VOLUNTEER APPLICATION
RESEARCH PLACEMENT

(Please Print)

Today's Date ____________________

Name: ____________________

Address: ____________________

City: ____________________ **State:** ______ **Zip:** __________

Telephone: ____________________ ☐ **Home** ☐ **Work** ☐ **Mobile**

E-Mail ____________________
(Please provide a valid e-mail address for ongoing correspondence)

Are you over 18 years of age? ☐ **Yes** ☐ **No** **Date of Birth** __________

RESEARCH PLACEMENT INFORMATION

Principle Investigator: ____________________

Department: ____________________

Phone Number: ____________________

E-Mail: ____________________

Duration of Assignment ☐ **3 mos.** ☐ **6 mos.** ☐ **1 yr** ☐ **>1 yr** ☐ **Open**

EDUCATION INFORMATION

Name/Location of School: ____________________

Last Year Completed: __________ **Degree Awarded:** __________

****

OFFICE USE ONLY:

Rcvd/Ack _____/_____ **Complete:** ☐ **Yes** ☐ **No**

Int. Request __________ **Int. Scheduled** __________

Dept. __________ **Comments:** __________

Please give us the name and number of a family member or other person whom we should contact in case of emergency:

Name: ______________________________

Relationship: ______________________________

Telephone: ______________________________ ☐ **Home** ☐ **Work** ☐ **Mobile**

AUTHORIZATION

I understand that Connecticut Children's Medical Center will consider me for a volunteer position on the basis of the information I have furnished on this application form, and that any false, misleading or incomplete statements made by me, or any omission of material fact shall prevent my volunteering or shall be cause for immediate dismissal from my volunteer assignment. I understand that the staff of the Volunteer Services Department will be conducting a background check on me prior to being placed in the hospital. As part of the volunteer application process, and at any time during my volunteer placement, I authorize Connecticut Children's or any of its affiliates to obtain the record of any conviction for commission of a felony.

______________________________ ____________________

Signature **Date**

Due to the large volume of applications received, submissions cannot be personally delivered to the Medical Center. Completed application packets must be faxed or mailed to the address listed below

Connecticut Children's Medical Center
Volunteer Services Department
282 Washington Street
Hartford, CT 06106
FAX (860) 545-9525

VOLUNTEER AGREEMENT

If I am accepted as a volunteer at Connecticut Children's Medical Center, I agree that:

- I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients or employees, and not seek to obtain confidential information from a patient.
- My services are donated to the medical center without contemplation of compensation or future employment.
- I shall not sell goods or services, request contributions, or distribute political or religious materials on medical center premises.
- I will provide documentation of a current TB test and I will submit documentation for the MMR series if requested by Volunteer Services. I understand that if my TB test is positive I will need to have further testing done by my own physician at my own expense and provide a physician's letter stating the findings.
- I shall make my best effort to fulfill my commitment to the medical center by completing all assignments that I accept.
- I shall attempt to resolve any problems related to my volunteer activities with my supervisor and if unsuccessful attempt to resolve such problems with the Volunteer Services staff.
- I shall notify my immediate supervisor if I am unable to work as scheduled.
- I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of

  1. failure to comply with medical center policies, rules and regulations;
  2. absences without prior notification;
  3. unsatisfactory attitude, work appearance; or
  4. any other circumstances which, in the judgment of the Coordinator of Volunteer Services, would make my continued service as a volunteer contrary to the best interests of the medical center.

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

________________________________ ____________________

Signature Date

VOLUNTEER PLEDGE OF CONFIDENTIALITY

Volunteer Services Department
Connecticut Children's Medical Center

I,___________________________________, have requested to be a volunteer. I understand that as a volunteer, I may have access to confidential patient information or information about a family. I understand that communication of, or access to such information, is acceptable only in discharge of my duties and responsibilities. Any such discussion shall not take place in public places (elevators, lobbies, cafeteria, off premises, etc.) or in the presence of persons not entitled to such information.

I further understand that the law provides for possible civil and criminal penalties for disclosure of confidential patient information. As such, I agree that I will not:

- Reveal to anyone the name or identity of a patient.
- Repeat to anyone any statements or communications made by or about the patient.
- Reveal to anyone any information that I learn about the patient as a result of discussions with others providing care to the patient.
- Write or publish any articles, papers, stories or other written materials that the names or identities of any patient can be discerned. If a paper or student journal is written about my volunteer work here, I agree that I will submit it to my hospital supervisor for review.

I have read this statement and understand my obligation to maintain patient confidentiality. I agree to honor that obligation and I understand that any breach of this policy may result in termination from the volunteer program.

________________________________ __________________
Signature Date

____
Printed

To: **Connecticut Children's Medical Center Volunteers**
Re: **Immunization Documentation**

Connecticut Children's MEDICAL CENTER

Please submit the following immunization form to your physician. Documentation verifying receipt of all immunizations listed below is required at time of application submission.

To be completed by physician:

Please provide record of your patient listed below, who has applied for volunteer work at Connecticut Children's Medical Center. In the event that vaccination records are unavailable or that the vaccinations for measles, mumps and rubella have not been received, your patient must be vaccinated prior to volunteering at Connecticut Children's Medical Center.

NAME: ______________________________

DATE TDaP BOOSTER ___________________________
DATE TETANUS OR T/D BOOSTER: ___________________________
DATE MMR #1: ___________________________
DATE MMR #2: ___________________________
DATE OF INFLUENZA VACCINATION: ___________________________

Were vaccinations after the age of 15 months? ☐ **Yes** ☐ **No**
Has the above patient had Chicken Pox? ☐ **Yes** ☐ **No**

Physician's Signature: ____

Date PPD #1 placed: ______________ Date PPD #2 placed: ____________
Date PPD Read: ______________ Date PPD Read: ____________
Results of PPD: ______________ Results of PPD: ____________
Read By: ______________ Read By: ____________

Signature: _______________________ Date: ______________________

In an attempt to discourage the spread of childhood diseases throughout the hospital community, we require ALL volunteers to provide documentation of specific vaccinations.

All volunteers will be required to provide documentation of the TDaP booster. This vaccination protects against diphtheria, tetanus and pertussis.

Pertussis (whooping cough) is a highly contagious disease. There has been a steady increase of pertussis in the U.S. over the last 20 years. Adults are the most common source to spread infection of pertussis to infants/children, driving the CDC recommendation to vaccinate age in adulthood. Infants and immune compromised children are at the greatest risk of serious complications-including death- from pertussis. In order to protect our most vulnerable patient population, an adult dose of pertussis vaccination is required.

Regarding measles vaccination, Connecticut Children's Medical Center requires that all volunteers born on or after January 1, 1957, provide documentation of having been; 1) Infected with measles or, 2) Having received the MMR vaccine or measles vaccine twice after January 1, 1969 at 15 months of age or older.

Volunteers joining Connecticut Children's Medical Center during flu season (October 1- December 31) will be required to show documentation of influenza vaccination as well. All volunteers are required to have annual influenza vaccinations, and will receive a hang tag for their badge each year to ensure compliance.