

Volunteer Screening Form – Volunteer Services

Volunteer name: _____ **Social Security Number:** _____

Department: _____ **Date:** _____

Section 1: Medical History

By signing this statement, I am certifying that to the best of my knowledge, I have 1) no long-term medical or psychological condition or 2) any other reason that might prevent me from safely working as a volunteer.

Volunteer signature _____

Or

I am under a medical provider's or therapist's care for a long-term medical or psychological condition, and have provided a letter to the volunteer office or Employee Health Services, from him/her indicating that I can safely and reliably work as a volunteer.

Volunteer signature _____
UMMS Representative _____

Section 2: Vaccine and screening required for all volunteers – to be completed by Volunteer Services or by Employee Health Services:

1. Measles, Mumps and Rubella: Has either:
 Documentation of 2-shot vaccine series, **or**
 Titer results for Measles, Mumps and Rubella showing immunity
2. Varicella (chickenpox): Has either:
 Documentation of 2-shot vaccine series, **or**
 Titer results for Varicella showing immunity
3. Tdap, Adult dose (Tetanus, Diphtheria and Acellular Pertussis) applicable only if working in high risk area: Mother Baby Unit, OBGyn Clinic, General Peds, PICU, NICU, Pediatric ED
 Show evidence of Tdap vaccination (if available) and
 Sign Tdap Declination form
4. Tuberculosis:
 Previous positive TB skin test (TST) or positive blood test in past, requires proof of positive result **and both**
 Completion of TB Screening Questionnaire (reviewed by EHS)
 Report of negative chest x-ray from time of conversion or later (radiology report or physician's letter) UMMS EHS does not provide services for x-rays., **or**
 Evidence of negative TB skin testing (step one) (a TST must occur within 90 days prior to start) **and**
 Evidence of negative TB skin testing (step two – can occur 1 – 3 weeks after step 1 placement), **or**
 Evidence of negative TB blood test within 90 days prior to start, satisfies 2 step requirement

 Referred to EHS for TB skin test /blood test or TB questionnaire (with proof of prior positive)

5. COVID Vaccination (not required to start, but necessary to meet CMS reporting requirements):
 ___ Evidence of primary series and boosters if received

Section 3: Additional requirements for clinical volunteers only. Clinical areas include: All inpatient units and ICU's, Psychiatry units, Emergency Departments, Bloodmobile and Pathology.

Hepatitis B:

- ___ Documentation of the completed hepatitis B vaccine series in past, **and**
- ___ documented immunity by titers (if > 18, EHS will draw titers) or physician statement,
or
- ___ Signed Hepatitis B Declination form
- ___ Referred to primary care provider to consider vaccination. Information on Hepatitis B vaccine provided

Section 4: Flu Vaccination (10/1 – 3/31):

All volunteers working in the an UMMS hospital or on non-clinical UMMS setting between October 1 - March 31, must comply with the UMMS Seasonal Flu Policy. The policy indicates that volunteers are required to be vaccinated annually against influenza unless there is a medical reason or a religious reason for declining flu vaccination.

- ___ Evidence of Flu vaccination for the current Flu Season, or
- ___ Evidence of Medical Contraindication using UMMS provided form (to be reviewed approved by EHS), or
- ___ Evidence of Religious Exemption using UMMS provided form or documentation from Religious Leader on organization Letterhead (to be reviewed approved by Human Resources)

Flu vaccination is provided to volunteers free of charge by UMMS Employee Health Services.

Parental Consent:

This consent must be signed by a parent or legal guardian of a minor (under 18 years of age) applying for a volunteer position at a University of Maryland Medical System hospital.

I am the parent/legal guardian of _____ who has applied for a position as a volunteer at a University of Maryland Medical System Hospital. By my signature below, I am consenting to University of Maryland Medical System Employee Health Services to perform tests for tuberculosis.

Tuberculosis (TB) is a disease that usually affects the lungs. TB germs are spread from person to person through the air. TB testing is performed by either doing a blood test to look for TB or doing a skin test. If a skin test is performed, A small needle will be used to put some testing solution, called tuberculin, just under the skin. For those taking the 2-step TB skin test, they are required to return to the hospital 2-3 days after the first test as well as return for the second step and follow up reading (4 visits in all)

Parent or Guardian's Name (Printed)	Signature of Parent or Guardian	Date

DO NOT SIGN BELOW THIS LINE FOR VOLUNTEER SERVICES

.....
 To be completed by volunteer services representative or an UMMS representative.

Form reviewed by:

 Signature/Name

 Date

CONFIDENTIALITY STATEMENT

I, _____, understand that during the normal course of volunteering for University of Maryland Capital Region Health, or during any other hospital-related activities, I may have access to highly personal and confidential paperwork and to confidential patient-specific and health care provider medical information from the medical record or elsewhere. This medical record or other information, such as a patient's medical transmission of data, administrative and financial data, is highly confidential, due to the Health Insurance Portability & Accountability Act (HIPPA) of 1996. I understand that I am obligated to respect the confidentiality of this information and that I am indirectly, or by implication, not to repeat any of the patient-specific or healthcare provider information referred to herein to any person not directly involved with the above described functions. I understand that my violation of the provisions of this confidentiality statement may result in legal sanctions or in disciplinary action against me.

Signature

Date



VOLUNTEER INTERVIEW QUESTIONS

Volunteer Applicant's Name _____ Date of Interview _____

Tell me about yourself?

Why do you want to be a volunteer here at the hospital?

What are your short and long term goals as a volunteer here at UM Capital Region Health?

What are your strengths?

What are your weaknesses?

How well do you work under pressure?

Why should we select you to be a volunteer for UM Capital Region Health?

Is there anything else that you would like us to know about you that will aid us in making our decision.

What is your availability? M_____T_____W_____T_____F_____S_____S_____

Do you have any questions?

VOLUNTEER AGREEMENT

If I am accepted as a volunteer, I agree to:

1. Keep all information regarding patients/clients confidential.
2. Give permission for the volunteer services staff to discuss my work history and performance with those I have listed as supervisors and references with my potential University of Maryland Capital Region Health Supervisor(s).
3. Sign in and out each day I volunteer according to the protocol set up for my particular area.
4. Volunteer a minimum of 100 hours per area.
5. I understand verbal or written verification of hours will only be given after I have contributed the minimum of 100 hours.
6. Volunteer a minimum of one four-hour shift per week at the same time on the same day. (for example: Mondays 9am-1pm.) if date and time changes immediately notify volunteer services coordinator and supervisor of my area.
7. Be punctual and regular in attendance.
8. Notify my supervisor(s) in advance if I cannot work my scheduled volunteer time.
9. Wear the hospital ID badge while on volunteer duty at all times.
10. Not expect compensation or employment as a result of my volunteer work.
11. Provide my own transportation to and from the volunteer work site at my expense.
12. Notify my supervisor(s) and the volunteer coordinator of my plans to resign at least two weeks in advance.
13. Return my University of Maryland Capital Region Health volunteer ID badge and red jacket the last day of volunteering.
14. Abide by the University of Maryland Capital Region Health's policies and procedures.
15. Complete the HireRight background/information form on line.
16. Submit copies of immunizations required and contact University of Maryland Capital Region Health's employee health office for immunizations if needed.
17. I agree that I will not officially become a volunteer until I have completed all training and submitted all required paperwork.
18. Abide by all of the rules and regulations in the volunteer handbook which I have received.

ADULT VOLUNTEER

Signature of Adult Applicant

Date

MINOR VOLUNTEER

I certify that:

1. I am at least 16 years old.
2. I am not volunteering as a court requirement or as an attorney referral.

Signature of Minor Applicant

Date

PARENT OR LEGAL GUARDIAN OF MINOR 16-17 YEARS OF AGE:

1. This applicant has my permission to volunteer at the University of Maryland Capital Region Health Medical Center/System.
2. I have read the above volunteer agreement.
3. I will support this applicant in fulfilling the above volunteer agreement.
4. I release University of Maryland Capital Region Health of any responsibility if the applicant should have an adverse reaction as a result of any immunizations given by the University of Maryland Capital Region Health Employee Health department.

Signature of Parent/Guardian

Date



ACKNOWLEDGEMENT

UNIVERSITY OF MARYLAND CAPITAL REGION HEALTH Review of Corporate/Facility Policies/Forms

My signature below indicates that I have received a copy of the University of Maryland Capital Region Health/Facility policies listed below:

- 230-107 Employment of Family Members
- 230-112 Substance Free Work Place
- 230-601 Employee Conduct and Progressive Disciplinary Action
- 230-605 Sexual Harassment
- 230-606 Volunteer Policy
- 230-608 Professional Behavior
- 230-610 Smoke and Nicotine-Free Environment
- 230-612 Dress Code and Personal Appearance
- 230-613 Customer Service and Service Recovery
- 230-722 Mandatory Influenza Vaccination Policy

Photography-Video Filming of Patients or Hospital Facilities

Social Media Policy

Violations of Confidentiality

I understand that as a volunteer of University of Maryland Capital Region Health, it is my responsibility to read, understand and adhere to all of the standards in the policies listed above, and located in the department(s) to which I report during the course of my volunteer work.

It is my responsibility to seek answers to questions about any policy or standard that I do not fully understand.

I completely understand that failure to comply with these policies and standards may be cause for disciplinary action up to and including termination. I understand that I am a volunteer at will and either I or University of Maryland Capital Region Health can terminate the relationship at any time for any reason.

v

Volunteer Name (Print)

Volunteer Signature

Date



PERSONAL RELEASE & WAIVER OF LIABILITY

By signing this document, I hereby grant permission to University of Maryland Capital Region Health to use photographs, video and audio recordings taken of me as part of the following activity:

I grant permission for use of my likeness and voice by University of Maryland Capital Region Health in possible marketing, advertising, and other public relations activities and/or publications, electronic or otherwise, without notifying me.

I hereby waive any right to inspect or approve the finished photographs or printed or electronic matter that may be used in conjunction with them now or in the future, whether that use is known or unknown to me, and I waive any right to royalties or other compensation arising from or related to use of the photograph, video or audio recordings.

I hereby agree to release, defend, and hold harmless University of Maryland Capital Region Health, its officers, directors, employees, agents, and contractors (including any vendors assisting in the production of these materials) from and against any claims, damages or liability arising from or related to the use of the photographs, including but not limited to any misuse, distortion, blurring, alteration, optical illusion or use in composite form, either intentionally or otherwise, that may occur or be produced in taking, processing, reduction or production of the finished product, its publication or distribution.

I have read this release before signing below and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable _____ acceptance of the terms of this release.

Date: _____ Name (printed): _____

Name (signed): _____

I am the parent and/or guardian of the minor who has signed above or is a participant. I agree that we shall both be bound by this agreement. _____

Patient/Guardian _____
Date: _____ Name (printed): _____

Name (signed): _____

Dear Volunteer Applicant,

Please complete the attached Volunteer Screening Form and provide copies of the following information. You can submit your completed form and required documents via email to umcapitalregionvolunteers@umm.edu or drop them off in person.

****Required Information:****

1. ****Medical History****: Completed section on the form, indicating your medical condition and ability to work as a volunteer.
2. ****Vaccine Records****:
 - Measles, Mumps, and Rubella (MMR): Documentation of the 2-shot vaccine series or titer results showing immunity.
 - Varicella (Chickenpox): Documentation of the 2-shot vaccine series or titer results showing immunity.
 - Tdap (Tetanus, Diphtheria, and Pertussis): Evidence of vaccination (if applicable).
 - Tuberculosis (TB): Evidence of a negative TB skin test or blood test within the last 90 days or a report of a negative chest x-ray (if applicable).
 - COVID-19 Vaccination: Evidence of the primary series and boosters (if received).
 - Hepatitis B (for clinical volunteers only): Documentation of the completed vaccine series and immunity by titers or a signed declination form.
 - Influenza (Flu) Vaccination: Evidence of current flu vaccination (if volunteering between October 1 and March 31).

****Parental Consent (for minors under 18 years of age)****: Signed consent form by a parent or legal guardian, allowing for tuberculosis testing.

****Submission Instructions****:

- Email: Send the completed form and required documents to umcapitalregionvolunteers@umm.edu.
- In-Person: Drop off the completed form and required documents at our office.

Thank you for your interest in volunteering with the University of Maryland Medical System. We look forward to welcoming you to our team.

Best regards,

****Volunteer Services Team****

University of Maryland Medical System



UNIVERSITY of MARYLAND MEDICAL SYSTEM

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Parent or Guardian's Name (Printed)	Signature of Parent or Guardian	Date
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.....
 To be completed by volunteer services representative or an UMMS representative.

Form reviewed by:

Signature/Name	Date
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Statement of Religious Objection to Influenza Vaccine

UMMS staff member: When the form below has been completed, please visit umms.org/FluVax to complete an online declination and to upload this completed document.

Employee Name		Date of Birth	
UMMS Member Org.		Employee ID	
Job Title		Name of Supervisor	
Email Address		Phone Number	

I am requesting a religious exemption from the Influenza Vaccine Mandatory Vaccination Policy, and in support of that request state the following:

1. I have sincerely held religious beliefs or practices that prohibit me from receiving the influenza vaccine. (Social, political, or personal preferences are not “sincerely held religious beliefs.”)
2. The nature of these sincerely held religious beliefs or practices are as follows (please describe the reason why your religious beliefs prohibit you from receiving the influenza vaccine)*:

If you had an *approved* religious exemption from the COVID-19 vaccines and the basis for your flu vaccine request is the same as your COVID-19 vaccine request: Please select the “I am requesting an exemption for the flu vaccine on the same grounds on which I requested an exemption for the COVID vaccine” option via the “Submit Your Religious Exemption” form at umms.org/FluVaxReporting. Then, you do not need to submit additional documentation for the flu vaccine.

By completing this form and signing below, I submit that I am providing truthful information regarding my sincerely held religious beliefs. I understand that I am expected to tell the truth. If UMMS becomes aware that I am not being truthful, I understand that I will be subject to corrective action, up to and including termination from employment.

Employee Signature: _____

Date: _____