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

☐ Vidant Medical Center	☐ Vidant Duplin Hospital	☐ Vidant SurgiCenter
☐ Vidant Beaufort Hospital	☐ Vidant Edgecombe Hospital	☐ The Outer Banks Hospital
☐ Vidant Bertie Hospital	☐ Vidant Pungo Hospital	☐ Other_____
☐ Vidant Chowan Hospital	☐ Vidant Roanoke-Chowan Hospital	

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? ☐NO ☐YES ☐WHEN?_____	EARLIEST DATE AVAILABLE

How did you hear about volunteering at VEH_____
Have you previously volunteered here? ☐Yes ☐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_____
(name) (relationship) (phone)

Physician to contact: Dr._____
(name) (phone)

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:
☐Yes ☐No If yes, Explain:_____

Are you related to anyone employed by us: ☐Yes ☐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:

_____
(organization) (reference person) (phone)

Why do you want to be a volunteer?_____

_____

_____

FOR OFFICE USE ONLY

START DATE_____

BEGINNING ASSIGNMENT_____

ASSIGNMENT AREA_____

TYPE

TIME

PRINT FULL NAME

(Last) (First) (Middle) (Preferred)

ORIENTATION DATE_____
(Month) (Day) (Year)

PLEASE CHECK ALL AREAS OF INTEREST

☐ CLERICAL ☐ RECEPTION/FAMILY WAITING ☐ PATIENT TRANSPORT
☐ NURSING ☐ OTHER_____
☐ 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 my 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):_____

_____

VIDANT HEALTH

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

VIDANT HEALTH

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 serous reaction to any tetanus of 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 serous 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 serous 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 serous 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 serous allergy to eggs or the drug neomycin should tell the doctor or nurse. If you are not sure, ask the doctor or nurse. **Tell the nurse if you have**: Ever had a serous 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 serous 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 serous 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:____________________