Paoli Hospital
Main Line Health®

Volunteer Services
255 West Lancaster Avenue
MOB III, Suite 239
Paoli, PA 19301

484.565.1099
mainlinehealth.org

Volunteer Application

Please print all required information

Personal Information

Last Name	First Name	MI	Date of Birth / /
Street Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Email Address

Preferred method of communication ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Other (please specify)

Availability

Can you commit to at least 6 months of weekly volunteer service? ☐ Yes ☐ No

Available work hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.-Sun.
Morning (8:00 a.m. to 12:00) or (9:00 a.m. to 1:00 p.m.)	☐	☐	☐	☐	☐	☐
Morning/Afternoon (10:00 a.m. to 2:00 p.m.)	☐	☐	☐	☐	☐	☐
Afternoon (12:00 to 4:00 p.m.) or (1:00 p.m. to 5:00 p.m.)	☐	☐	☐	☐	☐	☐
Evening (4:00 p.m. to 7:00 p.m.)	☐	☐	☐	☐	☐	

Emergency Contacts

Name	Relationship	Phone
Personal Physician	Phone	Address

Work Experience

Are you currently employed? ☐ Yes ☐ No ☐ Retired (if Yes) ☐ Full Time ☐ Part Time

Employer	Job Title	Phone
Career Experience		

References

1. Name	Address	Phone
2. Name	Address	Phone

Criminal History

We consider the safety and security of our patients to be of utmost importance. Criminal background checks will be performed at no cost to you.

1. Are you 18 years of age or older? □ Yes □ No

2. Have you ever been convicted of, or pled guilty to, a felony or misdemeanor? □ Yes □ No
   (Conviction includes a guilty plea)

If yes, please give exact details of conviction, offenses, where committed, sentencing court, date of sentence and nature of sentence. Please provide these details under separate cover.

Please note: A criminal conviction will not necessarily disqualify you from volunteering but will be considered in relation to specific assignment.)

3. Are you or have you ever been employed by any Main Line Health entity? □ Yes □ No

I certify that the information contained in this application is true and correct to the best of my knowledge and understand that any falsification, misrepresentation or omission on this application is grounds for rejection of this application or for dismissal if such statement is discovered subsequent to an assignment.

I authorize a criminal background check to be conducted on me with the report to be provided to Main Line Hospitals (Bryn Mawr Hospital, Bryn Mawr Rehab., Lankenau Medical Center, Paoli Hospital and Riddle Hospital).

I authorize any of the persons or organizations referenced in this application to give to Main Line Hospitals any and all information concerning my previous volunteer service, criminal background, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application and release all such parties, Main Line Hospitals, Inc., its parent, affiliates, and their respective officers, trustees, directors, agents, and employees from any and all liability for damages for or in connection with the collection, use, release or disclosure of such information. I authorize Main Line Hospitals to request and receive such information.

I agree that if offered an assignment, I will consent to a health screening, including, but not limited, to Tuberculosis testing. I understand that my assignment is conditional upon the satisfactory results of this screening. I also understand I must comply with Main Line Hospitals' policy requiring an annual influenza vaccination.

I understand that I must be punctual and regular in attendance, helpful in my assignment and careful to honor the confidential nature of what I observe. I agree to comply with the rules, regulations, and policies of Main Line Hospitals and the Volunteer Services Department and acknowledge that these rules, regulations and policies may be changed, interpreted, withdrawn, or supplemented at any time, and without prior notice to me. I understand that my service as a volunteer is conditional based on need and satisfactory service, and that either I or Main Line Hospitals may terminate my volunteer service at any time, with or without notice, for any reason. I understand that I will not be compensated for my volunteer service and that being accepted for volunteer service does not give rise to or create an employment relationship with Main Line Hospitals.

_____ _____

Signature Date

MAIN LINE HEALTH PROVIDES OPPORTUNITIES FOR VOLUNTEERISM WITHOUT DISCRIMIATION DUE TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, ANCESTRY, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENETIC INFORMATION OR HANDICAP

Volunteer Department Use Only

Volunteer Department Use Only

Date of Volunteer Orientation _____	Volunteer Handbook _____	Photo _____
QuantiFERON ____	Immunizations _____	Volunteer ID Number ____
Position Description _____	Uniform _____	ID Badge _____
Starting Date _____		Trained by _____

Assignment

Department	Day of Week	Hours
Remarks		

Evaluations

90 DAY Date: Initials:

Annual Date: Initials:
Annual Date: Initials:
Annual Date: Initials:
Annual Date: Initials:
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Annual Date: Initials:
Annual Date: Initials:

Signature: _____ Initials:_____

Signature: _____ Initials:_____

INACTIVE DATE: _____

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VOLUNTEER REFERENCE

_____ has applied for a volunteer position at Paoli Hospital. Your name has been given as a personal reference. Please complete this form and return it in the envelope provided. All information you supply will be kept confidential.

Length of time you have known applicant _____

Relationship to applicant _____

How would you rate the following characteristics?

	Superior	*Good*	*Fair*	*Poor*
Ability to follow directions	_____	_____	_____	_____
Reliability	_____	_____	_____	_____
Sound judgment	_____	_____	_____	_____
Exhibits initiative	_____	_____	_____	_____
Honesty/integrity	_____	_____	_____	_____
Ability to work with others	_____	_____	_____	_____

Any other comments or information you think might be helpful will be greatly appreciated. Please inform us about specific strengths or weaknesses of which you might be aware.

_____

_____

_____

_____
Name of Recommender

_____ _____
Telephone Number Date

Dana McKee
Manager, Volunteer Services
255 West Lancaster Avenue
MOB III, Suite 239
Paoli, PA 19301

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_____

_____

_____

_____
Name of Recommender

_____ _____
Telephone Number Date

Dana McKee
Manager, Volunteer Services
255 West Lancaster Avenue
MOB III, Suite 239
Paoli, PA 19301

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DEPARTMENT OF VOLUNTEER SERVICES

Statement of Agreement/Confidentiality Statement

I understand and agree that I must be punctual and regular in attendance, helpful in my assignments and careful to honor the confidential nature of what I observe and all other rules and regulations of the Volunteer Department. As a volunteer of the Paoli Hospital and the Main Line Health system, I may have access to privileged information of a highly confidential nature.

Privileged information consists of, but is not limited to, data regarding the following:

Employees: Salary and demographic information.
Patients: Diagnosis and procedures, content of medical records, and any personal information.
Family members of patients: Any and all personal information.

The confidentiality of privileged information is protected by law, and as a volunteer of the Main Line Health System, it is my responsibility to preserve and protect this confidentiality.

I am responsible for maintaining the strictest confidentiality regarding computer system access and information. This prohibits sharing of sign-on ID/password information and/or providing physical access to a terminal in "active" status. I will only access information on patients/employees about whom I have a business need to know. Likewise, I will discuss information only with employees who have a business need to know. I will not attempt to gain access to areas of the system(s) that are not necessary for the performance of my job.

Any unauthorized disclosure of privileged information, or any confidential information concerning current or past patient, or employee of the Main Line Health System, may result in immediate discharge from service with the System, and possible legal action against me.

I certify that the information on this application is true and correct to the best of my knowledge. I understand any falsification on this application may be considered cause for rejection. I give permission to Paoli Hospital to investigate the information contained in this application, including inquiries of Law Enforcement agencies, agencies where I have previously volunteered, and the U.S. Government to release information on me to Paoli Hospital.

DATE: _____ ***SIGNATURE:*** _____

FAQ Frequently Asked Questions

QuantiFERON - TB Gold in-Tube test (QFT)

Q: What is QuantiFERON TB Gold in-Tube test?

A: QuantiFERON - TB Gold in-Tube is an accurate, blood test that provides results showing if someone is either infected or not with the TB bacterium. QFT is unaffected by previous BCG vaccinations and most other environmental mycobacteria.

Q: Why is the QuantiFERON test better than the TB skin test?

A: The results through QFT are shown to be more accurate at detecting a tuberculosis infection than a TB skin test. A traditional TB skin test requires multiple visits to complete. A TB skin test may also result in false positives due to cross-reactivity with the BCG vaccination or responses to environmental mycobacteria. These and other limitations have shown QFT to be the most effective and best alternative to TB skin testing.

Q: What are the benefits of the QuantiFERON® - TB Gold in-Tube test?

A: Some of the benefits include:

- Requires only one visit
- Does not compromise previous test results
- Is a controlled laboratory test
- Is objective and not affected by interpretation
- Results can be available in as little as 72 hours

Q: Is the QuantiFERON test approved by the CDC and FDA for TB testing?

A: Yes, both the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) have approved the use of the QuantiFERON - TB Gold in-Tube test (QFT).

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Q: Who at Main Line Health will be required to receive the QuantiFERON test?

A: Currently, all new-hires of Main Line Health are receiving the QFT test, and Main Line Health will be transitioning all annual tuberculosis required employees and volunteers to the QFT test beginning July 1, 2012.

Q: I am a MLH employee who is currently required to complete an annual PPD Skin Test, will I need to complete the QuantiFERON test?

A: Infection Control is currently working to redefine which employees at MLH will be required to complete an annual tuberculosis test. If it is determined that your position *will* require an annual tuberculosis test to be completed, you will be required to complete the QuantiFERON test instead of the PPD Skin Test.

Q: I have a history of a past-positive PPD and normally complete an annual Positive PPD Questionnaire, will I be required to complete the QuantiFERON test for medical surveillance?

A: Yes, you will be required to receive the QuantiFERON test initially which will determine if you are a confirmed positive. If you are confirmed as a positive, you will be required to continue annual monitoring, regardless if your position is taken off the annual requirement list by Infection Control. If you are confirmed negative by the QFT test, the Infection Control guidelines will determine if you are required to complete an annual tuberculosis test.

Q: Where will the QuantiFERON test be offered?

A: Currently, the QFT test is being offered at the Paoli and Lankenau Occupational Health offices. Other testing locations are as listed on the QFT instructions sheet.

Additional Questions?

Please contact Occupational Health at 484-565-1293 and someone will assit you.

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INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORTS ONLY
(to be used for no other purposes)

Please write legibly:

Full Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Primary Phone Number: _____ Email Address: _____

Drivers License Number: _____ State of Issue: _____

Current Address: _____
(Number and Street, Apt # if applicable)

_____ _____ _____
City State Zip Code

List all Residence Addresses in Past Seven Years (attach additional sheets if necessary)

_____

_____

BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM
(FOR EMPLOYMENT PURPOSES)

In connection with your employment or application for employment, please be advised that we may obtain a *consumer report* and/or an *investigative consumer report* including information as to your creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. You have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 et seq.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq.*, is available at the Federal Trade Commission's web site (http://www.ftc.gov). For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

Consent to Obtain Consumer Reports

By signing below, I authorize the company to obtain one or more consumer reports regarding my creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and mode of living. [the following sentence is usually in the employment application, rather than the FCRA disclosure-- I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers.] I acknowledge and agree that this Background Check Disclosure and Authorization Form shall remain valid and in effect during the term of my employment.

Date: _____ Signature of Applicant: _____

Print Name: _____