Shriners Hospitals for Children™

Volunteer Application (Individual)

FOR HOSPITAL USE ONLY

App Received _____
Interview Date _____
Orientation Date _____

PERSONAL INFORMATION

Preferred Salutation (check one)
☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Other _____

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____

SSN _____ - _____ - _____ Driver's License _____
State & Number

Email Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell ( ) _____ Birthday _____
Month / Day / Year

Do you have any physical limitations or special needs that should be considered in your placement?
☐ Yes ☐ No
If yes, please describe: _____

Are you volunteering to meet any specific requirements (Community Service Hours, etc.) for a specific reason? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever been convicted of, on probation for, and/or received deferred adjudication for, or are awaiting trial for, any felony or misdemeanor? ☐ Yes ☐ No
If yes*, please explain and provide dates: _____

_____

* Criminal history will not necessarily disqualify an applicant.

PERSONAL REFERENCES (exclude relatives)

Name _____ Phone ( ) _____
Email _____ Alt Phone ( ) _____

Name _____ Phone ( ) _____
Email _____ Alt Phone ( ) _____

CURRENT EMPLOYMENT STATUS

Current Employment Status (check only one)
☐ Work Full-Time ☐ Work Part-Time ☐ Student ☐ Unemployed ☐ Retired

Employer _____

Supervisor Name _____ Phone Number (_____) _____

Your Title _____

Brief Description of Duties _____

EXPERIENCE/SKILLS

Check highest level of education completed:
☐ Did not complete high school ☐ High school graduate or GED
☐ Some college ☐ Associate's Degree / Completed 2 Yrs College
☐ 4-year Degree ☐ Advanced Degree

Have you ever volunteered before? ☐ Yes ☐ No
If yes, please provide:
Organization _____ How long? _____ Yrs _____ Mths

Brief description of duties/responsibilities: _

_____

Can you use a computer? ☐ Yes ☐ No
If yes, with what computer programs are you familiar:
☐ MS Word ☐ Excel ☐ PowerPoint ☐ Outlook ☐ Access

☐ Other _____
If no, would you like to learn the computer? ☐ Yes ☐ No

Would you be comfortable answering the telephone? ☐ Yes ☐ No

Are you fluent in any language(s), other than English?

SPEAK	WRITE
☐ Spanish	☐ Spanish
☐ Vietnamese	☐ Vietnamese
☐ French	☐ French
☐ Other _____	☐ Other _____

List any other skills, interests, certifications, or special abilities we should take into consideration.

_____

_____

INTERESTS & AVAILABILITY

Please indicate the type of service(s) you would most prefer to do in our hospital:
☐ Office Assistant ☐ Clinical Care Areas ☐ Pet Partners Program
☐ Child Life Areas ☐ Greeter / Tour Guide ☐ Special Events (Seasonal)

* If interested in the Pet Partners Program please list type of pet, and provide a copy of your Pet's Certificate of Training. List type of pet here: _____

Check days and provide specific times you are available to work for each.

DAY	MORNING	AFTERNOON	EVENING
☐ Monday			
☐ Tuesday			
☐ Wednesday			
☐ Thursday			
☐ Friday			
☐ Saturday			
☐ Sunday			

How long do you expect to be a volunteer for Shriners Hospitals for Children – Galveston?

☐ Seasonal ☐ Summer Only ☐ Less than six months ☐ Winter Texan ☐ Duration

Why do you want to volunteer at Shriners Hospitals for Children – Galveston? _____

_____

How did you learn about Shriners Hospital volunteer services? _____

MEDIA CONSENT

☐ I understand and hereby consent that my photograph may be taken for the purpose of promotion of services at Shriners Hospitals for Children. I am aware that I will not receive payment of any kind for my participation and grant Shriners Hospitals for Children the rights to their use for my future association with the hospital and for an unrestricted time.

AUXILIARY APPLICATION

☐ I am interested in joining the Shriners Hospitals for Children – Galveston Auxiliary. **I understand that the Auxiliary requires an initial membership payment of $5.00, due prior to starting your first work day.** After which a vote of approval will take place during the next Board Meeting. The Auxiliary board meets the 1st Wednesday of each month. Upon approval, annual dues of $5.00 will be expected. Additionally, I understand that certain rules & regulations, separate from those of the hospital, are to be adhered to as a member of the Auxiliary.

I certify that all information contained in this application is true and authorize its investigation, and hereby release all parties from any liability arising from such investigation. I also agree that any false statement, misrepresentation, or omission of facts on this application, regardless of when discovered, will result in immediate dismissal.

Should I be accepted as a Shriners Hospitals for Children - Galveston Volunteer, I have no expectation of remuneration for the services I will provide.

_____

Signature **Date**

PRE-VOLUNTARY DISCLOSURE & RELEASE

Name _____
First Middle Last

Any other name you have volunteered under: _____

Address _____

City _____ State _____ Zip _____

SSN _____ - _____ - _____ Driver's License _____
State & Number

Birthday _____ Daytime Phone _____
Month / Day / Year

Pursuant to the requirements of the Fair Credit Reporting Act, **I acknowledge that a consumer report[1] and/or investigative consumer report[2] may be made in connection with my application for volunteering with prospective facilities.** I understand that these investigative background inquiries may include credit, consumer, criminal, driving, prior volunteering, and other reports. These reports may include information as to my character, work habits, performance, and experience, along with reasons for termination of past volunteering from previous facilities. Further, I understand that agents may be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, criminal, civil, and other experiences, as well as claims involving me in the files of insurance companies.

I authorize, without reservation, any party or agency to furnish the above mentioned information. A photocopy of this authorization shall have the same effect as the original.

I understand the information obtained will be used as one basis for volunteering or denial of volunteering. I hereby discharge, release, and indemnify prospective school, their agents, servants and schools, and all parties that rely on this release and/or the information obtained with this release from any and all liabilities and claims arising by reason of the use of this release and dissemination of information that is false and untrue if obtained from a third party without verification.

It is expressly understood that the information obtained through the use of this release will not be verified by investigating agents.

The authorization granted herein expires one year from the date hereof.

I have read and understood the above information, and assert that all information provide by me is true and accurate.

If you are under the age of eighteen, the signature of a parent or guardian must be obtained.

VOLUNTEER'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____
(Required if applicant is under 18)

If you are denied voluntary, either wholly or party because of information contained in a consumer report, a disclosure will be made to you of the name and address of the investigative agency making such report. Upon your written request within a reasonable period of time, the investigative agency compiling the report will make a complete and accurate disclosure of the nature and scope of the investigation.

[1] A consumer report may consist of enrollment records, educational verification, licensure verification, driving record, previous address and public records relative to criminal charges.

[2] **An "Investigative Consumer Report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with person having knowledge**

TUBERCULOSIS SKIN TEST DOCUMENTATION

Employee / Volunteer Name: _____

Social Security Number: _____

Tuberculin Purified Protein Derivative (PPD) for intracutaneous (Mantoux) tuberculin testing:

Date Administered: _____ Site: _____Rt. _____Left (forearm)

Dose/Route 0.1 ml of 5 Tuberculin Units, intradermal (intracutaneous) or otherwise as follows:
_____

Name of Person Applying Test:

_____ _____

Print Name Signature and Title

Interpretation of Tuberculin PPD Skin Test:

Date of Reading: _____ Millimeters (MM) Induration: _____

Vesiculation/Ulceration/or Necrosis at Test Site _____ Yes _____ No

Name of Person Who Read Test:

_____ _____

Print Name Signature and Title

_____

Name of Institution

_____

Street City State Zip Code

Phone: Fax:

Return Documentation form to:

Shriners Hospitals for Children – Galveston (Volunteer Department)

815 Market Street, Galveston, TX 77550

Phone: (409) 770-6520 Fax: (409) 770-6547

SHRINERS HOSPITALS FOR CHILDREN-GALVESTON

OCCUPATIONAL HEALTH HISTORY QUESTIONAIRE

Name:_____ Date:_____ SS#:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: ( )_____ DOB:_____ Age:_____

Personal Physician/Provider:_____ Phone: ( )_____

Emergency Contact: Name_____ Relationship:_____ Phone: ( )_____

PERSONAL HEALTH HISTORY

Have you **ever had**, or **do you have**, any of the following? If **yes**, please indicate the year in which it occurred.

Skin problems or chronic rash	☐Yes ☐No	Liver trouble/hepatitis	☐Yes ☐No	Back pain/injury	☐Yes ☐No
Eye problems	☐Yes ☐No	Recurrent/persistent diarrhea	☐Yes ☐No	Sciatica/disc problem	☐Yes ☐No
Wear glasses/contacts	☐Yes ☐No	Weight problems/changes	☐Yes ☐No	Numbness/tightness in legs/feet	☐Yes ☐No
Hearing Loss/ear trouble	☐Yes ☐No	Thyroid trouble	☐Yes ☐No	Knee injury	☐Yes ☐No
Frequent colds	☐Yes ☐No	Herpes simplex or zoster	☐Yes ☐No	Foot problems	☐Yes ☐No
Allergies	☐Yes ☐No	Hernia/rupture	☐Yes ☐No	Severe/unusual headaches	☐Yes ☐No
Chronic cough	☐Yes ☐No	Alcohol/drug problems	☐Yes ☐No	Dizziness/fainting spells	☐Yes ☐No
Asthma	☐Yes ☐No	Shoulder/elbow/hand pain	☐Yes ☐No	Epilepsy/seizures	☐Yes ☐No
Lung problems	☐Yes ☐No	Diabetes	☐Yes ☐No	Sever weakness/tiredness	☐Yes ☐No
Shortness of breath	☐Yes ☐No	Carpal tunnel syndrome	☐Yes ☐No	Depression/anxiety	☐Yes ☐No
Tuberculosis	☐Yes ☐No	Tendonitis	☐Yes ☐No	Emotional/nerve problems	☐Yes ☐No
Heart trouble/attack	☐Yes ☐No	Numbness/tightness in arms/hands	☐Yes ☐No	Bruising of unknown cause	☐Yes ☐No
Palpitations	☐Yes ☐No	Discoloration of joints	☐Yes ☐No	Immune suppression	☐Yes ☐No
High blood pressure	☐Yes ☐No	Broken bones	☐Yes ☐No	Blood disease	☐Yes ☐No
Stroke or paralysis	☐Yes ☐No	Bone/joint problem	☐Yes ☐No	Tumors/cancer	☐Yes ☐No
Stomach/duodental ulcer	☐Yes ☐No	Arthritis/gout	☐Yes ☐No	Anemia	☐Yes ☐No
Yellow jaundice	☐Yes ☐No	Neck pain/injury	☐Yes ☐No		

51. Have you ever had a motor vehicle accident resulting in injury? ☐Yes ☐No

52. Have you ever had a work related injury or illness? ☐Yes ☐No

53. Have you ever had

a) Needle sticks/blood or body fluid exposures ☐Yes ☐No

b) Rash or symptoms related to glove use ☐Yes ☐No

c) Pain, numbness, or tingling related to repeated hand/wrist motions or keyboard use ☐Yes ☐No

54. Are you presently under a health provider's care of any condition? ☐Yes ☐No

55. Please list the dates and reason for your last medical examination _____

56. Have you ever had an illness or injury since your last medical examination? ☐Yes ☐No

57. Have you ever been hospitalized or had an operation? ☐Yes ☐No

58. Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants. animals, latex gloves, or any other substances? ☐Yes ☐No

Please describe any YES answers from questions 51-58. Include dates: _____

_____

_____

59. What medications do you regularly or frequently take?_____

60._____

61._____

I HERBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS HEALTH QUESTIONNAIRE FOR EMPLOYEMENT UIS TRUE AND CORRECT AND ANY OMMISSION OR MISREPRESENTATION OF FACTS WILL BE A BASIS FOR IMMEDIATE DISMISSAL.

Signature: _____ Date: _____

OCCUPATIONAL HEALTH NOTES: _____

_____

_____

Occupational Health Nurse Signature: _____ Date: _____

SHRINERS HOSPITALS FOR CHILDREN-GALVESTON

NATURAL RUBBER LATEX (LATEX) SCREENING FOR EMPLOYEES AND STAFF

The questions in the questionnaire may identify food allergies, medications or medical and surgical history that are sometimes found in people who have latex allergy. A positive response to any of the following questions means additional information may be needed to make a determination whether you should avoid contact with latex. The Employee Health Nurse will evaluate your responses and make any recommendations regarding latex that you may need. **Answer each question. If a question does not apply to you, leave the field blank.**

DEFINITIONS FOR WORDS IN THE TOOL

Anaphylactic: An allergic reaction so severe it may be life-threatening. These occur very rarely.
Congenital Abnormalities: A deformity or skeletal problem you are born with. The most important are those that require surgery to correct. E.g. spina bifida (sometimes called "open spine.")
Latex Birth Control Devices: Condoms and Diaphragms.
Dental Cofferdams: A latex (rubber) barrier (sometimes called "dam") placed in the mouth during procedures, e.g. when capping teeth.

FURTHER QUESTIONS

Why is it important if I am on specific medications? The listed medications are beta-blockers. If a person is on a beta-blocker medication and has a mild natural latex rubber allergy, the beta-blocker medication could cause the person to have an allergic asthmatic attack because the medication and the allergy both cause the lung to tighten up.

This tool is not intended to be all-inclusive. Individuals who are uncertain whether they are or may be sensitive to natural rubber latex should consult their physician.

Employee Name: _____ Dept/Rm:_____

1. Have you ever had an anaphylactic reaction to latex device/products? ☐Yes ☐No
   If yes, under what circumstances did it occur?

2. Have you ever been told by a doctor that you have an allergy to any latex product? ☐Yes ☐No
   If yes, what specifically did the doctor say you were allergic to?

3. Do you have any congenital abnormalities (i.e. spina bifida, myeloma, myelodysplasia)? ☐Yes ☐No

4. Have you had a reaction to the following personal sources of latex?

Balloons	☐Yes	☐No	Pacifiers, teething rings	☐Yes	☐No	Face masks	☐Yes	☐No
Rubber gloves	☐Yes	☐No	Belts, bras, suspenders	☐Yes	☐No	Elastic bandages	☐Yes	☐No
Hot water bottles	☐Yes	☐No	Rubber grips	☐Yes	☐No	Elastic cuffs/waistbands	☐Yes	☐No
Rubber bands, balls	☐Yes	☐No	Latex birth control devices	☐Yes	☐No	Ostamy bags	☐Yes	☐No
Foam pillows	☐Yes	☐No	Dental cofferdams	☐Yes	☐No	Shoewear	☐Yes	☐No
Baby bottles, nipples	☐Yes	☐No	Erasers	☐Yes	☐No	Other_____	☐Yes	☐No

5. After handling latex products, have you experienced any of the following?

Difficulty breathing	☐Yes	☐No	Itching (hands, eyes)	☐Yes	☐No	Hives	☐Yes	☐No
Chapping or cracking of hands	☐Yes	☐No	Redness	☐Yes	☐No	Other_____	☐Yes	☐No
Runny nose/ congestion	☐Yes	☐No	Selling	☐Yes	☐No			

6. Do you have a history of the following?

Contact dermatitis	☐Yes	☐No	Hay fever	☐Yes	☐No	Autoimmune Disease	☐Yes	☐No
Asthma	☐Yes	☐No	Eczema	☐Yes	☐No	Lupis	☐Yes	☐No

7. Do you have any food allergies? ☐Yes ☐No If yes, are you allergic to the following?

	Recent onset	Long-standing		Recent onset	Long standing		Recent onset	Long standing		Recent onset	Long-standing
☐ Banana	☐	☐	☐ Tomatoes	☐	☐	☐ Peaches	☐	☐	☐ Potatoes	☐	☐
☐Avocados	☐	☐	☐ Kiwis	☐	☐	☐ Papaya	☐	☐	☐ Chestnuts	☐	☐
									☐ others	☐	☐

If yes, describe the reaction:

8. Do you take any of the following medications? ☐ Yes ☐ No
propranolol (Inderal), atemolol (Tenormin), acebutolol (Sectral), betaxolol (Kerlone), bisoprolol (Zebeta), carteolol (Cartrol), carvedilol (Coreg), esmolol (Brevibloc), Iabetolol (Trandate, Normodyne), metoprolol (Lopressor), nadolol (Corgard), penbutalol (Levatol), pindolol (Visken), sotalol (Betapace), and Timolol (Blocadren).

9. Have you had any previous surgeries? ☐ Yes ☐ No How many before the age of one year?___ Types of surgical procedures:_____

10. Have you ever had extensive dental work? ☐ Yes ☐ No Define "extensive"_____

11. Does your occupation involve contact with products containing latex? ☐ Yes ☐ No If yes, which products?_____