

Dear Community Member:

We are delighted that you have expressed an interest in becoming a Main Line Health volunteer!

Volunteers are our most valuable asset performing a variety of non-medical services in both patient and non-patient departments. Main Line Health volunteers come from all walks of life in the surrounding community, but all share the common goal of assisting our professional staff in providing the excellent patient care for which our facilities are known. They also enable us to provide services for both the patients and the community that could not be provided otherwise.

Our volunteers are an integral part of the Main Line Health family, and an assignment and schedule will be worked out for you depending upon your interests, skills, time availability and the needs of the hospital. We prefer our volunteers commit to at least 3 months of weekly volunteer service, however any offer of service will be considered and valued.

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

1. Fill out the application and return it to the Department of Volunteer Services at your desired location.
2. For adults, please give the two reference forms to employers, co-workers or someone who would be willing to attest to your good character and work ethic. Please ask your references to return the forms to the Department of Volunteer Services at your desired location.

Once your application and both references are received and reviewed, the volunteer office will call you to schedule an appointment to discuss your interests and develop a placement.

We will look forward to meeting you and having you become a member of the MLH team!

Bryn Mawr Hospital, MLHC Newton Square

484-337-3058

BMHVolunteers@mlhs.org

130 S. Bryn Mawr Ave.

Bryn Mawr, PA 19010

Paoli Hospital, MLHC Exton, Collegeville, King of Prussia

484-565-1099

PHVolunteers@mlhs.org

255 W. Lancaster Ave.

Paoli, PA 19301

Bryn Mawr Rehabilitation Hospital

484-596-5599

BrynMawrRehabVolunteers@mlhs.org

414 Paoli Pike

Malvern, PA 19355

Riddle Hospital, MLHC Concordville

484-227-3170

RHVolunteers@mlhs.org

1068 W. Baltimore Pike

Media, PA 19063

Lankenau Medical Center, MLHC Broomall

484-476-2138

LMCVolunteers@mlhs.org

100 E. Lancaster Ave.

Wynnewood, PA 19096

Lankenau Institute for Medical Research

484-476-3440

Olshefskit@mlhs.org

100 E. Lancaster Ave

Wynnewood, PA 19096

Volunteer Office Requirements:

Clearances: All required clearances must be completed prior to your start date. Any potential cost will be the responsibility of the volunteer.

- ☐ *Background Check*
- ☐ *Child Abuse History Clearance Go to: www.compass.state.pa.us/CWIS/Public/Home to complete this requirement.*
- ☐ *FBI Fingerprinting or attestation form. Your volunteer coordinator will notify you if you are expected to complete this requirement.*

Occupational Health Requirements:

Adult Volunteers (18yrs and older) are required to make a new volunteer appointment with occupational health. To schedule an appointment please call 484-565-1293. All requirements below must be completed before starting. If you have received any of the above requirements with your personal provider, please bring a copy of your immunization records with you to your appointment.

All adult volunteers are required to have the following. *If an immunization is required, they will be provided by Occupational Health at no expense:*

- a. *QuantiFERON Gold Blood Test*
- b. *Immunity to Measles, Mumps, And Rubella (MMR) – 2 documented doses of MMR vaccination or positive lab titer*
- c. *Immunity to Varicella (Chicken Pox)- 2 Documented doses of Varicella vaccination or positive lab titer. Note: This is not the same as Shingles Vaccine.*
- d. *Tdap (Tetanus, Diphtheria, and Pertussis) vaccination*
- e. *Hepatitis B – positive titer and 3 documented doses of Hepatitis B vaccine.*
 - *Or Titers with Signed Hepatitis B declination form (only applicable to certain roles)*
- f. *(Proof of Covid Vaccination – 2 documents doses of Moderna or Pfizer or 1 dose of J&J)*
- g. *Flu Shot during Flu Season – September- March*

Occupational Health Locations:

Broomall
1991 Sproul Road
Suite 600
Broomall, PA 1908
Fax:610.886.0164

Concordville
1020 Baltimore Pike
Suite 100
Glen Mills, PA 19342
Fax:484.227.7781

Exton
154 Exton Square Parkway
Exton Square Mall – Lower-Level
Exton PA 19341
Fax:610.903.1090

Wynnewood
306 East Lancaster Ave
Suite 200
Wynnewood, PA 19096
Fax:484.476.7855

Adult Volunteer Application

Please print all required information

Please select a preferred location:	<input type="checkbox"/> Bryn Mawr Hospital	<input type="checkbox"/> MLHC Broomall
	<input type="checkbox"/> Bryn Mawr Rehab Hospital	<input type="checkbox"/> MLHC Collegeville
<input type="checkbox"/> Lankenau Medical Center	<input type="checkbox"/> MLHC Concordville	
<input type="checkbox"/> Paoli Hospital	<input type="checkbox"/> MLHC Exton Square	
<input type="checkbox"/> Riddle Hospital	<input type="checkbox"/> MLHC King of Prussia	
	<input type="checkbox"/> MLHC Newtown Square	

Personal Information			
<input type="checkbox"/> Adult <input type="checkbox"/> College <input type="checkbox"/> High School <input type="checkbox"/> Court Directed <input type="checkbox"/> Musicians OnCall Program			
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 <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Other (please specify)			
Have you ever been convicted of, or pled guilty to, a felony or misdemeanor? Conviction includes a guilty plea. <input type="checkbox"/> Yes <input type="checkbox"/> No 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. <i>Please note: A conviction will not necessarily disqualify you from volunteering but will be considered in relation to specific assignment.</i>			

Volunteer Experience:	Work Experience:
Why are you interested in becoming a volunteer at MLH? To facilitate the application process, please indicate if you have applied or volunteered at another facility within the Main Line Health System. <input type="checkbox"/> Yes (if so, where) _____ <input type="checkbox"/> No	Job Skills: _____ _____ _____ _____

Emergency Contacts		
Name	Relationship	Phone
Personal Physician	Phone	Address

Availability						
Available hours***	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat. - Sun.
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***Shift times fluctuate upon facility and departments

Volunteer Application Agreement

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 Entities (applicants over the age of 18 only)

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 DISCRIMINATION DUE TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, ANCESTRY, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENETIC INFORMATION OR HANDICAP.

DEPARTMENT OF VOLUNTEER SERVICES

Statement of Agreement/Confidentiality Statement for Adult

STATEMENT OF RESPONSIBILITY AND CONFIDENTIALITY

For and in consideration of the benefit provided the undersigned in the form of experience in the health care field at Main Line Hospitals, Inc., Riddle Memorial Hospital and/or any of their affiliates (hereinafter collectively referred to as "Facility"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury, illness or loss sustained by the undersigned while participating in the experience at Facility unless such injury, illness or loss arises solely out of Facility's gross negligence or willful misconduct.

This undersigned hereby acknowledges his/her responsibility under applicable state and Federal law and this Agreement to keep confidential a) any information regarding the patients of Facility, b) any sign on and password assigned to undersigned by Facility, and c) all confidential information of Facility. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility.

The following shall bind the person who has signed below. The undersigned agrees that this Statement of Responsibility and Confidentiality may be electronically signed and that any such electronic signature shall have the same legal effect as a handwritten signature. In addition, the undersigned agrees that when they sign and deliver this form to Facility, whether by hand delivery, email, fax, scan or any other means, this form becomes binding irrespective of whether Facility is in possession of the original signed copy.

Dated this ____ day of _____, 20__

Signature

Print Name

Applicants Age 18 and Older

**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: _____

Driver's 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)

Applicants Age 18 and Older

**BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM
(FOR EMPLOYMENT/VOLUNTEER PURPOSES)**

In connection with your employment/volunteer 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.

Signature

Print Name

Date

All community volunteers are asked to sign a Volunteer Agreement. This implies commitment to volunteer service.

As a community volunteer, I understand that I am expected to:

1. Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff and not seek to obtain confidential information from a patient.
2. Become familiar with the hospital's policies and procedures and uphold its mission and values.
3. Donate my services to the hospital without contemplation of compensation or future employment.
4. Be punctual and conscientious, conduct myself with dignity, courtesy, and consideration of others and endeavor to make my work professional in quality.
5. Adhere to professional dress code including wearing the hospital issue ID and jacket.
6. Complete orientation and send health screening information as needed.
7. Carry out assignments and seek the assistance of the volunteer supervisor when necessary.
8. Take any problems, criticism, or suggestions to my volunteer supervisor.
9. Work the shift and department as indicated by the needs.
10. Adhere to the department's sign-in procedures.
11. I understand that COVID-19 testing/treatment will not be covered by MLH either directly or under any MLH insurance policy or program.
12. **Notify the Volunteer Office if I am unable to volunteer.**
13. I understand that any observed or reported inappropriate behavior will be addressed as soon as possible after occurrence before it should become habitual through silence and tacit approval.
14. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules, and regulations; (b) absences without prior notification; unsatisfactory work, or appearance, or (d) any circumstance which, in the judgment of the hospital, would make continued presence as a volunteer contrary to the best interests of the hospital.

I have read each of the above statements, and I have been given the opportunity to ask questions so that I understand each statement.

Volunteer Signature: _____ Date: _____

Department Representative: _____ Date: _____

Revised 7/6/2021.

VOLUNTEER REFERENCE-Adult

(family references not permitted)

_____ has applied for a volunteer position at Main Line Health.

Your name has been given as a personal reference. Please complete this form and return

to the volunteer department where candidate is applying. 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

VOLUNTEER REFERENCE-Adult

(family references not permitted)

_____ has applied for a volunteer position at Main Line Health.

Your name has been given as a personal reference. Please complete this form and return

to the volunteer department where candidate is applying. 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

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).

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 assist you.



Main Line Health
Well ahead.SM