

**Please return to:**  
Mount Nittany Medical Center  
Volunteer Resources  
155 Wellness Way  
State College, PA 16803  
814.231.7836



**FOR VOLUNTEER OFFICE USE ONLY**

Application Date \_\_\_\_\_ Assignment \_\_\_\_\_  
Interview Date \_\_\_\_\_  Adult  High School Student  College Student  
Orientation Date \_\_\_\_\_ Start Date \_\_\_\_\_

# VOLUNTEER APPLICATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

E-mail address: \_\_\_\_\_ Local Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_

## In Case of Emergency, Notify

Name \_\_\_\_\_ Parent/Guardian/Other \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

## Education and Work Experience

Current Employer \_\_\_\_\_

Job Title \_\_\_\_\_ College 1 2 3 4 Grad. Date \_\_\_\_\_

Work Phone \_\_\_\_\_ College Major \_\_\_\_\_

### Skills/Preferences

- Patient Floors
- Endoscopy
- Guest Services
- Office/Special Projects
- Emergency Department
- Snack Bar/Gift Shop

Have you volunteered at  
Mount Nittany Medical  
Center before?  
 Yes  No

Can you substitute occasionally?  
 Yes  No

**Availability**

Check the boxes for the days and times you are most often available to volunteer.

	S	M	T	W	T	F	S
Morn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aft.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eve.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever pled guilty or been convicted of a crime?  Yes  No

If yes, when did the offense occur? \_\_\_\_\_ Nature of crime: \_\_\_\_\_

Are you required to volunteer?  Yes  No. If yes, by whom? \_\_\_\_\_

How did you hear about our Volunteer Program? \_\_\_\_\_

**Volunteer – Please Read and Sign:**

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and belief, and hereby grant Mount Nittany Health permission to verify such answers and investigate references.

Believing that Mount Nittany Health has a real need for my services as a volunteer worker,

- I acknowledge and understand that (i) I am offering my services voluntarily, (ii) any services provided as a volunteer are separate and independent from any services provide as an employee of Mount Nittany Health (if applicable), and (iii)I will not be compensated for any services provided while serving as a volunteer;
- I will be punctual and conscientious in the fulfillment of my duties and accept supervision gracefully;
- I will conduct myself with dignity, courtesy, and consideration;
- I will consider as CONFIDENTIAL all information which I may hear directly or indirectly concerning a patient or Mount Nittany Health Employee, and will not seek information in regard to a particular patient;
- I will escalate any issues, concerns or suggestions to the Supervisor of Volunteers;
- I will uphold Mount Nittany Health’s Mission and Values and interpret them to the community at large.
- I understand that a Tuberculin skin test is required for all volunteers and that the test will be provided to me free of charge at Mount Nittany Health;

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**For Junior Volunteers Only:**

Parent or Guardian: Please acknowledge the above consent form by signing below.

Signed \_\_\_\_\_

DATE \_\_\_\_\_

**ORIENTATION CHECKLIST**

Mission & Vision Statements		Emergency Announcements	
Confidentiality Statement		Infection Control	
HIPAA		Customer Service	
Sign-In Books		National Patient Safety Goals	

Schedules and Call-Offs		Uniforms and Dress Code	
Assignment Guides and Checklists		Benefits	

**Health Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

E-mail address: \_\_\_\_\_ Local Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Please attach proof of the following immunizations:** (be sure your records indicate vaccine dates, etc. Anything listed as 'unverified' will not be considered proof)

**TUBERCULOSIS:**

Tuberculin screening (tuberculin skin test or blood assay for *M. tuberculosis*) is required unless you have had a positive test or are deferred from testing for other reasons. Only results of testing performed within the past one (1) year will be accepted.

Exempt from testing: ( ) NO ( ) YES

If yes, reason: \_\_\_\_\_

Date of tuberculin screening: \_\_\_\_\_ Result: \_\_\_\_\_

If tuberculin screening is/was positive, attach a copy of a chest x-ray report done within the past one (1) year.

**VARICELLA (CHICKEN POX):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody), or
- \_\_\_ proof of vaccination with two doses Varicella zoster vaccine.

**PERTUSSIS (WHOOPING COUGH):** Attach a copy of the following:

- \_\_\_ proof of vaccination with one dose TDAP Vaccine

**MUMPS:** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity, or
- \_\_\_ proof of vaccination (two doses on or after age one)

**RUBELLA (GERMAN MEASLES):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody), or
- \_\_\_ proof of vaccination (one dose on or after age one).

**RUBEOLA (MEASLES):** Attach a copy of any of the following:

- \_\_\_ laboratory evidence of immunity (antibody), or
- \_\_\_ proof of vaccination (two doses on or after age one)

Signature: \_\_\_\_\_ Date \_\_\_\_\_

If you cannot provide evidence of immunity as described above, a blood test (titer/s) will be performed by the Medical Center to determine your immunity status. **If you are a student, you can get your records from your school health services department.** If you have any questions contact the Volunteer Resources Department office at 814.231.7836

## Reference Form:

This form is to be completed by the applicant's reference.

\_\_\_\_\_ has applied to be a volunteer at Mount Nittany Medical Center and has given your name as a reference. Because we strive to provide our patients with quality care, it would be helpful to have your comments on whether you consider this person well-suited to healthcare volunteer service.

Please return this completed form to the address provided below. Your prompt and frank reply will be greatly appreciated, and will be considered confidential. Volunteers cannot begin their assignments until a reference is returned.

Sincerely,

Monique Behrer  
Supervisor, Volunteer Services  
mtb0523@mountnittany.org

\_\_\_\_\_  
Name of Applicant: \_\_\_\_\_  
Name of Reference: \_\_\_\_\_  
How do you know Applicant? \_\_\_\_\_  
Reference Address: \_\_\_\_\_  
Reference Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Comments: \_\_\_\_\_

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## Child Protective Services Law

In order to comply with the Child Protective Service Law, Mount Nittany Health volunteer candidates must secure the PA Child Abuse Clearance. Please include the clearance with your application. If you have not been a resident of Pennsylvania for the last 10 years, you will also need to have an FBI/Federal Criminal History Record clearance, which includes fingerprinting. Please notify the Volunteer Resources Department if you need this additional clearance.

### PA Child Abuse Clearance APPLICATION INSTRUCTIONS

Register online at: <https://www.compass.state.pa.us/cwis/public/home>. You will need your previous addresses and the names of everyone who lived with you at any time since 1975 to the present.

- 1. Select **Create a New Account**, click next
- 2. Fill in needed info, click finish
- 3. Go to your email to retrieve temporary password
- 4. Go back to the site, click login
- 5. Click **Access My Clearances**, click continue
- 6. Login with username ID & temporary password
- 7. Create password (you'll want to retain your ID & password for future use), click **submit**
- 8. Login again with your new password
- 9. Click **agree to terms**, click next, click continue
- 10. Select **Create An Application**, click begin
- 11. Click **Regular Contact With Children**
- 12. Verify your information & add needed information, click next
- 13. Fill needed information, click next
- 14. Add all previous addresses since 1975, click next
- 15. Add household members since 1975, click next
- 16. Verify summary information
- 17. Type in full name for **E-Signature**, click next
- 18. Be sure to check that this is for a volunteer position.