



New Milford Hospital

Member
NewYork-Presbyterian Healthcare System
Affiliate: Columbia University College of Physicians & Surgeons

21 Elm Street
New Milford, Connecticut 06776
Phone: (860) 355-2611, Ext. 4407
Fax: (860) 210-7422
E-Mail: yagid@newmilfhosp.org

APPLICATION FOR VOLUNTEER SERVICES

Name: _____

Home Address: _____

Home Phone: _____

Occupation: _____

Business Address: _____

Business Phone: _____

Email Address: _____

Student Status: _____

Grade/School Attending

Junior Volunteer (15 - 18 years of age) Yes No

Adult Volunteer Yes No

Do You Have Friends or Relatives Employed or Volunteering at New Milford Hospital?
 Yes No

If yes, Name and Relationship: _____

Department: _____

Have you ever been convicted of a felony? Yes No

If yes, please explain: _____

Areas of interest that best reflect your skills/qualifications: _____

Please Complete Next Page

Other volunteer activities in which you have participated (present or past): _____

Your availability:

Day(s) of the week: _____

Time of day you are available to volunteer: _____ a.m. _____ p.m.

Are you available to volunteer Year Round? or

Winter

Spring

Summer

Fall

Personal Reference (Not Related to You):

Name _____

Address _____

Telephone _____

ALL APPLICANTS MUST HAVE AN INTERVIEW WITH THE DIRECTOR OF VOLUNTEER SERVICES IN ORDER TO COMPLETE THE APPLICATION PROCESS

I understand that my placement as a volunteer is dependent upon satisfactory completion of the application, interview and orientation process, and training for the volunteer position to which I will be assigned. I hereby give New Milford Hospital my permission to contact the individual whose name is provided as a reference above.

I understand that I am expected to inform the Director of Volunteer Services of any significant change in my health status that would negatively impact my ability to perform the tasks to which I am assigned.

I also understand that any falsification of the statements provided in this application will result in the cancellation of my application or discharge from the hospital service if I have already been placed.

Signature: _____ Date: _____

Parent/Guardian Signature Giving Permission (for Junior Volunteers Ages 14 - 18)

_____ Date: _____

Date of Birth (optional): _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Home Phone # _____ Work # _____

**POST ACCEPTANCE INFORMATION:
FOR COMPLETION BY DIRECTOR OF VOLUNTEERS:**

Assignment: _____ Days: _____ Times: _____



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INFECTION CONTROL/EMPLOYEE HEALTH

Volunteer Health Screening Consent Form

Name of Volunteer: _____
Please Print

Signature: _____

Date of Birth: _____

All volunteers, especially those who work in patient contact areas of the Hospital, may be put at risk of exposure to infectious disease. For this reason, we consider volunteers as employees of the Hospital in regard to certain requirements of Infection Control and Employee Health Programs.

All volunteers are required to complete self-learning modules prior to the start of their service. Important information concerning Infection Control and Employee Health is contained in these modules. In addition, Employee Health Programs will be given annually on OSHA Standards, including blood borne diseases, AIDS and Hepatitis B, the pulmonary disease Tuberculosis and Standard Precautions. Attendance is required for all employees and volunteers who work in patient contact areas.

Our policy on Tuberculosis screening requires all employees and volunteers to have TB skin testing done upon joining the Volunteer Services Program (some high risk volunteers are tested more frequently). TB skin testing will only be done on those with negative results in the past. Any exemptions from skin testing or medical evidence of recent skin testing (within three months) must be documented by a physician and sent to the Employee Health Coordinator.

The hospital also offers vaccination against the blood borne virus infection, Hepatitis B, free of charge to volunteers who work in patient care areas. A blood test to determine immunity is done prior to offering the vaccine and one month after completion of the Hepatitis B vaccine series.

Parental consent is necessary for all health screenings and/or vaccinations of those volunteers under the age of 18 years. Please read the reverse side of this form and sign the appropriate consents. The signed consent form should be presented to the Employee Health Coordinator prior to receiving any screening.

Any questions are to be directed to Judy Pilch, RN, Employee Health Coordinator at extension 7486.

See Next Page for Required Parental Consent Signatures

Parental Consent(s)

I grant permission for my son/daughter to receive the TB skin testing.

Signature Date

I grant permission for my son/daughter to receive the Hepatitis B vaccine and the associated blood testing for immunity.

Signature Date

Refusal of Parental Consent for Hepatitis B

I understand that due to my son/daughter’s possible occupational exposure to blood or other potentially infectious materials, he/she may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity for my child to be vaccinated with Hepatitis B vaccine at no charge to myself. However, I decline for my child to receive the Hepatitis B vaccination at this time. I understand that by declining this vaccine, my son/daughter may continue to be at risk of acquiring Hepatitis B, a serious disease, If, in the future, my son/daughter continues to have possible occupational exposure to blood or other potentially infectious materials and I want him/her to be vaccinated with Hepatitis B vaccine, I can have my son/daughter receive the vaccination series at no charge to me.

Parent/Guardian Signature Date

Any questions are to be directed to Judy Pilch, RN, Employee Health Coordinator at extension 7486.