RWJBarnabas HEALTH | **Corporate Care**
Employee Health and Wellness

Volunteer Application Medical Clearance Checklist

Name:	Phone Number:
ADULT (18 y/o or older) **OR** TEEN (17 y/o or younger):	Date of Birth:
Email:	
Department: VOLUNTEER SERVICES / RESOURCES	Social Security #:

	For Medical Professional (MD, DO, APN, PA)	
	Task	**Notes**
☐	Physical exam within past 12 months	By PCP with vaccine and titer documentation attached
☐	Tuberculosis (TB) screening via blood or two skin tests	TB blood or two skin tests (e.g. QFTG, QFTplus4T, or TSPOT) collected within the past 3 months (documentation must be attached – see attachment #2)
☐	Proof of immunity to all the following viruses:	Documentation must be attached
	☐ Rubella (German Measles)	A positive IgG titer or proof of 1 MMR vaccine
	☐ Rubeola (Measles)	A positive IgG titer or proof of 2 MMR vaccines, given > 4 weeks apart
	☐ Mumps	A positive IgG titer or proof of 2 MMR vaccines, given > 4 weeks apart
	☐ Varicella (Chicken Pox)	A positive IgG titer or 2 VARIVAX vaccines, given > 4 weeks apart
	☐ Hepatitis B (Blood test required regardless of vaccination status) ☐ Teen Volunteer: Has three (3) Hepatitis B vaccinations	A positive hepatitis B surface Antibody titer BLOOD TEST for immunity (HepBsAb); If negative (not immune), then either a Hepatitis B vaccine series *started* or a signed declination form at your final appointment.
	☐ Proof of vaccine for TDaP (Tetanus, Diphtheria, pertussis)	Must be the ADULT version of the vaccine – Adacel or Boostrix. (The childhood DTAP is *not acceptable).*
	☐ Proof of Influenza (Flu) vaccine	Flu season only: Approx. Sept – April
	For Volunteer Applicants:	
	☐ Ensure both pages of the medical attestation forms are completed by your provider, and signed/dated.	If you are 17 or younger, you must be accompanied by a parent or legal guardian with their valid photo ID.
	☐ Make your appointment with Employee Health to submit your Medical Attestation form, vaccination documentation, and blood test results	Call Employee Health to make your appointment. *Please do not send any medical forms or paperwork to the Volunteer Department.*
	☐ You will be cleared to volunteer after submitting all requisite medical information above and completing a urine drug screening at your appointment.	All appointments must be no later than 2 PM, Monday-Friday, to accommodate the drug screening process.

Medical Provider: _____ _____ _____

(MD, DO, APN, PA) PRINT Name, Title | Sign | Date

RWJBarnabas HEALTH

Tuberculosis (TB) Screening/Respiratory Assessment: ALL must complete Parts A, B, C

NAME:_____ DOB _____ Dept: Volunteer_____

A. RISK assessment:

1. **Do you have any history of a Positive Tuberculosis Test** (Skin (PPD/TST) or Blood)?_____
   If Yes: When was your FIRST Positive TB test? _____. Do you have proof? _____
   Did you take a complete course of medication for TB (usually 4 - 12 months)? _____
   If yes, what did you take?_____, for how many months?_____

2. Have you lived in another Country?_____ Where?:_____How many years?_____

3. Are you currently Immune Suppressed? _____ If yes, how?_____

4. Have you had prolonged close contact with someone with Tuberculosis? _____

B. SYMPTOM evaluation: Do you have any of these symptoms of contagious TB? Circle Yes or No

1. Fever / Chills..... Yes / No
2. Loss of appetite.....Yes / No
3. Coughing up blood.....Yes / No
4. Unexplained Weight Loss.....Yes / No
5. Tires easily (without a reason).....Yes / No
6. Night Sweats (other than menopause).....Yes / No
7. Coughing frequently for greater than 3 weeks.....Yes / No

Volunteer SIGNATURE: _____ **DATE:**_____

C. TB Testing (must be with in past 3 months):

TB Blood test: (QFTG/QFTplus4T/TSPOT) **Date Collected-** _____ **Result:** _____
OR
TB Skin test: (2 Step PPD/TST tuberculosis test):

PPD#1: Date plant- _____ Date read- _____ Reading (mm) _____

PPD#2: Date plant- _____ Date read- _____ Reading (mm) _____

D. Respiratory Assessment: Required for Positive Symptoms or Positive TB test (or history of positive test).

1. **CXR** (PA, w/in 1 year) Date:_____ Result:_____

2. TB blood test (if not already done): Date:_____ Result: _____

3. Exam: Coughing:_____ Temp:_____ BMI: _____ Lung Exam (Spec Atten Upper Lobes):_____

I attest the above-named Individual has completed ALL medical requirements listed above in Attachments I and II, is free of communicable disease, and if any of their viral antibodies are negative/equivocal, they are currently compliant with the associated vaccine series schedule. All documentation is retained in my Medical Facility and will be provided if requested.

Medical Provider: _____ _____ _____
(MD, DO, APN, PA) PRINT Name, Title Sign Date

Phone#:_____ License#_____ Address:_____

RWJBH Employee Health Only:
Reviewed by:_____ **TB Risk category:**_____ **ENTER into AGILITY:** _____

Medical Clearance Form - NEW VOLUNTEER Applicant

RWJBH Medical Facility-Volunteer Site: **Jack & Sheryl Morris Cancer Center** 165 Somerset Street New Brunswick, NJ.

Name: _____ DOB: _____

Cell/Contact Phone: _____

_____ "Teen" Volunteer (14-17y/o) OR _____ Adult Volunteer (> or = 18y/o)

_____ YES, the above-named New Volunteer is medical cleared to VOLUNTEER at RWJBH medical facilities

_____ YES, the above-named New Volunteer is medically cleared to VOLUNTEER at RWJBH medical facilities with the following Restrictions/Limitations:

_____

_____

_____ NO, the above-named New Volunteer is NOT medically cleared to VOLUNTEER at RWJBH medical facilities.

DATE Tuberculosis Screening Completed: _____

DATE Influenza Vaccine (usually September to May): _____

Was **Influenza Vaccine given** at **RWJBH facility or Other facility? (please circle one).**

_____ _____

RWJBH Employee Health Medical Staff Date

New Volunteer- Consent and Authorization to Treat Form.

Name (Please Print): _____ Date of Birth: _____

- I hereby give my consent for diagnostic testing and a physical examination to evaluate my suitability for Volunteering within RWJBH. I understand that this exam and subsequent exams are to determine my Volunteer placement and continued Volunteer status and not intended to take the place of personal medical care. Additionally, these tests/exams should not be considered complete health assessments; for that I must contact my personal physician.
- I further consent to diagnostic testing, exam, and/or treatment for any injury or illness that occurs in relationship to my Volunteering, or for any other conditions for which I seek care in the Corporate Care/Employee Health Department.
- I understand that my medical records will be maintained in a confidential manner. If I transfer to an alternate site within RWJBH, I agree that my Volunteer medical records may be transferred to the Corporate Care/Employee Health Department responsible for the site at which I am Volunteering.
- My responses to any Volunteer Medical History Record Questionnaire will be used to evaluate suitability for Volunteering and/or whether a reasonable accommodation for any disability will be needed.
- I understand that it is important to provide all medical information to the best of my knowledge. If there is information I am uncertain of in this Volunteer application to this request, I must discuss it with a representative from Corporate Care/Employee Health Department. Omitting information or providing false information on the medical history form is grounds for withdrawal or termination of Volunteer assignments.
- The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____

Volunteer Signature Date

For MINORS (Less than 18 years old; e.g. anyone who is 14-17 years old):

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Printed Name Date

_____ _____

Witness Signature Date

( ) I have received and read this Consent and Authorization to Treat Form and do NOT provide consent for diagnostic testing, examination, treatment; as a result, I understand my Volunteer Application may be denied.

_____ _____

Volunteer or Parent/Guardian Signature Date