Please return to:
Mount Nittany Medical Center
Volunteer Resources
1800 East Park Avenue
State College, PA 16803
814.231.7836

MOUNT NITTANY HEALTH

FOR VOLUNTEER OFFICE USE ONLY

Application Date _____ Assignment _____

Interview Date _____ ☐ Adult ☐ College Student

Orientation Date _____ Start Date _____

VOLUNTEER APPLICATION

Last Name_____ First Name_____ MI _____

E-mail address:_____ Local Home Phone_____

Address_____ Apt. #_____ Cell Phone_____

City _____ State _____ ZIP_____

Date of Birth _____

In Case of Emergency, Notify

Name _____ Parent/Guardian/Other_____

Address_____ Home Phone _____ Cell Phone _____

City _____ State_____

Zip_____

Education and Work Experience

Current Employer _____

Job Title _____ College 1 2 3 4 Grad. Date _____

Work Phone _____ College Major _____

Skills/Preferences

☐ Patient Floors
☐ Endoscopy
☐ Guest Services
☐ Office/Special Projects
☐ Emergency Department
☐ Snack Bar/Gift Shop
☐ Spiritual/Pastoral Care
☐ Pet Therapy

Have you volunteered at Mount Nittany Medical Center before?
☐ Yes ☐ No

Can you substitute occasionally?
☐ Yes ☐ No

Availability

Check the boxes for the days and times you are <u>most often</u> available to volunteer.

	S	M	T	W	T	F	S
Morn.	☐	☐	☐	☐	☐	☐	☐
Aft.	☐	☐	☐	☐	☐	☐	☐
Eve.	☐	☐	☐	☐	☐	☐	☐

Have you ever pled guilty or been convicted of a crime? ☐ Yes ☐ No
If yes, when did the offense occur? _____ Nature of crime: _____

Are you required to volunteer? ☐ Yes ☐ No. If yes, by whom? _____

How did you hear about our Volunteer Program?_____

Volunteer – Please Read and Sign:

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief, and hereby grant Mount Nittany Health permission to verify such answers and investigate references.

Believing that Mount Nittany Health has a real need for my services as a volunteer worker,

- I acknowledge and understand that (i) I am offering my services voluntarily, (ii) any services provided as a volunteer are separate and independent from any services provide as an employee of Mount Nittany Health (if applicable), and (iii)I will not be compensated for any services provided while serving as a volunteer;
- I will be punctual and conscientious in the fulfillment of my duties and accept supervision gracefully;
- I will conduct myself with dignity, courtesy, and consideration;
- I will consider as CONFIDENTIAL all information which I may hear directly or indirectly concerning a patient or Mount Nittany Health Employee, and will not seek information in regard to a particular patient;
- I will escalate any issues, concerns or suggestions to the Supervisor of Volunteers;
- I will uphold Mount Nittany Health's Mission and Values and interpret them to the community at large.
- I understand that a Tuberculin skin test is required for all volunteers and that the test will be provided to me free of charge at Mount Nittany Health;

NAME _____ DATE _____

ORIENTATION CHECKLIST

Mission & Vision Statements		Emergency Announcements	
Confidentiality Statement		Infection Control	
HIPAA		Customer Service	
Sign-In Books		National Patient Safety Goals	
Schedules and Call-Offs		Uniforms and Dress Code	
Assignment Guides and Checklists		Benefits	

Health Information

Last Name _____ First Name _____ MI _____

E-mail address: _____ Local Home Phone _____

Address _____ Apt. #_____ Cell Phone _____

City _____ State_____ ZIP _____

Date of Birth _____

Personal Physician: _____ Allergies:_____

Please attach proof of the following immunizations: (be sure your records indicate vaccine dates, etc. Anything listed as 'unverified' will not be considered proof)

TUBERCULOSIS:
Tuberculin screening (tuberculin skin test or blood assay for *M. tuberculosis*) is required unless you have had a positive test or are deferred from testing for other reasons. Only results of testing performed within the past one (1) year will be accepted.
Exempt from testing: ( ) NO ( ) YES
If yes, reason: _____
Date of tuberculin screening: _____ Result: _____
If tuberculin screening is/was positive, attach a copy of a chest x-ray report done within the past one (1) year.

VARICELLA (CHICKEN POX): Attach a copy of any of the following:
___ laboratory evidence of immunity (antibody), or
___ proof of vaccination with two doses Varicella zoster vaccine.

PERTUSSIS (WHOOPING COUGH): Attach a copy of the following:

___ proof of vaccination with one dose TDAP Vaccine

COVID 19: Attach a copy of the following
____ proof of vaccination (2 doses for Pfizer or Moderna; 1 dose for Johnson & Johnson)
____ signed declination form

MUMPS: Attach a copy of any of the following:
___ laboratory evidence of immunity, or
___ proof of vaccination (two doses on or after age one)

RUBELLA (GERMAN MEASLES): Attach a copy of any of the following:
____ laboratory evidence of immunity (antibody), or
____ proof of vaccination (one dose on or after age one).

RUBEOLA (MEASLES): Attach a copy of any of the following:
___ laboratory evidence of immunity (antibody), or
___ proof of vaccination (two doses on or after age one)

Signature:_____ Date_____

If you cannot provide evidence of immunity as described above, a blood test (titer/s) will be performed by the Medical Center to determine your immunity status. **If you are a student, you can get your records from your school health services department.** If you have any questions contact the Volunteer Resources Department office at 814.231.7836

Reference Form:

This form is to be completed by the applicant's reference.

_____ has applied to be a volunteer at Mount Nittany Medical Center and has given your name as a reference. Because we strive to provide our patients with quality care, it would be helpful to have your comments on whether you consider this person well-suited to healthcare volunteer service.

Please return this completed form to the address provided below. Your prompt and frank reply will be greatly appreciated, and will be considered confidential. Volunteers cannot begin their assignments until a reference is returned.
Sincerely,

Amelia Hull
Supervisor of Volunteer Services

_____

Name of Applicant: _____
Name of Reference: _____
How do you know Applicant?_____
Reference Address: _____
_____
Reference Phone: _____ Email:_____
Comments:

Please return to:
Mount Nittany Medical Center
Volunteer Resources
1800 East Park Avenue
State College, PA 16803
814.231.7836

Child Protective Services Law

In order to comply with the Child Protective Service Law, Mount Nittany Health volunteer candidates must secure the PA Child Abuse Clearance. Please include the clearance with your application. If you have <u>not</u> been a resident of Pennsylvania for the last 10 years, you will also need to have an FBI/Federal Criminal History Record clearance, which includes fingerprinting. Please notify the Volunteer Resources Department if you need this additional clearance.

PA Child Abuse Clearance APPLICATION INSTRUCTIONS

Register online at: https://www.compass.state.pa.us/cwis/public/home. You will need your previous addresses and the names of everyone who lived with you at any time since 1975 to the present.

- 1. Select **Create a New Account**, click next
- 2. Fill in needed info, click finish
- 3. Go to your email to retrieve temporary password
- 4. Go back to the site, click login
- 5. Click **Access My Clearances,** click continue
- 6. Login with username ID & temporary password
- 7. Create password (you'll want to retain your ID & password for future use), click **submit**
- 8. Login again with your new password
- 9. Click **agree to terms**, click next, click continue
- 10. Select **Create An Application,** click begin
- 11. Click **Regular Contact With Children**
- 12. Verify your information & add needed information, click next
- 13. Fill needed information, click next
- 14. Add all previous addresses since 1975, click next
- 15. Add household members since 1975, click next
- 16. Verify summary information
- 17. Type in full name for **E-Signature,** click next
- 18. Be sure to check that this is for a volunteer position.

Consent for Tuberculin Skin Test for Volunteers under age 18 only:

All volunteers ***who have been interviewed*** must have a tuberculin skin test before starting volunteer activities. The test will be provided, at no charge to the volunteer, during the orientation process.

If you are under 18, your parent or guardian must sign this form before you receive the tuberculin skin test. Please bring this signed letter with you when you come to the hospital for your appointment.

For parents/guardians of junior volunteers (under age 18):

I have read this letter, and I give my permission for _____

to receive a tuberculin skin test at Mount Nittany Medical Center.

Signature of Parent or Guardian Date