Terrebonne
GENERAL HEALTH SYSTEM
Volunteer Auxiliary

# Volunteer Auxiliary at Terrebonne General Health System
# Consideration Form for Adult Volunteering

Thank you for your interest in the Terrebonne General Health System Volunteer Program. The Volunteers at Terrebonne General create a special partnership with staff and play an important role in our commitment to deliver quality patient care. A volunteer's willingness to give of their time and talents helps to enrich the healthcare experience of our patients. By partnering with us you help to foster our mission of providing exceptional healthcare with compassion.

## General Information

1.) The application process takes approximately 3 weeks.
2.) You have to complete a day of orientation that will be on a Monday from 8am-3pm.

## Instructions for Submitting Your Application

1.) Submit completed application packet.
2.) Applications should be returned to: Terrebonne General Health System
Attention: Elmy Savoie
P.O. Box 6037, Houma, LA 70361

## Once the Application is Received

1.) The background check will be submitted.
2.) Once the background check comes back to me:
    a.) I will call you to set up an appointment to come in and meet with me to complete some additional paperwork.
    b.) On this same day, you will meet with the employee health nurse to complete medical clearance to start.

Sincerely,

Elmy Savoie
Executive Director of Foundation
Terrebonne General Health System
985-873-4603
Elmy.savoie@tghealthsystem.com

# Terrebonne General Health System
# ADULT VOLUNTEER APPLICATION

Name: _____ Date:_____

Address:_____
Street City State / Zip

Phone:_____ Cell Phone:_____ Other:_____

Emergency Contact Person:_____
Name Relationship Phone

Family Physician:_____Phone:_____

Are you physically able to perform the job duties associated with the position for which you are applying? _____

If no, discuss:_____

How did you hear about the Volunteer Program? _____

Work Experience:_____

Special Skills or Interest:_____

## Volunteer Experience

| Institution | Address | Phone Number | Dates |
|---|---|---|---|
| | | | |
| | | | |

Have you ever been convicted of a crime in the past 10 years excluding misdemeanors and summary offenses, which has not been annulled, expunged or sealed by the court? ___Yes___No. If "yes" describe in full:

_____

_____

Can you donate at least 6 months of service to the Volunteer Program? ___Yes ___No

Applicant Signature:_____Date:_____

Opportunities for volunteers are provided without regard to race, color, sex, age, religion, national origin, marital status, sexual preference/orientation, qualified disability and veteran status.

Terrebonne
GENERAL HEALTH SYSTEM

**Employee Health Office**
**Volunteer Medical Clearance to Work –Page 1**

**NAME: _____DOB: _____SSN: _____**
**Position: _____Date of Hire: _____**
**MEDICAL HISTORY:**

1. List all allergies_____
   _____
2. LATEX Allergy [ ] Yes [ ] No Manager notified: _____
3. List all current medications and MD prescribing them: _____
   _____
4. Are you currently receiving treatment from MD, chiropractor, psychiatrist, psychologist or other health care worker? [ ] No [ ] Yes. If yes, explain _____
   _____
5. Have you ever had hepatitis A, B, or C? [ ] No [ ] Yes, list what type_____
6. Have you ever had another infectious disease? [ ] No [ ] Yes, explain _____
7. Have you ever had Tuberculosis? [ ] No [ ] Yes, when? _____
8. Have you ever had a positive Tb skin test or TB blood test ? [ ] No [ ] Yes, when?_____
   __
9. Have you ever received treatment for Tb? [ ] No [ ] Yes, when? _____
10. Date and results of last chest x-ray:
    _____
11. Have you ever received treatment for a back, neck, or knee condition from MD, Chiropractor, therapist, or other health care worker? [ ] No [ ] Yes, explain _____
    _____
12. Has a physician restricted your activity? (Example: no lifting, no standing for long periods of time, etc) [ ] No [ ] Yes , explain _____
    _____ Resolved [ ] Yes [ ] No
13. Have you ever received a disability rating for any reason? [ ] No [ ] Yes, explain _____
    _____
14. Do you possess sufficient strength to lift, transfer, move, climb steps, and assist disabled patients in a wheelchair and carry medical supplies and/or equipment safely? [ ] Yes [ ] No, explain
    _____
    _____
15. Have you ever had surgery to any part of your body? [ ] No [ ] Yes, explain _____
    _____
    _____

## Employee Health Office Volunteer Medical Clearance to Work –Page 2

Please check current or previous conditions below :

16. If you answer yes to any of the following conditions, please explain : the nature of your injury; condition or the type of treatment received; the name, address, and phone number of the doctor providing the treatment and any impairment or disability that may have been assigned as a result of the injury on the back of this page

_____

## Employee Health Office (to be filled out by Employee Health)
## Volunteer Medical Clearance to Work—Page 3

**IMMUNIZATION STATUS:**

**Hepatitis B**

| | | | |
|---|---|---|---|
| Heart Disease | [ ] Yes [ ] No | Cervical Fusion | [ ] Yes [ ] No |
| High Blood Pressure | [ ] Yes [ ] No | Knee Pain | [ ] Yes [ ] No |
| Arteriosclerosis | [ ] Yes [ ] No | Numbness or tingling of extremities | [ ] Yes [ ] No |
| Varicose Veins | [ ] Yes [ ] No | Rotator cuff injury | [ ] Yes [ ] No |
| Diabetes | [ ] Yes [ ] No | Arthroscopy | [ ] Yes [ ] No |
| Blood Disorder | [ ] Yes [ ] No | Neck Pain | [ ] Yes [ ] No |
| Thrombophlebitis | [ ] Yes [ ] No | Neck injury | [ ] Yes [ ] No |
| Cancer | [ ] Yes [ ] No | Ruptured Disc | [ ] Yes [ ] No |
| Hodgkin's Disease | [ ] Yes [ ] No | Bulging Disc | [ ] Yes [ ] No |
| Epilepsy | [ ] Yes [ ] No | Leg pain | [ ] Yes [ ] No |
| Poliomyelitis | [ ] Yes [ ] No | Fractured or broken bones | [ ] Yes [ ] No |
| Cerebral Palsy | [ ] Yes [ ] No | Shooting pains from back to lower extremities | [ ] Yes [ ] No |
| Multiple Sclerosis | [ ] Yes [ ] No | Back pain | [ ] Yes [ ] No |
| Parkinson's disease | [ ] Yes [ ] No | Back injury | [ ] Yes [ ] No |
| Stroke | [ ] Yes [ ] No | Difficulty moving lower extremities | [ ] Yes [ ] No |
| Mental Disability | [ ] Yes [ ] No | Carpal Tunnel Syndrome | [ ] Yes [ ] No |
| Head Injury | [ ] Yes [ ] No | Loss of sight | [ ] Yes [ ] No |
| Dizziness | [ ] Yes [ ] No | Difficulty with Vision | [ ] Yes [ ] No |
| Anxiety or Depression | [ ] Yes [ ] No | Difficulty with Hearing | [ ] Yes [ ] No |
| Headaches | [ ] Yes [ ] No | Sicilicosis | [ ] Yes [ ] No |
| Spinal Fusion | [ ] Yes [ ] No | Asbestosis | [ ] Yes [ ] No |
| Nervous Breakdown | [ ] Yes [ ] No | Bronchitis | [ ] Yes [ ] No |
| Mental Retardation | [ ] Yes [ ] No | Asthma | [ ] Yes [ ] No |
| Difficulty with Reflexes | [ ] Yes [ ] No | Emphysema | [ ] Yes [ ] No |
| Arthritis | [ ] Yes [ ] No | MRSA | [ ] Yes [ ] No |
| Osteomyelitis | [ ] Yes [ ] No | VRE | [ ] Yes [ ] No |
| Muscular Dystrophy | [ ] Yes [ ] No | Prostate Problems | [ ] Yes [ ] No |
| Removal of Lumbar Disc | [ ] Yes [ ] No | Ulcers | [ ] Yes [ ] No |
| Removal of Cervical Disc | [ ] Yes [ ] No | Other | [ ] Yes [ ] No |

[ ] Series of 3 vaccines completed. Date completed_____

[ ] Positive Serology. Date of titer: _____
[ ] Need Series—(Job Related) Date initiated: _____ Disclaimer/Refusal [ ]
[ ] Had Series, No Documentation [ ] Obtain Titer [ ] Sign Disclaimer
[ ] N/A

**MMR (**Measles, Mumps, Rubella)
[ ] Proof of 2 doses of live vaccine on or after 1st birthday
[ ] Positive serology. Date of titer: _____
[ ] Had 2 MMR, No Documentation [ ] Obtain titer
[ ] Had only 1 MMR, MMR provided: _____ [ ] Disclaimer/refusal
[ ]Born <1957, Obtain titer

**Varicella Zoster** (Chicken Pox)
[ ] Reliable history of varicella
[ ] Proof of two varicella vaccines
[ ] Positive serology. Date of titer: _____
[ ] Needs varicella live virus vaccine Date initiated:_____ Disclaimer/refusal [ ]
[ ]Unknown, check titer

**Tetanus**
Last tetanus shot: _____

**Flu Vaccine**
Did you take the flu shot this year? _____
Instructed to bring the following to the Employee Health Office: _____
_____ by this date: _____

.

**COVID Vaccine**

**Manufacturer:**
**[ ] Pfizer [ ] Moderna [ ]Janssen Dates of vaccine _____**

**[ ] Exemption [ ] Religious [ ] Medical [ ] Offered, Educated & Declined Date:_____**

**PPD Screening**
[ ] Current PPD (within 1 year) Date of PPD_____
[ ] **2 Step PPD required**
Date initiated: _____Date read: _____
Date of 2nd PPD: _____Date read: _____
[ ]**1 Step PPD required**: Date applied:_____ Date read:_____

[ ] History of Positive PPD in the Past [ ] TBQ Completed Q Gold results:

Have you ever received a BCG (Tuberculosis vaccine)? [ ] No [ ] Yes, when? _____

I certify that all of the answers are complete and true. I understand that any misstatements or omissions of fact are cause for dismissal. I hereby authorize Terrebonne General Medical Center to perform the Physical Exam and whatever testing may be deemed necessary as part of my Medical Clearance to work.

Signed: _____ Date:_____



**PHYSICAL EXAM:**

This position requires that the individual be able to lift or transfer adult patients, stoop, bend, lift/move objects and have adequate sensory ability to detect smell and/or odors, good vision, hearing and normal reflexes. The work could involve carrying supplies of as much as 25 pounds and climbing stairs. This person should possess sufficient strength to lift, transfer, move climb steps and assist disabled patients, (up to 150 lbs.) and carry medical supplies and/or equipment safely.

Height: _____ Weight: _____ B/P: _____ Pulse: _____

Note:_____
_____

Color Blind: [ ] No [ ] Yes Director notified: _____

**The employee candidate will have a:**

[ ] PPD 2 step [ ] PPD 1 step [ ] MMR Titer [ ] Varicella Zoster IgG [ ] Q Gold [ ]TBQ
[ ] Hepatitis B titer [ ] Chest X-Ray [ ] CBC w/diff [ ] Liver Function tests [ ] BUN
[ ] Creatinine [ ] T dap [ ] Td [ ] Influenza [ ] COVID

**Does this applicant require further testing?** [ ] No [ ] Yes—obtain the following:

_____

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**MEDICAL CLEARANCE STATEMENT:**

[ ] It is my medical opinion from the information obtained thus far that this person is free of infectious illness and is in a state of health that will allow satisfactory performance of the tasks required for this position.

[ ] Further medical clearance is necessary prior to employment regarding the following:
_____

Employee Health Nurse Signature: _____Date: _____

[ ] EH Summary reviewed and explained. Copy provided to employee.

**RELEASE AUTHORIZATION AND**
**FAIR CREDIT REPORTING ACT DISCLOSURE**
**[FOR EMPLOYMENT PURPOSES]**

The applicant for employment acknowledges that this company may now, or at any time while employed, verify information within the application, resume or contract for employment. 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.*

Please be advised that we may also obtain an *investigative consumer report* including information as to your 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. Please be advised that 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.

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).

**By signing below, 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 Release and Authorization shall remain valid and in effect during the term of my contract.**

**For Maine Applicants Only**
Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

**For New York Applicants Only**
You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

**For Washington Applicants Only**
If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

**For California*, Minnesota, and Oklahoma Applicants Only:** A consumer credit report will be obtained through Certiphi Screening, Inc., P.O. Box 541, Southampton, PA 18966.

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____
Initials Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____
Initials Initials

***California Applicants**: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report).

Date:_____ Signature of Applicant: _____

Print Full Name: _____

(Continued on Page 2)

**INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORTS ONLY**
**(to be used for no other purposes)**

Full Name _____

Date of Birth: _____/_____/_____* Social Security #: _____-_____-_____

Driver's Licenses Number: _____ State of Issue: _____

Current Residence Address: _____
(Number and Street)

_____ _____
State Zip Code

List all Residence Addresses in Past Seven Years (attach additional sheets if necessary)

_____

_____

_____

_____

_____

_____

# Volunteer Checklist

Volunteer Name: _____

Sent out info on: _____

| | |
|---|---|
| Application Completed | |
| Consent for Background | |
| Background Entered | |
| Choose Work Area | |
| Purchase Jacket / Patch | |
| Orientation Date | |
| Badge / # | |
| Badge # to Val | |
| Review Parking | |
| Confidentiality Pledge | |
| Handbook Reviewed | |
| Medical Clearance | |
| 1st PPD | |
| 2nd PPD | |
| Email Rachel | |
| Notify the cafeteria | |
| Put in Database | |
| Orient Reminder on Calendar | |
| Give Job Description | |