VOLUNTEER SERVICES

Application and Personnel Record

Today's Date ______________ ____________________

(Please Check One) ☐ Teen ☐ College Student ☐ Non-Student

Last Name	First Name	Middle Initial
☐ Mr. ☐ Mrs. ☐ Ms.	Date of Birth	

Have you ever served as a volunteer at AFCH or UWHC before? ☐ No ☐ Yes
If yes, when? ____

Permanent Address

Street Address			Apt	Phone Number (______) ________________
City	State	Zip	E-Mail Address	

Campus Address (if applicable)

Street Address			Apt	Cell Phone (______) ________________
City	State	Zip	E-Mail Address	

Emergency Contact

Name		Relationship	Home Phone (_______) __________________
Street Address			Cell Phone (_______) __________________
City	State	Zip	Work Phone (_______) __________________

Employment Information (if applicable)

I am: ☐Employed ☐Unemployed ☐Retired

Employer			Occupation	
Street Address			Department or Suite Number	
City	State	Zip	Work Phone (______) ______________	You may contact me at work. ☐ Yes ☐ No

Availability

Area(s) of volunteer interest: ____

Preferred day and time to volunteer: ---

- I certify that the statements made in this volunteer application are true and correct, and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release the University of Wisconsin Hospitals & Clinics (hereafter UWHC) and American Family Children's Hospital (hereafter AFCH) from any liability whatsoever for supplying such information.

- I understand that I will not be paid for my services as a volunteer.

- I have received the AFCH/UWHC's volunteer personnel policies and I agree to abide by the volunteer personnel policies of the AFCH/UWHC.

- I understand that I must complete the process and start volunteering in my assigned shift, in a timely manner, or communicate to Volunteer Services the reason for the delay.

- I understand I must accurately and truthfully complete a criminal background check form and submit it to volunteer services prior to beginning to volunteer or at the time of my placement interview.

Applicant's Signature: _______________________________ Date: ___________

UW HOSPITALS & CLINICS COMMITMENT AND CONFIDENTIALITY AGREEMENT

- I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, medical staff, and not seek to obtain confidential information from a patient.
- My services are donated to the hospital without contemplation of compensation or future employment, and given with humanitarian and charitable reasons.
- I shall submit to examinations, which may include chest x-rays, skin tests, appropriate laboratory tests and/or immunizations that may be necessary as part of my volunteer service. I authorize person (s) making tests of x-ray films to report the results to the UW Health Employee Health.
- I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
- I shall attempt to resolve any problems related with my volunteer activities with my supervisor, and if unsuccessful, attempt to resolve any such problems with the Manager of Volunteer Services.
- I shall make my best effort to fulfill my commitment to AFCH/UWHC by completing all assignments that I accept.
- I shall at all times uphold the Mission, Vision, Values and Code of Conduct of AFCH/UWHC.
- I understand that Volunteer Services reserves the right to terminate any volunteer status as a result of: a) failure to comply with UWHC policies, rules and regulations; b) absences without notification; c) unsatisfactory attitude, work or appearance; or d) any other circumstances which, in the judgment of the area supervisor or volunteer manager would make my continued services as a volunteer contrary to the best interests of AFCH/UWHC.
- I understand that AFCH/UWHC assumes no responsibility for any contact, visits or services provided by me outside of the responsibilities assigned through the volunteer program of UW Health Volunteer Services.

Certification of Accuracy and Completeness:
I certify that all of the information provided in this application is true and complete to the best of my knowledge. I acknowledge that I may be required to verify information prior to assignment and that any omitted, false or misleading information may disqualify me from volunteer consideration and may be grounds for dismissal.

Background Disclosure and Check:
I understand that I must fill out a Wisconsin Background Information Disclosure (BID) form and that a background check will be performed as required by law. The BID form is considered part of this application. I understand that I may be removed from my volunteer status is UWHC discovers certain crimes or offenses.

Confidentiality:
I understand that UWHC volunteers may have access to confidential patient information in the course of their duties. I promise to maintain the confidentiality of patient information and understand that unauthorized access to such information or release of such information will result in discipline that can include termination.

I have read each of the above conditions and I agree to be bound by them.

Name (please print) ____

Applicant's Signature: ________________________________ Date: ___________

VOLUNTEER SERVICES

Volunteer Reference Form

____ is applying for a volunteer position at UW Health and would like you to be a reference on their behalf. Please answer the following questions and return this letter to the potential volunteer.

1. How long have you known him/her; and in what capacity: ______________________

   ____

   ____

2. Describe any of his/her notable strengths: ___________________________________

   ____

   ____

3. Describe any notable weaknesses: ____

   ____

   ____

4. Do you feel the applicant is appropriate for interaction with patients and families, please explain: ____

   ____

   ____

5. Any additional comments: ____

   ____

   ____

____________________________________ ______________________ _____________

Signature | Phone | Date

Volunteer to hand in to Volunteer Services during Placement Interview.

VOLUNTEER SERVICES

Volunteer Reference Form

_________________________________ is applying for a volunteer position at UW Health and would like you to be a reference on their behalf. Please answer the following questions and return this letter to the potential volunteer.

6. How long have you known him/her; and in what capacity: ____________________
   ____
   ____
7. Describe any of his/her notable strengths: _______________________________
   ____
   ____
8. Describe any notable weaknesses: _____________________________________
   ____
   ____
9. Do you feel the applicant is appropriate for interaction with patients and families, please explain: ____
   ____
   ____
10. Any additional comments: ____
   ____
   ____

________________________________ ____________________ ___________

Signature Phone Date

Volunteer to hand in to Volunteer Services during Placement Interview.

Employee Health Service
University of Wisconsin Hospital and Clinics
800 University Bay Dr
Madison, WI 53705
Office: 608-263-7535
FAX: 608-262-7284

Walk-In Clinic Hours:
Mon – Wed & Friday 9-11am and 1-4pm

Volunteer Health Assessment

This form must be completed before you are seen in Employee Health Service (EHS) for your health assessment. You will not be cleared to volunteer until TB testing and immunization/immunity documentation is complete. If you have any questions regarding this form, please call EHS at (608) 263-7535.

DATE:______________**NAME: Mr. /Ms.**____
(Please Print)

BIRTHDATE:________________ **SOCIAL SECURITY NUMBER:**____________________________

ADDRESS:____**DAYTIME PHONE:**______________________
(street, city, state, zip)

Immunizations and Infection Control

Please provide documentation (day/month/year) of vaccines and/or antibody titers as requested below**. This information is required before you start your work at University of Wisconsin Hospital and Clinics. Please attach records/titer results**. You can obtain this information from your school, vaccine record, and physician's records. Please call EHS if you have any questions. If you have no records of immunizations or titers for those diseases noted below, you will need to either be immunized or have titers done at your primary care clinic.

Chicken Pox
Date of Disease: __________________
Dates of Vaccine: (1) ________________ (2)____________
Date of Titers & Result: (1) ________________ (2)____________

Measles-Mumps-Rubella (MMR)
MMR #1 ____________________
MMR #2 ____________________

------------------------------------OR-------------------------

Chicken Pox
Date of Disease: __________________
Date of Titers & Result: (1) ________________ (2)____________

Rubeola (Red Measles)
Dates of Vaccine: (1) _________________ (2) ____________
Date of Titer & Result: ____________________

Mumps
Dates of Vaccine: (1) _________________ (2)____________
Date of Titer & Result: ____________________

Rubella (German measles)
Date(s) of Vaccine: (1) _________________ (2)____________
Date of Titer & Result: ____________________

1. Current CDC guidelines state that health care workers (HCWs) born in/after 1957 need to have two doses of MMR given on/after their first birthday. If MMR vaccines were not given, the individual vaccines given at different times are acceptable if two doses of the vaccine were given on/after their first birthday. One dose of rubella vaccine satisfies the rubella immunity documentation.
2. For HCWs who do not have vaccine records; titers to the above diseases indicating immunity are acceptable.
3. HCWs born before 1957 will need to provide: 1) Titers to the above disease indicating immunity OR 2) One dose of MMR vaccine given on/after their first birthday.
4. For those who had the Chicken Pox disease, a titer indicating immunity or two doses of the varicella vaccine are required.

Tuberculosis

The TB skin test is mandatory unless you have had a positive TB skin test in the past or have documentation of a negative TB skin test within the last 6 months. The TB skin test must be read in 48-72 hours in Employee Health Service. If you cannot return to have the test read, please speak with one of the EHS clinicians to make other arrangements.

Have you ever been told you had tuberculosis? Yes No
If yes, when?________________
Provide documentation of diagnosis, chest x-ray and treatment

Date & Result of most recent NEGATIVE TB skin test *(must be within 6 months of start date)*. Attach documentation.
Date:________________
Result:_______________

Have you ever had a POSITIVE TB skin test? If yes;
Dates:_______________
Result (measurement):________
Chest x-ray: Date and results. Attach documentation

Do you have any chronic health condition? Yes No
If yes, specify:____
Are you currently under the care of a physician? Yes No
If yes, specify reason____

TO BE COMPLETED BY EHS

PPD-5TU

Given By__________________Date_____________________
Read By __________________Date _________________

Result:________mm induration

2nd Step (if necessary)

Given By__________________Date____________
Read by __________________Date____________

Result:________mm induration

CXR: Indication:_______________ Date_________ Result

EHS recommendations:

_______Cleared for volunteering
_______Not cleared: Reason______________________________
_______Volunteer office notified Date_________________

EHS Signature & Date: ______ ____