

Please check the box to the left of the appropriate facility:

- ☐ Vidant Medical Center
☐ Vidant Beaufort Hospital
☐ Vidant Bertie Hospital
☐ Vidant Chowan Hospital

- ☐ Vidant Duplin Hospital
☐ Vidant Edgecombe Hospital
☐ Vidant Pungo Hospital
☐ Vidant Roanoke-Chowan Hospital

- ☐ Vidant SurgiCenter
☐ The Outer Banks Hospital
☐ Other _____



VIDANT HEALTH™ VOLUNTEER SERVICES APPLICATION FOR VOLUNTEER SERVICE

To The Applicant:

We appreciate your interest in Vidant Health and we are sincerely interested in your qualifications to serve our patients and families. Questions on this application are asked for the sole purpose of considering you for volunteer service. We do not discriminate on the basis of race, religion, sex, national origin, age, or handicap status. A 3-MONTH COMMITMENT IS REQUIRED FOR SCHOOL OR JOB REFERENCE.

Date: _____

(Circle One) Mr./ Ms. / Miss / Mrs.

Name (Last)	(First)	(Middle)	(Preferred)	HOME PHONE
Present Address (number and street)				BUSINESS PHONE
City, State, Zip Code			CELL PHONE	
OCCUPATION			CELL PROVIDER	
DATE OF BIRTH		EMAIL ADDRESS		
HAVE YOU WORKED FOR VIDANT? IF YES, WHEN? _____		HAVE YOU WORKED HERE BEFORE? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> WHEN? _____		EARLIEST DATE AVAILABLE
How did you hear about volunteering at VEH _____ Have you previously volunteered here? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____ Are you currently a student? If so, where? _____				

MISCELLANEOUS REQUIRED INFORMATION (PLEASE ANSWER ALL QUESTIONS CAREFULLY)

In case of emergency, notify _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (name) (relationship) (phone) </div>		
Physician to contact: Dr. _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (name) (phone) </div>		
Describe any work-related limitations, physical or emotional _____		
Hobbies, Education, Skills, Interests _____		
Have you ever pleaded guilty or been convicted of a crime other than a minor traffic violation: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Explain: _____		
Are you related to anyone employed by us: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and relationship _____		
If you desire to earn volunteer hours for school or another organization with a special program for credit (club, etc., we do not accept community service hours) please list: <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> (organization) (reference person) (phone) </div>		
Why do you want to be a volunteer? _____ _____ _____		

BEGINNING ASSIGNMENT TYPE _____

ASSIGNMENT AREA _____

TIME _____

START DATE _____

FOR OFFICE USE ONLY PRINT FULL NAME (Last) (First) (Middle) (Preferred)

ORIENTATION DATE (Month) (Day) (Year)

PLEASE CHECK ALL AREAS OF INTEREST

- | | | |
|--|---|--|
| <input type="checkbox"/> CLERICAL | <input type="checkbox"/> RECEPTION/FAMILY WAITING | <input type="checkbox"/> PATIENT TRANSPORT |
| <input type="checkbox"/> NURSING | <input type="checkbox"/> OTHER _____ | |
| <input type="checkbox"/> NO PREFERENCE | | |

VOLUNTEER COMMITMENT – Most volunteer positions require the volunteer to commit a minimum of four (4) hours of service once a week. Special service areas require cross-training and a commitment of a total of four (4) months. A three month commitment is required for a school or job reference.

TRAINING/HEALTH – A JCAHO volunteer orientation and health screen is required before placement and cross training. An update of the health screen and JCAHO competency review is required annually. All current required immunizations will be given unless documented proof is submitted with the application.

Name: _____

Date: _____

ACKNOWLEDGEMENT AND RELEASE: SUBSTANCE PREVENTION POLICY

I have been informed and acknowledge that Vidant Health (VH) and its subsidiary corporate entities have a Substance Abuse Prevention Policy which includes a Zero Tolerance Provision. I understand that applicants for positions with these corporations may receive pre-employment drug screening as part of the hiring process and that hiring decisions are contingent upon the results.

I specifically consent and agree to provide body fluid samples (blood and/or urine) for drug and/or alcohol screening in accordance with the policy as part of the application process.

I understand that if I am not accepted because of a positive drug screen, I will not be reconsidered for volunteer service at VH or any of its subsidiary corporate entities until I can document twelve (12) continuous months of treatment for drug abuse.

I understand and specifically consent and agree that any positive drug screening results will be furnished to the appropriate Volunteer Department and to my professional licensing board, if appropriate, I further understand that once accepted, subsequent positive screens or refusal to provide samples when requested will make me subject to disciplinary action up to and including termination.

SIGNATURE OF VOLUNTEER

SIGNATURE OF PARENT/GUARDIAN
(If under 18 years of age)

DATE

DISCLOSURE/AUTHORIZATION STATEMENT

By this document, Vidant Health (VH) and its subsidiary corporate entities disclose to you that a consumer report may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment.

This shall authorize the procurement of a consumer report by VH and its subsidiary corporate entities as part of the pre-employment background investigation. If hired, this authorization shall remain on file and shall serve as an ongoing authorization for the appropriate corporate entity by which I am employed to procure consumer reports at any time during my employment period.

In connection with this request, I authorize all corporations, companies, former employers, supervisors, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, motor vehicle bureaus, military services and persons to release information they may have about me to the corporate entity of Vidant Health with which this form has been filed or an agent acting on its behalf and release all parties involved from any liability and responsibility for doing so.

This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

I understand that I have the right upon written request within a reasonable period of time, to request additional disclosure as to the nature and scope of the investigation.

I authorize the National Personnel Records Center, St. Louis, MO or other custodian of my military records to release to the corporate entity of VH to which I am applying or its agent acting on its behalf, information or photocopies of my military personnel and related medical records or only the following information/records:

Applicant's Signature	Print Name (Full Name)	Date
Birth Name (Full Name)	Social Security Number	
Date of Birth	Driver License Number	State
Military Service#:	Branch of Service:	
From:	to	



VIDANT HEALTH™

Criminal Record Check Form

Criminal record checks will be performed on every applicant at Vidant Health (VH) or its subsidiary corporate entities.

If the information you furnish on this form is found to be false, you will be disqualified/dismissed.

You will not be considered for future employment/service for 18 months.

Please answer the following questions concerning your past history (Check all that apply):

1. Have you ever been
 - a. Convicted of a misdemeanor? Not necessary to include minor traffic infractions. ☐ Yes ☐ No
 - b. Convicted of a worthless check(s) (if you have paid off a check at Magistrate's office or Courthouse this is probably a worthless check conviction)? ☐ Yes ☐ No
 - c. Convicted of any DWI's (Driving While Impaired)? ☐ Yes ☐ No
 - d. Convicted of violation or violations of any drug laws the Controlled Substances Act of North Carolina or similar laws of any state or nation? ☐ Yes ☐ No
 - e. Convicted of any crimes of violence such as assault, harassment, communicating threats, rape, kidnapping, manslaughter, murder? ☐ Yes ☐ No
 - f. Convicted of a felony? ☐ Yes ☐ No
 - g. Convicted of any crime involving child abuse, child neglect, or indecent liberties with a minor? ☐ Yes ☐ No
 - h. Convicted of a violation or violations of a Professional Practice Act? ☐ Yes ☐ No

IF THE ANSWER TO ANY OF THE FOREGOING QUESTIONS IS "YES", PLEASE EXPLAIN EACH CONVICTION ON THE BACK SIDE OF THIS FORM, INCLUDING COUNTY AND STATE OF CONVICTION. IF NEEDED, ADDITIONAL SHEETS ARE AVAILABLE UPON REQUEST IN THE OFFICE FROM WHICH YOU OBTAINED THIS APPLICATION.

2. Please list all names you have ever been known by including birth name, previous marriage(s), legally changed, nicknames and aliases.

(1) _____ (2) _____
(3) _____ (4) _____

3. Please list street, city and state where you have lived for the last ten (10) years including military and school addresses (use additional sheet if more space is needed).

Street _____	Street _____	Street _____
City _____ County _____	City _____ County _____	City _____ County _____
State _____ Zip _____	State _____ Zip _____	State _____ Zip _____
Dates from _____ to _____	Dates from _____ to _____	Dates from _____ to _____

I hereby certify that the answers on this application and this insert are true and correct, all that any misrepresentation or false information on my part will disqualify me as a candidate for employment/service, or if employed, will be grounds for discipline up to and including termination.

In connection with this request, I authorize all law enforcement agencies, city, state, county and federal courts to release information they may have about me to the corporate entity of VH to which I am applying or someone acting on their behalf.

Signature of Applicant _____

Date _____

Print Full Name _____

Social Security Number _____

Date of Birth _____

Valid Driver's License Number (if you do not have license state reason) _____

Current Address _____

State where license was issued _____

City _____ State _____ Zip _____

Dates: from _____ to _____

Date of Birth is required solely for purpose of conducting a criminal record check and will not be used for any other reason in the employment/service or application process.

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____

Please use this sheet to explain your conviction(s).

DATE of Conviction: _____

COUNTY & STATE of Conviction: _____

CONVICTION: (Crime for which you were convicted): _____



Occupational Health

Confidential Record

Name (First, Middle & Last)

Date of Birth

/ /

Age

Street Address

City, State Zip Code

Personal Physician's Name

Physician's Address

Physician's Phone number

- -

Name of Emergency Contact

Emergency Contact Phone Number

- -

Allergies (Food-Medication-Latex, etc.)

ACKNOWLEDGEMENT OF INSTRUCTION REGARDING ACCIDENTAL INJURY

If you sustain an injury while on duty at Vidant Health, please go to VEH Occupational Health.

ACKNOWLEDGMENT OF INSTRUCTION REGARDING BLOOD EXPOSURES

All **blood exposures** are to be immediately reported to the Manager/Supervisor/Charge Person and an Employee Event Form is to be **taken** to Vidant Edgecombe Hospital's Occupational Health Department in GLC and given to the Occupational Health Nurse. If Occupational Health is closed, the Manager/Supervisor/Charge Person will contact the Patient Care Coordinator **immediately**. The Patient Care Coordinator will review the source patient's chart, and order a blood exposure panel (including a rapid HIV Test) and complete a risk assessment. If necessary, she will contact the source patient's attending physician and obtain orders for testing. She will direct the employee to the Emergency Department **only if post exposure chemoprophylaxis is indicated**. Otherwise, the employee will place the Employee Event form in the box outside the door of Occupational Health **and** contact the Occupational Health Nurse in person or by phone **as soon as the department re-opens**. Employees may also call the Blood Exposure Hotline (641-7789) for specific instructions at the time a blood exposure occurs. As a contracted employee, please follow the algorithm for non-VH employees and blood exposures.

I have read the above information, and have had an opportunity to ask questions which have been answered. I understand that it is my responsibility to complete an Employee Event form at any time I have a job-related injury or exposure to any communicable disease.

Signature

Date

/ /

Vidant Employee Clinic

Date



TD – MMR

Tetanus/Diphtheria Vaccine

Tetanus is a disease caused by a germ that is often found in dirt. This germ enters the body through a cut or wound. Tetanus is commonly called “lockjaw”. The first symptoms are tightening of the muscle of the face so the person cannot open his mouth or swallow. Eventually all muscles of the body go into severe spasm, including those that control breathing. Tetanus can eventually cause death.

Diphtheria is a disease that can cause infection in the nose and throat and interferes with breathing. It can also lead to heart failure, paralysis, and death. Diphtheria is included in your tetanus shot because the immunity against diphtheria given to you by your childhood immunization decrease with time.

When Should You Get TD?

1 – If it has been more than 5 years since your last TD and you received a dirty cut, wound, or severe burn. 2 – You should receive a booster every 10 years throughout life.

Tell the Occupational Health Nurse if:

- 1 – You have ever had a serious reaction to any tetanus or diphtheria vaccine or thimerosal a mercurial antiseptic.
- 2 – You have a moderate to severe illness other than a cold.
- 3 – You are taking a drug such as cortisone, prednisone, anticancer drugs, or undergoing a treatment such as radiation therapy.
- 4 – You are pregnant.

Risks From Taking The Vaccine: As with any medication, there are some risks involved in receiving the vaccine. These risks are much smaller than the risks from the disease if people stopped using the vaccine. Most people have no problem with receiving TD. You may, however, have soreness, redness, or swelling where the shot was given. This may last 1-3 days. Tylenol or Motrin may be used to reduce discomfort or an ice pack, may be applied. Severe problems such as deep aching pain, muscle wasting in upper area could possibly occur. Notify the Occupational Health Nurse of any serious problems as soon as possible. For more information, ask the nurse, she can give you the vaccine package insert or suggest other sources of information.

Measles, Mumps, and Rubella (German Measles) are serious diseases. They spread when germs pass from an infected person to the nose or throat of others.

Measles causes: rash, cough, fever. **It can lead to:** ear infection, pneumonia, diarrhea, seizures, brain damage, and death.

Mumps causes: fever, headaches, and swollen glands under the jaw. **It can lead to:** hearing loss, meningitis (infection for brain and spinal cord coverings). Males can have painful swollen testicles.

Rubella causes: rashes, mild fever, swollen glands, arthritis (mostly in women). **Pregnant women can lose their babies.** Babies can be born with birth defects such as: deafness or blindness, heart disease, brain damage.

Benefits of the vaccines: Vaccination is the best way to protect against measles, mumps, and rubella. Because most children get the MMR vaccines, there are now many fewer cases of these diseases. There would be many more cases if we stopped vaccinating children.

Who should get MMR Vaccine? Most doctors recommend that all young children get MMR vaccines. But there are some cautions. Tell your doctor or nurse if the person getting the vaccine is less able to fight serious infections because of a disease he/she was born with; treatment with drugs such as long term steroids; any kind of cancer; cancer treatment with x-rays or drugs. Also, people with AIDS or HIV infection usually should get MMR vaccine. Pregnant women should wait until after pregnancy for MMR vaccine. (Pregnancy should be avoided for 3 months following a live virus vaccine). People with a serious allergy to eggs or the drug neomycin should tell the doctor or nurse. **Tell the nurse if you have:** Ever had a serious allergic reaction or other problem after getting MMR; now has a moderate or severe illness; has ever had a seizure; has a parent, brother, or sister who has had seizures; has gotten immune globulin or other blood products (such as transfusion) during the past several months. If you are not sure, ask your doctor or nurse. What are the risks from MMR vaccine? As with any medicine, there are very small risks that serious problems, even death, could occur after taking a vaccine. The risks from the vaccine are much smaller than the risks from the diseases if people stopped using vaccine. Almost all people who get MMR have no problems from it. Mild or moderate problems: Soon after the vaccination, there may be soreness, redness, or swelling where the shot was given. **1-2 weeks after the first dose, there may be:** rash (5-15 out of every 100 doses), fever of 103 or higher (5-15 out of every 100 doses). This usually lasts 1 -2 days. Swelling of glands in the cheeks, neck, or under the jaw; a seizure (jerking and staring spell) usually caused by fever is rare. 1-3 weeks after the first dose, there may be: pain, stiffness, or swelling in one or more joints lasting up to 3 days (up to 40 out of every 100 doses in young women). Rarely, pain or stiffness lasts a month or longer, or may come and go; this is most common in young and adult women. Acetaminophen or ibuprofen (non-aspirin) may be used to reduce fever and soreness. Severe problems: (very rarely); serious allergic reaction, low number of platelets (a type of blood cell) that can lead to bleeding problems. (This is almost always temporary), long seizures, decreased consciousness, or coma. Problems following MMR are much less common after the second dose. What to do if there is a serious reaction: Call a doctor or get the person to a doctor right away. Write down what happened and the date and time it happened. Ask your doctor or nurse to file a Vaccine Adverse Event Report form or call (800) 822-7967 (toll free). The National Vaccine Injury Compensation Program gives compensation (payment) for persons thought to be injured by vaccines. For details call (800) 338-2382 (toll free) CDC-U.S. Department of Health & Human Services Public Health Services-Centers for Disease Control.



VIDANT HEALTH™

VH Corporate Health Volunteer Immunization Record

Name: _____ Date of Birth: _____ Date: _____

Allergies: _____ Current Medications: _____

Varicella History (Chicken Pox)

- If history is unknown or negative, a titer will be needed
- Two doses of vaccine will be needed for those with negative titers

☐ Positive History ☐ #1 ____/____/____ #2 ____/____/____

☐ Titer Results: _____ Date: ____/____/____

Hepatitis B

- 3 dose series, up to two series or positive titer

☐ #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

☐ Titer Results: _____ Date: ____/____/____

Rubella

- 1 dose vaccine after first birthday or positive titer

☐ ____/____/____ ☐ Titer Results: _____ Date: ____/____/____

Rubeola (Measles)

- 2 doses after the first birthday for persons born on or after January 1, 1957
- 1 dose or documentation or positive titer for persons born before January 1, 1957.

☐ #1 ____/____/____ #2 ____/____/____ ☐ Titer Results: _____ Date: ____/____/____

Mumps

- 1 dose after first birthday for persons born on or after January 1, 1957 or positive titer
- 1 dose or positive titer strongly recommended for persons born before January 1, 1957.

☐ ____/____/____ ☐ Titer Results: _____ Date: ____/____/____

MMR

- You may choose to have MMR (combination of Measles, Mumps & Rubella) immunizations instead of individual immunizations

☐ #1 ____/____/____ #2 ____/____/____

Td/Tdap

- 1 dose Tdap (Adacel) given in place of Td if less than age 64, Not be given within 2 years of Td.

☐ Td ____/____/____ ☐ Td ____/____/____

PPD Skin Test

PPD given: ____/____/____	By: _____	Read ____/____/____	Results: _____	By: _____	Manuf: _____	Lot# _____	Exp. _____
PPD given: ____/____/____	By: _____	Read ____/____/____	Results: _____	By: _____	Manuf: _____	Lot# _____	Exp. _____
PPD given: ____/____/____	By: _____	Read ____/____/____	Results: _____	By: _____	Manuf: _____	Lot# _____	Exp. _____
PPD given: ____/____/____	By: _____	Read ____/____/____	Results: _____	By: _____	Manuf: _____	Lot# _____	Exp. _____

☐ Chest x-ray results: _____ on ____/____/____

☐ Documentation of Past Positive Test Provided ____/____/____ Results: _____