ QUANTIFERON)	(1) DATE ______ INDURATION ____ MM (2) DATE ______ INDURATION ____ MM OR QUANTIFERON RESULT: ______	AND	if positive or history of positive test *Chest X-RAY* within past 3 months Attach Report ______

HEPATITIS B	VACCINE SERIES DOSE 1 ______ DOSE 2 ______ DOSE 3 ______	&	HEPATITIS B SURFACE ANTIBODY TITER ______	OR	EXEMPTION ______

*Hepatitis B antibody titer is *recommended* for proof of immunity.

SEASONAL FLU VACCINE If your rotation will be between the dates *November 1 and April 30*, please attach a copy of the documentation verifying your receipt of the seasonal flu vaccine.

Signature of Healthcare Provider verifying above information: ______________________
Print Name: ______________________
Address: ______________________ Date: ______________
______________________ Phone: ______________
____

Communicable Disease Questionnaire Form

Name: ______________________ Date of Birth: __________ Department/Ext ______________

Home/Cell Phone Number: ________________ Home e-mail: ________________________

Signs & Symptoms of Tuberculosis

□ Yes □ No Have you lost unexplainable weight in the last 6 months without dieting?
If yes, how much? ________

□ Yes □ No Are you experiencing a loss of appetite? If yes, for how long? ______________

□ Yes □ No Do you, on a regular basis, have unexplainable night sweats or wake up with the sheets wet from sweating? If yes, for how long ________________

□ Yes □ No Do you have a frequent persistent cough? If yes, for how long? ______________

□ Yes □ No Are you bothered by being tired all the time? If yes, for how long? ___________

□ Yes □ No Are you bothered by shortness of breath? If yes, for how long? ______________

□ Yes □ No Do you cough up blood? If yes, for how long? _________________________

□ Yes □ No Have you been having increased temperature (unexplained fevers)? If yes, for how long? ___________

History

□ Yes □ No Have you ever taken medication (prophylaxis) for TB? If yes, please provide details (i.e., name of medication, length of treatment): ____________________________

□ Yes □ No Have you ever had a positive TB Skin or blood test? If yes, year: _____________

□ Yes □ No Have you ever been diagnosed with TB disease? If yes, year: ________________

□ Yes □ No Have you ever had a chest x-ray due to testing positive for latent or active TB? If yes, when? ___________

□ Yes □ No Have you ever received the BCG vaccine?

Travel History

□ Yes □ No Were you born in the US? If no, where? ______________
When did you come to the US? ________

□ Yes □ No In the past 12 weeks, have you traveled outside of the United States?
If YES, please tell us where you went and when: ____________________

□ Yes □ No Within the past 21 days, have you traveled to/from an area where Ebola is known to be active? (Guinea, Liberia, Sierre Leone or Mali)

□ Yes □ No Have you been in contact with *anyone* that has traveled out of the country in the past 21 days? If YES, where did that person travel to? ________________

□ Yes □ No Do you have any of the following symptoms: Fever, Severe headache, Muscle pain, Vomiting, Diarrhea, Abdominal pain, Any unusual bleeding?

I understand if I should experience any of the signs & symptoms of Tuberculosis above or any communicable disease at any time during the year, I will contact Employee Health immediately.

Signature: ___________________________ Date: __________________

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name__________ Full Middle Name__________ Last Name__________

Mailing Address__________ City__________ State____ Zip Code ________

Other Names Used __________ Telephone__________

States Where You Have Lived? __________

○ Male ○ Female Race____ Height 5 ' 0 " Weight____ lbs Date of Birth________ Social Security Number ☐☐☐-☐☐-☐☐☐☐
(Enter a letter from below)

Hair Color________ Eye Color________ City/State of Birth __________

Race		
	A	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ◯ Yes ◯ No
If "Yes," give full details and state.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ◯ Yes ◯ No If "Yes," give full details of each offense and the state in which convicted.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

*** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED***

PRINT

CLEAR FORM