HSHS
St. Elizabeth's
Hospital

Volunteer Services Department
One St. Elizabeth's Boulevard
O'Fallon, IL 62269
618-234-2120, ext. 11280

Dear Perspective Student/Youth Volunteer,

Thank you for your interest in our volunteer program! Volunteering in a hospital is a rewarding experience. In addition to the satisfaction you will receive from helping others, you may also get insight into the medical field as a possible profession. Remember that not all volunteer assignments involve direct contact with the patients, yet each and every assignment is important to the overall functioning of the hospital as well as providing a quality health care experience to patients and visitors.

Youth Volunteer Qualifications:

1. Be 16-18 years of age
2. Complete an application
3. Obtain parental/guardian signature on all necessary volunteer permission forms
4. Have the personal reference form completed by a teacher, counselor, or clergy member (it is not appropriate for friends or relatives to complete the personal reference forms)
5. Attend the appropriate initial orientation and training sessions as well as any additional training that may be required as a volunteer
6. Complete a health screening including a drug screening, TB test and physical
7. Be responsible for maintaining a volunteer uniform vest in adherence to the Volunteer Department's dress code. The uniform vest must be worn while volunteering
8. Carefully read through the Volunteer Orientation Manual provided to you at the time of the interview and sign the Acknowledgement Form
9. Accept your assignment in good faith and volunteer on a set schedule for a minimum of three months

Volunteering is rewarding but it is work, therefore, your assigned department relies on you so be on time, come with a cheerful disposition and a helpful attitude.

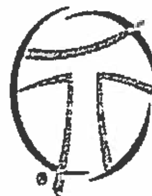
Please complete the attached application and obtain the letter of recommendation and the required signatures. Once you have the application completed in its entirety, mail it back to the hospital. Once your application has been received, an interview will be set up with Human Resources.

Thank you again and we look forward to your participation in our volunteer program.

Sincerely,

Donna Meyers
Director, Mission Integration/Volunteers
HSHS St. Elizabeth's Hospital

Volunteer Services Department
One St. Elizabeth's Blvd.
O'Fallon, Illinois, 62269
618/234-2120 ext. 11280



HSHS
St. Elizabeth's
Hospital

Youth Volunteer

PLEASE PRINT

DATE______________ SCHOOL________________________________
GRADE JUST COMPLETED __________________
GRADE AVERAGE__________________________
SOCIAL SECURITY # ______________________ BIRTHDATE____________

NAME____
LAST FIRST MIDDLE

HOME ADDRESS ____
STREET CITY ZIPCODE

HOME PHONE ___________________ CELL PHONE_______________

EMERGENCY CONTACTS:

FATHER'S NAME_________________ BUSINESS PHONE______________
MOTHER'S NAME________________ BUSINESS PHONE______________

DO YOU HAVE PREVIOUS EXPERIENCE AS A VOLUNTEER? YES____
NO____

WHERE? ____

HOBBIES, INTERESTS,TRAINING,PREVIOUS HOSPITAL WORK?

____

____

COMMUNITY AFFILIATION (CHURCH, CLUBS, ETC.)

____

____

NAME & NUMBER OF FAMILY PHYSICIAN__________________________

____

I understand that in the course of my volunteer work I may be exposed to information of a confidential nature pertaining to patients and/or their families.

I will consider as confidential all information which I may hear directly and will not seek information in regard to a patient except as it pertains to my volunteer assignment.

I will uphold the traditions and the standards of this hospital and will safeguard its reputation by maintaining the highest standards of confidentiality.

SIGNATURE________________________________ DATE _______________

Volunteer Services Department
211 South Third Street
Belleville, IL 62220
618/234/2120, ext. 1280

Please give serious consideration to your schedule before completing this form. Volunteer assignments are primarily on a weekday basis.
Please list your three choices in order of preference
DAY / TIME
MONDAY ____________________
TUESDAY ____________________
WEDNESDAY ________________
THURSDAY __________________
FRIDAY ______________________

HOSPITAL VOLUNTEER PLEDGE

Believing that the hospital has real need of my service as a Volunteer, I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously. I will conduct myself with dignity, courtesy and consideration. I will consider confidential all information which I may hear directly or indirectly concerning a patient, doctor, or any members of the staff and will not seek information in regard to a patient. I will take any problems, criticisms or suggestions to the Coordinator of Volunteer Services. I will endeavor to make my work of the highest quality. I will uphold the traditions and standards of St. Elizabeth's Hospital and will interpret them to the community at large. I pledge to serve in the capacity of a Volunteer for at least a three month commitment. I promise to observe hospital ethics and the hospital's regulations.
DATE _________________________

SIGNATURE ____

PARENTAL PERMISSION
Permission is granted for __________________________________ to participate in the Volunteer program at St. Elizabeth's Hospital. I understand that neither St. Elizabeth's Hospital nor the Department of Volunteer Services will assume any responsibility for my child prior to their signing in for duty or following their signing off of volunteer duty. I also understand that I will be responsible for their transportation to and from the hospital.

DATE ____________________ SIGNATURE __________________________
Parent or Guardian

Nov 2017

TO BE COMPLETED BY TEACHER, COUNSELOR, OR MINISTER
PERSONAL REFERENCE FOR

____
Applicant's name

The above student has applied to our Volunteer program. This program requires discipline, dependability, responsibility, pleasing personality, the ability to get along with others, personal neatness and the ability to accept and follow instructions.
In the hospital environment the student must consider all information concerning the hospital and patients as confidential.
Our program is designed to teach, expose the student to the hospital and encourage interest in the health care field.
Would you kindly complete the form below and return it to the Volunteer Services office at your earliest convenience? This student will not be considered for the program until all forms are completed. The information requested will be kept in strict confidence.

ATTITUDE____

____

ABILITY TO GET ALONG WITH OTHERS______________________________

____

____

APPEARANCE____

____

DEPENDABILITY____

____

ABILITY TO FOLLOW INSTRUCTIONS______________________________

____

____

DO YOU HAVE ANY INFORMATION CONCERNING THE APPLICANT'S HONESTY OR INTEGRITY? ______________________________

____

HOW LONG HAVE YOU KNOWN THE APPLICANT?

____

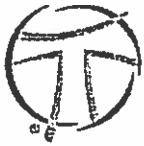
ADDITIONAL COMMENTS______________________________________

____

____

SIGNATURE______________________________ DATE ______________
RELATIONSHIP TO APPLICANT______________________________
PHONE NUMBER______________________

Nov. 2017



St. Elizabeth's Hospital Confidentiality Acknowledgement

Any information gained through association with St. Elizabeth's Hospital or its affiliates as an employee is confidential and, for the protection of all parties involved, must not be shared by or with anyone who is not properly authorized. Anyone employed by or associated with St. Elizabeth's Hospital shares in the responsibility to strictly protect the confidentiality of all hospital information. This level of confidentiality applies to information gained in any manner or from any source including verbal, written and electronic source.

Information concerning the treatment of patients is confidential and is not to be disclosed to any person or entity without appropriate patient authorization, subpoena, or court order. Confidential information or data is defined as any information where the individual, hospital(s), or physician(s) is named or otherwise identifiable. Any breach of confidentiality by an employee or volunteer may be cause for discipline up to and including termination of employment and/or prosecution under the law.

As a condition of my employment or association with St. Elizabeth's Hospital and its affiliates, I agree not too directly or indirectly disclose this information without proper authority including but not limited to the specific scenarios given below:

1. I will avoid any action that will provide confidential information to any unauthorized individual or agency.
2. I will not engage in any action or discussion involving privileged or confidential information in any form in common areas of the hospital or its affiliate entities (i.e. cafeteria, elevators, hallways, stairwells). If I observe any action or discussion involving confidential information, I will report it immediately to my supervisor.
3. I will not review patient information or files for which I am not authorized.
4. I will not make copies of any patient or other confidential data without specific authorization.
5. I will not remove confidential information from the facility except as authorized in the performance of my job.
6. I will not discuss in any manner, with any unauthorized person, employee, or non-employe, confidential information of any kind.
7. I will not provide my computer password or file access codes to any other employee or other unauthorized person. I will use only my assigned logon ID(s) and password(s) when using hospital hardware. I will use St. Elizabeth's Hospital computer capabilities only to the extent I am authorized to complete my job function.
8. If I observe unauthorized access or release of confidential records or data to other persons, I will report it immediately to my supervisor. I understand that failure to report violations of confidentiality by others is just as serious as my own violation.

I have read and understand this Acknowledgement and Agreement and will demonstrate my willingness to abide by these policies and procedures by signing below. I further understand and acknowledge that this Acknowledgement and Agreement does not constitute an employment contract and does not alter the at-will nature of my employment relationship with St. Elizabeth's Hospital or its affiliates.

Signature______________________________ Date______________________________
Print Name______________________________ Employee Number__________________
Department______________________________

HSHS
St. Elizabeth's
Hospital

INITIAL HEALTH EVALUATION

Name: ______________________ Date of Birth: __________ Age: _____ Male: ____ Female: ____

Address: ______________________ State: _____ Zip: ________ Phone #: __________

Emergency contact / relationship: ______________________ Phone #: __________

Your physician, include address: ______________________

Job title: ______________________

Social Security #: ______ _____ ________

MEDICAL HISTORY

Please check any of the following medical conditions/symptoms that you have EVER had:

Condition	If YES, please describe:	Condition	If YES, please describe:
☐ Thyroid disease		☐ Heart disease	
☐ Arthritis/Bursitis		☐ High Blood Pressure	
☐ Back Pain/Sciatica		☐ Heart murmur	
☐ Numbness/Tingling of an extremity		☐ Unexplained weight loss/gain	
☐ Depression/Anxiety disorder		☐ Chest pain	
☐ Epilepsy/Seizures		☐ Ankle swelling	
☐ Tuberculosis/Positive skin test		☐ High cholesterol	
☐ Diabetes		☐ Peptic ulcer/Reflux disease	
☐ Chemical exposure		☐ Jaundice/Liver disease	
☐ Hives/Eczema/Skin disorder		☐ Frequent headaches	
☐ Carpal tunnel syndrome		☐ Loss of consciousness	
☐ Blood or Plasma Transfusion		☐ Severe dizziness	
☐ Wear glasses/contacts		☐ Insomnia/Sleep disorder	
☐ Visual symptoms		☐ Broken bones/dislocations	
☐ Hearing difficulty		☐ Joint/Tendon injury or pain	
☐ Allergies/Hay fever		☐ Hernia	
☐ Wheezing Asthma		☐ Difficulty urinating	
☐ Chronic Cough		☐ Kidney or bladder disease	
☐ Shortness of breath		☐ Cancer	
☐ Chicken Pox			

At the present time, are you:

1. Undergoing treatment for any health problems? .... ☐ YES ☐ NO
2. Restricted in any way from physical activity? .... ☐ YES ☐ NO
3. Restricted from driving vehicles? .... ☐ YES ☐ NO

Explain any above questions answered "YES": ______________________

____

1. What medicines or drugs (prescription or non-prescription) do you routinely take? State "none" if none.

____

2. List any known allergies to medications or other things. State "none" if none.

____

3. List any surgeries and the year. State "none" if none.

____

4. What best describes your smoking/tobacco habits?

☐ Never smoked/chewed ☐ Used to smoke/chew ☐ Still smoke/chew

How many cigarettes/cigars - per day ______ per week ______

5. How many alcoholic beverages do you consume per week (beer, wine, or mixed drinks)? ______________

6. List the date and reason for hospitalizations/surgeries not previously mentioned. ______________

____

____

	Current Job	Previous Job	Previous Job
Employer			
Years worked			
Job title			
List any exposure to hazardous substances			

Please answer the following Yes/No questions:

Do you have any hobbies or other activities that involve hazardous substances? .... ☐YES ☐NO

Have you ever been ill due to your work? .... ☐YES ☐NO

Have you ever have a job involving repetitive motion? .... ☐YES ☐NO

Do you have any hobbies involving repetitive motion? .... ☐YES ☐NO

Have you ever used vibrating hand tools? .... ☐YES ☐NO

Do you regularly participate in any sport that stresses the hand, arms, and shoulders? .... ☐YES ☐NO

Have you ever had a skin problem in response to wood, metal, or chemicals? .... ☐YES ☐NO

Have you ever had breathing problems from chemical fumes? .... ☐YES ☐NO

I certify that all the above questions were answered correctly. I understand that any misrepresentation or omission of facts may be cause for immediate dismissal. I agree that further medical examinations required by St. Elizabeth's Hospital are made with my consent. I further agree to abide by the policies and practices of St. Elizabeth's Hospital governing employee and student health. I understand that my physical and mental health must be adequate to perform my job/student requirements.

Applicant signature: ______________________________ Date: ____________ Time: ________

I have interviewed the above named applicant.

☐ Approved for hire

☐ Further screening from Health Care Provider requested.

EHS staff signature: ______________________________ Date: __________ Time: ______

PHYSICAL SCREENING per Employee Health Staff

(To be completed by Employee Health Staff)

Height: ____________________ Weight: ________________________

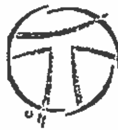
Blood Pressure: ______________ Respirations: ____________________

Vision:

20/_______ ☐ corrected

☐ uncorrected

Color: ☐ Pass ☐ Fail



Parental Consent for Minor Applicants
Substance/Alcohol Abuse Testing
Medical Treatment

I ________________________________(parent name/legal guardian name) hereby give my consent to St. Elizabeth's Hospital and to the Occupational Medicine Department to administer/perform the following lab tests and physical assessment for ____________________________ (applicant name). The purpose of such testing includes pre-employment screening, post exposure testing if necessary, annual flu vaccinations and/or reasonable suspicion testing at a future date. I furthermore give my permission for the test results to be released to St. Elizabeth's Hospital People Services Department.

- Rubella, Rubeola, Varicella Titer, as determined by need.
- Mantoux Tuberculin Skin testing.
- Physical Assessment and screening to include blood pressure, pulse, eye exam, height and weight.
- Appropriate urine and/or alcohol breath test(s) to identify the presence of drugs and/or alcohol.

Annual Flu Vaccinations

I further understand that the purpose of any performed analysis/drug test is to determine or rule out the presence of non-prescribed or prohibited dangerous controlled substances in my child's urine or alcohol in my child's bloodstream.

I hereby and herewith release St. Elizabeth's Hospital, its colleagues, agents and contractors from any and all liability whatsoever arising from this request for a urine sample or breath analysis, from the testing of the urine or breath sample, and from decisions made concerning my child's continuation of employment based upon the results of the analysis.

I give my consent and agree to have ________________________(Minor Applicant's name) cooperate in all aspects of the testing program. I also understand that the results of these tests will be released to the parent/guardian who signed this release.

______________________ Applicant Signature	______________________ Parent/Guardian Signature
______________________ Applicant Name	______________________ Parent/Guardian Name
______________________ Date Signed	______________________ Date Signed
______________________ Witness Signature	______________________ Date Signed

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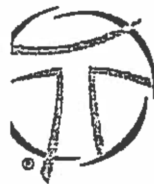


Reminders prior to arriving for your physical:

1.) Bring a photo ID (driver's license or any other state issued photo ID)
2.) Bring any vaccination records with you, including if you have had any previous Tuberculosis or Hepatitis inoculations.

If you are unsure about any vaccinations you may have received and cannot obtain medical records a blood test can be performed the day of your physical in the hospital's lab.

New Volunteers need the following:

MMR- 2 dates or positive titers for the Rubeola and Rubella virus. If not available, R and R titers can be drawn at our lab.

Chicken Pox history- had the disease or proof of 2 Varicella vaccines.
Can be sent for titers if none of the previous available.

2 step TB- we can accept one outside TB if it was given within the previous 12 months and verification can be provided with the date given, results, and date read.

TB given and then read 2-3 days later
2 weeks after the first the 2nd TB given and read in 2-3 days.

Nov. 2017

HSHS
St. Elizabeth's
Hospital

Employee Health Services
211 South Third Street
Belleville, IL 62220
618-234-2120 ext 1489

HEPATITIS B VACCINE SERIES

HISTORY & REVIEW

The undersigned certifies that he/she has read the following document and has had an opportunity to ask questions. The benefits and risks of the vaccine are outlined in the Hepatitis B Vaccine Series Informed Consent.

The vaccine will be provided free of charge for hospital staff who are considered "high risk" as defined by IC/EHS Policy VI.

The vaccine is a series of three deltoid injections. Hospital staff not in the defined "high risk" group may obtain the vaccine at cost by contacting EHS.

Hepatitis B Vaccine will not be administered to those that are acutely ill at the time of immunization, those that have allergies to yeast products, or those that are pregnant.

PLEASE COMPLETE ONE OF THE FOLLOWING RESPONSES:

_____ I request the Hepatitis B Vaccine Series, since I have not previously completed the Hepatitis B Series and it is my understanding that my job assignment places me in a defined "high risk" group.

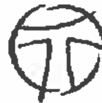
_____ I have previously received the Hepatitis B Vaccine Series. Please include date of series. ____________________

_____ I am requesting the vaccine to be provided at cost since I am not at "high risk" and I have not previously completed the Hepatitis B Series.

_____ I decline the Hepatitis B Series at this time. (IF THIS OPTION IS CHOSEN, AND THE EMPLOYEE IS DEFINED IN A "HIGH RISK" CATEGORY, THE "HIGH RISK" HEPATITIS B DECLINATION FORM MUST BE COMPLETED.)

______________________________ ______________

Name Date



Consent for Release and Treatment

Name:____

Address:____________________City_____________State_____Zip____________

Home Phone:______________________Cell Phone:________________________

Social Security Number______-_____-______ DOB:____/____/____ Age:__________

EMPLOYER: St.Elizabeth's Hospital – 211 South Third – Belleville, IL 62220 – (618)-234-2120

Department_____________ Supervisor_____________Extension_______________

CONSENT FOR RELEASE AND TREATMENT

I authorize agents of St. Elizabeth's Hospital to provide and perform medical treatment, physical evaluations, tests and procedures and to obtain medical information including from other sources deemed necessary for the purpose of evaluation of health status. I have been reasonably informed of the nature of the evaluations/tests.

I hereby authorize St. Elizabeth's Hospital to release information regarding the above evaluation to my (potential) employer or assigned agent of the employer. This consent for release of information is subject to revocation at any time except to the extent that the action has already been taken. This consent expires upon the satisfaction of the completion of all employer requirements pertaining to pre-employment, worker compensation treatment/screening.

I also authorize St. Elizabeth's Hospital to obtain from other medical facilities, medical records, and physicians, medical information on myself, including but not limited to medical records, x-rays, slides and/or tissue samples for the purpose of evaluation and treatment of worker compensation injuries and pre/post employment evaluations.

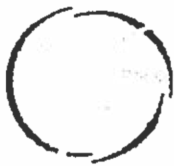
I have read the above information and understand its content and significance.

________________________ ____________________

Signature of Client Date

________________________ ____________________

Signature of Witness Date



St. Elizabeth's
HOSPITAL

Attachment C-1

EMPLOYMENT APPLICANT
CONSENT FORM FOR DRUG TESTING

I have been advised of St. Elizabeth's Hospital Drug Free Workplace Directive regarding applicants who have received a conditional offer of employment. I hereby voluntarily consent to submit to a drug test as required for employment at St. Elizabeth's Hospital. I also voluntarily consent to allow the Employee Health Nurse to arrange for the collection of one or more specimens from me as necessary. I understand and acknowledge that failure to test when requested, an alteration, adulteration, or substitution of the specimen, or a positive result of the drug test will result in the withdrawal of my conditional job offer. I also understand that I will not be eligible to make application for employment at St. Elizabeth's Hospital for a period of 1 year, should I test positive for this drug screen.

____
Name of Applicant (Please Print)

______________________________ ______________________________
Signature of Applicant Date (to be completed by Applicant)

____
Name of Witness to Signature of Applicant (Please Print)

______________________________ ______________________________
Witness Signature of Applicant Date (to be filled in by Witness)