



Volunteer Application

OFFICE USE ONLY

Background Check _____

Orientation scheduled _____

Orientation attended _____

**MUST be turned in with completed Volunteer Health Clearance Form.
Applications received without Volunteer Health Clearance Form will be returned.**

Date _____

Please print.

First name _____ Last name _____

Middle name _____

Email address _____

Street address _____

City _____ State _____ Zip _____

Home phone () _____ Cell phone () _____

Date of Birth ____/____/____ Age _____ Social Security # _____

Driver's License # _____ State issued _____

Emergency contact name _____ Emergency Phone () _____

Permanent address (if different from above): _____

Employment Status: Full Time Part Time Retired Not Employed

Employer _____ Occupation _____

Students: High school students must be 16 and able to do a weekday shift.

Name of school _____ Field of Study/Major _____

Skills and Experience:

What languages (other than English) do you speak?

Language _____ Conversational Fluency: Fair Good Excellent

Language _____ Conversational Fluency: Fair Good Excellent

Volunteer experience: _____

Experience with children: _____

Other pertinent experience (classes, work experience): _____

Are you interested in a career in health care? Which field? _____

continued on next page

Your first name _____ Your last name _____

There are many valid reasons to volunteer at Children's Hospital Oakland.

Please check the ONE below that BEST describes yours:

- Want to help
- Interest in being around children
- Learning about a health career
- Suggested by a friend/co-worker
- Extra time available
- School credit

Other: _____

How did you learn about our volunteer program? _____

Available Time (NOTE: Evening and weekend shifts are extremely limited.)

Please make a check ("X") in the box to indicate which time(s) you are available to volunteer.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9 a.m. to 1 p.m.					
1 to 5 p.m.					

We require two references. Please give accurate addresses so that we can mail them reference forms. (Prefer persons in the "helping fields," clergy, teacher, counselor. **No family members, please.**)

1. _____
Name Address City State Zip

2. _____
Name Address City State Zip

Have you ever been convicted of a felony or a misdemeanor? Yes No

STATEMENT OF COMMITMENT:

As a Children's Hospital Oakland volunteer, I will:

- ✓ agree to volunteer for a minimum of **100 hours and 1 shift per week**
- ✓ notify the volunteer office or the department to which I am assigned any time I am unavailable for my assignment
- ✓ decline to perform any task for which I feel I have not been adequately trained or which would put me or others at risk
- ✓ respect patient, family, and staff confidentiality; which I understand is both a patient right and the Hospital's legal responsibility. Users of electronic, verbal or written information systems have the same obligation regarding confidentiality. Information that must be considered confidential includes patient name, diagnosis and family background
- ✓ abide by the rules and regulations of Children's Hospital & Research Center Oakland and the Volunteer Department, which include wearing the name badge and volunteer uniform (when required), and recording hours with the volunteer office
- ✓ maintain the customer service standards in my interactions with patients, families and staff
- ✓ permit images or photos of me in my role as a volunteer to be used in public relations brochures or videos
- ✓ give permission for a background check to be performed by the California Dept. of Justice.

Volunteer Signature Date

Prospective volunteers under the age of 18 need the signature of a parent or guardian: As the parent/guardian of the above prospective minor volunteer, I support and recommend him/her in this opportunity.

Parent/Guardian Signature Print Name Date

Interviewer Signature Date

Mail this application with Health Clearance Form to: Volunteer Office, Children's Hospital Oakland, 747 52nd Street, Oakland, CA 94609 or fax to 510-597-7133



Volunteer Health Clearance Form

Before you begin to volunteer you must complete the Children's Hospital & Research Center Oakland's health clearance which is required of all employees and volunteers. This form may be used to document your tuberculosis (TB) and Rubella, Rubeola (measles), Mumps and Varicella immunity or you may provide other documentation that may be copied.

Name _____ Date _____

Date of Birth ____/____/____ Age _____ Telephone _____

SECTION I. TB CLEARANCE Please complete A or B for TB clearance.

May be done by your healthcare provider or at Children's. Documentation can be a copy of your immunization card/record, information on your medical provider's stationary or your provider can use this form.

A If you have NEVER had a positive TB test: You must provide documentation of **TWO** negative TB tests within the last 15 months; one of which must be within the past 3 months.

#1 TB Test (PPD): Date given _____ RFA/LFA Signature _____

Date Read _____ Result _____ Signature _____

#2 TB Test (PPD): Date given _____ RFA/LFA Signature _____

Date Read _____ Result _____ Signature _____

Clinic Stamp Required _____

Clinician Name, Title _____ OR Documentation Attached _____

TB Skin Test Information: The two-test requirement conforms to Children's Employee Health/Infection Control and CDC requirements. **TB tests and test readings are offered at no cost by Children's Employee Health Clinic. NO APPOINTMENT IS NECESSARY.** You must return to have your TB Test results read within 24-48 hours. Please go to in Room 148 of the main hospital during these drop-in hours:

Monday, Tuesday, Wednesday, Friday: 7 to 9 a.m.

Monday, Wednesday, Friday: 2 to 3 p.m.

Closed on holidays

For the skin test reading only: You must return to have your TB Test results read within 48-72 hours. If you must come later than 3 p.m., after 4:30 p.m. you can ask the ambassador at the main entrance desk to have the on-call nursing supervisor paged to read the test. Make sure that you obtain the paperwork ahead of time from Employee Health for the supervisor to complete.

NOTE: If you are under 18 years of age you must have written parental permission for the test. Forms can be obtained from the Volunteer Office.

B If you have EVER had a positive TB test: If you have ever had a positive TB skin test, you will always have a positive reaction. Employee Health requires that you provide written documentation of the positive TB skin test (including date, number of millimeters reaction) as well as results of a negative chest xray **within the last 12 months.**

1. Written documentation of positive TB skin test including date and number of millimeters reaction must be attached. It is attached.

AND

2. Report of chest x-ray done within the last year must be attached. It is attached OR Information provided below:

Chest x-ray: Date _____ Result _____

Clinician Name, Title _____

Clinician Signature & Stamp Required _____

Chest X-Ray & Positive Skin Test Information

If you do not have proof of your positive TB Skin Test, you may be required to have further TB skin testing and/or x-rays. More information and chest x-ray order forms can be obtained by the Employee Health Clinic during drop-in hours listed above. There is no charge for the x-ray and it can be done Monday through Friday on a drop-in basis in the Diagnostic Imaging Department after you have obtained the order form and are registered.

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Your first name _____ Your last name _____

SECTION 2. Measles/Mumps/Rubella Immunity

You must provide written documentation of immunity to the following diseases. This is the responsibility of the volunteer and will not be done by Children's.

- **Rubeola (measles):** Proof of immunity, demonstrated by vaccination with **TWO** doses of live measles containing vaccine (preferably MMR), one after the age of 4 or blood IgG test showing immunity to Rubeola.
- **Mumps:** Proof of immunity, demonstrated by vaccination with **TWO** doses of mumps vaccine or **TWO** MMRs or blood IgG test showing immunity to Mumps.
- **Rubella (German measles):** Proof of immunity, demonstrated by vaccination with Rubella vaccine on or after your first birthday or with MMR, or blood IgG test showing immunity to Rubella.

A MMR (Measles/Mumps/Rubella Vaccine): (1) Date _____ (2) Date _____ (after the age of four)

Clinician Name _____ Clinician signature & Stamp Required _____

OR

B Rubella titer: Result _____ Date _____ **Rubeola titer:** Result _____ Date _____ **Mumps titer:** Result _____ Date _____

Clinician Name _____ Clinician Signature & Stamp Required _____

OR

C Documentation attached

SECTION 3. Varicella/Chicken Pox Immunity

Have you had the Chicken Pox? **YES**—Proceed to Section 4 General Health Questions **NO**—Complete A, B or C below. If unsure or checked "NO" you must show proof of immunity demonstrated by vaccination with **TWO** doses of Varivax vaccine or blood IgG test showing immunity to Varicella.

A Varicella (Chicken pox vaccine): (1) Date _____ (2) Date _____

OR

B Varicella titer: Result _____ Date _____

Clinician Name _____ Clinician signature & Stamp Required _____

OR

C Documentation attached

Note on Immunizations: If you need both a TB test and MMR or Varicella immunization, the vaccine must be administered after the final TB skin test reading. Otherwise, the vaccine may cause a false reaction to the TB skin test. If you have either vaccination done before the TB test reading you will have to wait 4 weeks before having the TB testing repeated, which will delay your application process. You can receive the MMR vaccine from your healthcare provider, student health service or Berkeley Public Health located at 830 University Ave. Drop-in Tuesdays and Thursdays 1 p.m. to 4 p.m., sliding scale, 510-981-5350.

SECTION 4. General Health Questions

1. Do you have a contagious disease? YES NO If Yes, you must call Employee Health for an appointment before turning in volunteer application/health form. (510-428-3620, option #4).

2. Do you have any health conditions that would restrict your full participation in Children's volunteer program? This includes back problems that might limit lifting. (Restrictions do not limit your ability to participate in the program but may restrict your specific placement.)
 YES NO If Yes, you must call Employee Health for an appointment before turning in volunteer application/health form: 510-428-3620, opt. #4.
Pregnant women must have written approval from their doctor to volunteer.

We recommend awareness of the minimal risks in a hospital setting and suggest you consult your primary care provider or health service regarding:

- Being in good health and free of all contagious diseases.
- Having an adult Diphtheria-Tetanus or Diphtheria-Tetanus-Petussis booster within the last 10 years.
- **Do not enter any room marked "Airborne Precautions." If you are exposed to chicken pox or shingles or any other potentially infectious disease, notify Employee Health at 510-428-3620, option #4.**

FOR VOLUNTEER OFFICE USE ONLY:

CLEARANCE - Form must be kept in Volunteer office or department during the volunteer's duration of service. TB, measles and general health requirements completion verified by (must be volunteer office, EH or dept. manager):

Name (print) _____ Title _____

Signature _____ Date _____