Paoli Hospital
Main Line Health®

Volunteer Services

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

484.565.1099
mainlinehealth.org

Dear Student,

Thank you for your interest in becoming a Junior Volunteer at Paoli Hospital. Enclosed please find an application and other important material.

Junior Volunteers are vital to our Volunteer Program. The experience is designed to expose you to health careers, to challenge you, to introduce you to other students, and provide you with an opportunity to work with adults, patients, and hospital staff.

In order to facilitate your application, please follow these guidelines.

1. Fill out the application and return it to the Department of Volunteer Service.

2. Give the two reference forms: one to an adult, (no relatives), who has managed or supervised you, and the other to a Guidance Counselor or Teacher who would be willing to attest to your good character References are accepted either by direct mail from assigned reference or with a signed envelope along with application.

Once your application and both references are received and reviewed, I will call you to schedule an appointment.

At your interview you will be given a Volunteer Handbook, position description, and an assignment. You are assuming an important responsibility by making a commitment to Paoli Hospital. We rely upon you to be punctual, reliable, and respectful of the Vision and Values, which is the mission of our Paoli family.

I will look forward to meeting you.

Sincerely yours,

Dana McKee

Dana McKee, Manager
Volunteer Services

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Application for Junior Volunteer Service

Please print all required information

Personal Information

Last Name	First Name	MI	Nickname	Date of Birth / /
Street Address	City		State	Zip
Home Phone	Cell Phone		Email Address	
Preferred method of communication ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Other (please specify)				
Mother's Name			Father's Name	

Availability

Time Availability : School Year Program	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.-Sun.
Weekday : starts at 3:00 pm	☐	☐	☐	☐	☐	
Time Availability : Summer Program						
Weekday: 9:00 am–1:00 pm or 1:00 pm–5:00 pm	☐	☐	☐	☐	☐	

**Weekend opportunity positions are offered to those students who have fulfilled a 50 hour volunteer requirement.*

Emergency Contacts

Name	Relationship	Phone
Personal Physician	Phone	Address

School and Community Activities/Clubs

School	Grade	Year of Graduation
Clubs and Activities		

I hereby certify that I will observe the strictest code of confidentiality and will consider all PH patient and hospital information private and not to be the subject of conversation with other people.

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.

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Volunteer Department Use Only

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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	Shift
Remarks		

90 DAY Date: Initials:

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

Signature:_____ Initials:_____

Signature:_____ Initials:_____

INACTIVE DATE: _____

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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:*** _____

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Department of Volunteer Services

School Guidance Counselor or Teacher Recommendation

Name of Student: _____

The above student has expressed an interest in the Junior Volunteer Program at Paoli Hospital.

Because of the concern we have for our patients' welfare as well as the students' well being, we are interested in the following information regarding each applicant.

I WOULD RATE THE ABOVE STUDENT AS FOLLOWS:	GOOD	FAIR	POOR
Ability to Follow Instructions			
Ability to Follow Through on Assignments			
Attendance			
Cooperation With Adults			
Cooperation With Peers			
Degree of Responsibility			
General Appearance (Neat & Clean)			
Reliability			

Comments

Thank you for your cooperation in making this information available to us. It will be kept in strict confidence.

Dana McKee, Manager, Volunteer Services

I Do ____ I Do Not ____ recommend this student.

Name:_____ Title _____

School_____

Signature_____Date_____

Parental Permission for School to Release Information

I give my permission to (Name of School) _____ to release information on my son/daughter requested by the Volunteer Department of Paoli Hospital.

Date _____ **Signed** _____

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Department of Volunteer Services

Letter Recommendation for Junior Volunteer Program

NAME_____ DATE_____
Last First Middle

ADDRESS _____

CITY, STATE, ZIP, CODE_____

SCHOOL_____

The above applicant is a candidate for admission to the Junior Volunteer Program at Paoli Hospital. Please use your judgment to comment on the following, which assesses potential, maturity, and personal competencies of the applicant. Your cooperation in completing and returning this recommendation is greatly appreciated. Thank you for your time and consideration.

1. How long have you known this applicant? _____

   In what capacity do you know the applicant? _____

2. Is the applicant self motivated and does he/she follow through? _____

   _____

3. Dependability_____

4. Appearance _____

5. Additional comments _____

   _____

6. To the best of your knowledge would you recommend this young person for the Paoli Hospital Junior Volunteer Program? _____

   _____

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO APPLICANT _____

SIGNATURE_____ DATE_____

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Occupation and Travel Health

To Whom It May Concern:

I hereby give my consent for tuberculosis (TB) testing, QuantiFERON, and flu vaccination (during flu season) on my child

_____ (PRINT NAME OF MINOR CHILD)

I understand that my child must have these vaccinations to volunteer at a Main Line Health facility. The minor volunteer must have this form completed before testing may be given. Students under the age of 18 must be accompanied by a parent for placement of PPD and flu vaccination.

_____
Print name of Parent/Guardian

_____
Signature of Parent/Guardian

Date: _____

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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).

Main Line Health®
Well ahead.®

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.