WITHAM HEALTH SERVICES

Volunteer Organization Application to Volunteer

Delivering Care, Saving Lives, and Healing

Name: (Please print) Last First Middle Initial

Date: / /

Since 1974 the Volunteer Organization has touched the lives of Witham Health Services customers.

When you give of yourself to help others, you make a difference.

Witham Health Services Volunteers

Make a difference!

We believe in our core values:

- Quality
- Caring
- Respect
- Integrity
- Commitment
- Dedication
- Confidentiality
- Financial Viability

Vision

Our vision is to be a vital and caring community hospital responding to the changing health care environment, as well as the diverse and changing needs of our growing community. We are committed to high quality care and continual learning and improvement. Our interactions with each other, our patients, and their families are characterized by mutual respect, honesty, integrity, and trust.

Please refer further questions to:

Volunteer Department
2605 N. Lebanon Street
Lebanon, IN 46052
Phone: 765-485-8175
www.witham.org

Our Mission, Our Community Role, Our Passion

Name: _____ Birthday: _____
First *Middle Initial* *Last*

Address: _____ City: _____ Zip: _____

Social Security # _____ Phone: _____

Email Address: _____

Employed or retired: _____ If employed, name of employer: _____

Have you previously been employed by Witham? ☐ Yes ☐ No

If yes, which departments: _____

Skills (e.g., typing, creative, musical, mathematical, etc.): _____

Previous volunteer experience/training: _____

Have you ever plead "guilty" or "no contest" to, or been convicted of a crime? ☐ Yes ☐ No

If yes, explain: _____

(Any Witham Health Services Volunteer position is subject to criminal background checks which include felonies and misdemeanors.)

Do you have any pending criminal charges? ☐ Yes ☐ No

List two (2) professional references:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

List two (2) personal references:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

If you are under 18, parental permission will be required for health screen and TB testing and will require parental signature. Refer to the Consent for Health Screening Exam Form that is included with this application packet.

Please check all areas you are interested in working:

☐ Comfort Care & Magazine Cart ☐ Dietary ☐ Greeter & Information Desk
☐ Office Assistant (various departments and responsibilities) ☐ Pastoral Care Team
☐ Physician Office ☐ Purchasing & Receiving ☐ Rehab
☐ Sales Associate in Gift Shop or Boutique ☐ Other (please list) _____

Availability: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ Mornings ☐ Afternoons

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that I am required to abide by all rules and regulations of Witham Health Services and to comply with all policies and procedures in the policy or procedure manual or other communications to volunteers. I further understand policies and procedures and conditions are subject to modifications without notice. I understand that if I am 18 years old or older, I will be subject to a criminal background check.
I hereby acknowledge that I have read the above statement and I understand and accept these terms.

Signature of Applicant: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____
(If under age 18)

Witham Health Services
Notice to Volunteers Regarding Background Information

I understand that a consumer report (background screening report) and/or an investigative consumer report (reference checks and/or interviews) that may include information from public or private sources regarding my character, driving records, criminal history, court records (both civil and criminal), qualifications and experience, work habits, and/or other information relevant to my volunteer service may be obtained in connection with my application as a volunteer with Witham Health Services.

I understand that, if I am approved for volunteer service by Witham Health Services, this background check authorization will be kept on file and may be used at any time during my service to procure further information when, in the judgment of Witham Health Services, such may be necessary.

I hereby release and discharge to the extent permitted by law, Witham Health Services, its employees, any individual or agency obtaining information for Witham Health Services, and any personal or professional reference, from any and all claims, damages, losses, liabilities, costs, or other expenses arising from the retrieving, reporting and/or disclosure of information in connection with this background investigation.

I understand that I am volunteering my services and declare in no way shall I be considered an employee or subcontractor or independent contractor of Witham Health Services.

By signing below, I, _____, have read, understand and consent to the above. I further authorize that a photographic copy or a telephonic facsimile of this document shall be valid for purposes present and future. My signature below certifies that all information I have provided in connection with this background check is true, accurate and complete to the best of my knowledge.

Authorization

_____ _____

Print Name (last, first, middle) *Social Security Number*

_____ _____ _____

Date of Birth (MM/DD/YYYY) *Drivers License Number* *Drivers License State*

(For ID Purposes Only)

Any other names I have been known by: _____

Current Address: _____

Previous Addresses (last 10 years): _____

_____

_____

_____ _____

Signature *Date*

WITHAM HEALTH SERVICES

Witham Health Services
Post-Offer Health History Questionnaire (Part 1 of 2)

Last Name	First Name		Middle Name
Address	City	State	Zip
Date of Birth			Gender
Cell Phone			
Social Security Number			
Position			Department
Email Address			
Emergency Contact			Relationship
Phone			

PLEASE READ

The purpose of this screening is to determine your physical ability to do the essential functions of the job you have been offered. The information provided in this questionnaire is confidential and shall be used to determine medical clearance for employment in the position applied for.

- I understand that employment for the position applied for is contingent upon FINAL MEDICAL CLEARANCE from Employee Health Services and upon available reasonable accommodations.
- I certify that the information provided by me in this questionnaire is complete and true to the best of my knowledge.

I agree this record is to be considered part of the basis for employment and that falsification of this record, including failure to answer any questions, will be grounds for withdrawal of the employment offer or dismissal. I hereby understand if any additional medical information is necessary to determine my ability to do the essential functions of the job, I will help Employee Health Services obtain the necessary information. I may be asked to obtain these records or may be asked to sign a release of information form authorizing Employee Health Services to receive these records. I also authorize the review of these records for this pre-placement evaluation. I understand, under the Department of Health Adopted Rules Governing Communicable Diseases, certain communicable diseases must be reported to the Commissioner of the Department of Health.

_____ _____

Signature *Date*

Employee Name: _____

Health History: Do you currently have or have you had any of the following:

Yes	No	(Please check Yes or No to all questions)	Employee Nurse comments
		Allergies to drugs / medication	
		Allergies / Sensitivities - Other	
		Asthma / Wheezing / Chronic respiratory problems	
		Blurred vision / Vision problems	
		Carpal tunnel	
		Chest pain	
		Closed head injury / Concussion	
		Depression / Mental health problems / Psychiatric disorders	
		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	
		Immune System	
		Spleenectomy (spleen removed)	
		Kidney, heart, lung, bone marrow or pancreas transplant	
		Currently taking steroid medication	
		Current or recent chemotherapy or radiation therapy	
		HIV infection	
		Other	
		Do you have any physical / mental health / medical problems that could prevent you from doing the job for which you have been hired?	
		If female: Are you pregnant now or do you plan on becoming pregnant in the next three months? (Asked for purposes of immunization only)	
Current medications or treatments:			
Current medical problems / chronic illness not listed above:			

Employee Name: _____

Yes	No	Neck / Back / Shoulder Assessment	Employee Nurse comments
		Do you have neck, back or shoulder pain?	
		Do you have chronic pain in your back, 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 are they?	
		Do you have any current restrictions or limitations?	
		Arm /Wrist / Hand Assessment	
		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 are they?	
		Do you have any current restrictions or limitations?	

Latex Allergy History (Please answer all the questions)

Yes	No	Please answer the following questions concerning latex allergies:	Employee Nurse comments
		Have you had rashes on your hands or itching after wearing gloves?	
		Have you developed hives after wearing gloves or being around latex?	
		Have you developed shortness of breath or wheezing after wearing gloves or being exposed to latex?	
		Have you ever had throat swelling or an anaphylactic reaction related to latex?	
		Do your lips swell up or itch after you blow up a balloon?	
		Have you reacted to condoms or diaphragms? (swelling, pain, itching, hives)	
		Do you have reactions (swelling, itching, trouble breathing or swallowing, hives) during dental procedures?	
		Have you had eczema or rashes on your hands?	
		Are you allergic to fruits or vegetables?	

(To be completed at time of Employee Health Interview)

_____ Employee instructed in procedure to follow for Injury / Illness / Blood and Body Fluid Exposure.
(RN)

_____ I have received the above information and have an understanding of the procedure.
(EE initial)

_____ Employee instructed on the availability / recommendations for the Hepatitis B vaccine.
(RN)

_____ I have received and understand the information on the Hepatitis B vaccination.
(EE initial)

Witham Health Services
Post-Offer Health History Questionnaire (Part 2 of 2)

Employee Name: _____

Immunity Profile

Tuberculosis (TB)

Have you ever had a positive TB skin test? ☐ Yes ☐ No

Date: _____

If positive, were you treated? ☐ Yes ☐ No ☐ N/A

Medication: _____

Length of treatment: _____

Most recent Chest X-ray:

Date: _____

Reading: _____

Have you ever had the BCG vaccine? ☐ Yes ☐ No

Date: _____

Location: _____

Have you had any of the following symptoms which were unexplained in the past year?

☐ Fever ☐ Loss of appetite
☐ Cough ☐ Night sweats
☐ Bloody sputum ☐ Weight loss
☐ Weakness ☐ Fatigue

PPD #1

Date placed: _____ Time: _____

Placed by: _____ Site: _____

Date read: _____ Time: _____

Read by: _____

Results: ☐ Negative ☐ Positive

Induration _____mm

PPD #2

Date placed: _____ Time: _____

Placed by: _____ Site: _____

Date read: _____ Time: _____

Read by: _____

Results: ☐ Negative ☐ Positive

Induration _____mm

TBGold

Date Drawn: _____

Result: _____

2-Step Skin Test

Documentation complete

☐ Yes ☐ No ☐ N/A

Chest X-Ray

Documentation complete

☐ Yes ☐ No ☐ N/A

TB Gold

Documentation complete

☐ Yes ☐ No ☐ N/A

Hepatitis B

Do you have proof of 3 vaccines? ☐ Yes ☐ No

#1 _____ #2 _____ #3 _____

Do you have a positive titer? ☐ Yes ☐ No

Lab Verification

Hep B Antibody drawn: ☐ Yes ☐ No

Site drawn: _____ Result: _____

Series started: ☐ Yes ☐ No

Series Declined: ☐ Yes ☐ No

Date: _____ Reason: _____

Documentation provided

☐ Yes ☐ No

Documentation complete

☐ Yes ☐ No

Measles (Rubeola), Mumps, and Rubella

Do you have proof of 2 vaccines? ☐ Yes ☐ No

#1 _____ #2 _____

Do you have a positive titer? ☐ Yes ☐ No

Lab Verification

Rubeola Antibody drawn? ☐ Yes ☐ No

Mumps Antibody drawn? ☐ Yes ☐ No

Rubella Antibody drawn? ☐ Yes ☐ No

Site drawn: _____ Result: _____

Documentation provided

☐ Yes ☐ No

Documentation complete

☐ Yes ☐ No

Varicella

Do you have proof of 2 vaccines? ☐ Yes ☐ No

#1 _____ #2 _____

Do you have a positive titer? ☐ Yes ☐ No

Lab Verification

Varicella Antibody drawn? ☐ Yes ☐ No

Site drawn: _____ Result: _____

Documentation provided

☐ Yes ☐ No

Documentation complete

☐ Yes ☐ No

TDaP

Date of most recent vaccine: _____

Documentation provided

☐ Yes ☐ No

Influenza

Date of most recent vaccine: _____

Documentation provided

☐ Yes ☐ No

_____ _____

Signature *Date*

Employee Name: _____

Physical Condition

Height: _____ Weight: _____

BP: _____ Pulse: _____ O_2: _____ Resp: _____ Temp: _____

Vision

	Corrected	Uncorrected
Right Eye	20/	20/
Left Eye	20/	20/
Both Eye	20/	20/

Color Vision

Results: _____

Urine Drug Screen

On site results: _____ Negative _____ Positive

Collected in dry bathroom: _____

Bluing agent used: _____

Smoke: _____ Seatbelt: _____ Drink/Drive: _____

ETOH: _____ Sunscreen: _____ Hearing Protection: _____

Drugs: _____ Exercise: _____

_____ _____

Screener's Signature *Date*

Employee Name: _____

LAB VERIFICATION OF IMMUNITY:

Rubeola Titer	Immune	Not Immune	Equivocal	Date: _____
Mumps Titer	Immune	Not Immune	Equivocal	Date: _____
Rubella Titer	Immune	Not Immune	Equivocal	Date: _____
Varicella Titer	Immune	Not Immune	Equivocal	Date: _____
Hepatitis B Anti.	Immune	Not Immune	Equivocal	Date: _____

VACCINATIONS:

☐ **MMR** ☐ **HepB** ☐ **Tdap** ☐ **Flu**

MMR: Vaccine #1 Date: _____ Vaccine #2 Date: _____

HepB: Vaccine #1 Date: _____ Vaccine #2 Date: _____ Vaccine #3 Date: _____

Tdap: Vaccine Date: _____

Flu: Vaccine Date: _____

Witham Health Services
Consent for Health Screening Exam

I, _____ understand the policy of Witham Health Services requires all persons associated with hospital service to be given a health screening exam to determine the absence of communicable disease.

I understand that the exam is to be completed before volunteer service will be considered.

I understand that the health screening exam will consist of the following tests/vaccinations:

PPD – for tuberculosis
Flu vaccine

I understand that the health screening exam will be provided at no cost by Witham Health Services, but that the hospital will not accept responsibility for treatment of conditions that may be discovered during the exam.

I further understand that if the results of the health screening exam indicate that I have a communicable disease, I will not be considered for volunteer services until the condition has been satisfactorily treated and I have received clearance from the Witham Health Services Employee Health Department.

Having read and understood the above information, I do hereby request and consent to the performance of a volunteer health screening exam by the employee health service.

_____ _____
Signature *Date*

_____ _____
Witness Signature *Date*

_____ _____
Parent/Guardian Signature *Date*

Witham Health Services Volunteer Organization

Areas Available for Volunteering:

Administrative Assistant for various offices
Café Assistant
Guest Services Representative at the Entrances
OB Assistant
Pastoral Care (Chaplaincy)
Radiology Assistant
Retail Sales Associate in the Retail Shops
Rehab Assistant
Surgery Department Assistant,
Surgery Waiting Room Guest Services Representative
And much more!

Requirements to Volunteer:

- Complete and submit the volunteer application and required paperwork.
- Background screen.
- Interview with Director of Volunteer Services.
- Meeting with Employee Health Nurse.
- Attendance at New Employee Orientation (Approximately 2.5 hours).
- Attendance at volunteer training session (annually) (Approximately 3.5 hours).
- Volunteer a minimum of 4 hour per week.

Perks of Volunteering at Witham Include:

- Complimentary meal (up to $8) for each 4 hour shift worked.
- Free Witham polo shirt & ID badge to wear during the volunteer shift.
- Discount at the Waterfall's Edge Gift Shop & Pavilion Boutique.
- Meet new people and make new friends!
- Being a part of the outstanding Witham team and helping citizens of our community!

For more information, contact Amy Mitchell,
Director of Volunteers, Pastoral Care & Retail Sales
Phone: (765) 485-8175
Email: amitchell@witham.org

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