

Office Use Only

Application Received _____ PIN # _____
 Interview _____ Jersey Size _____
 Orientation _____ [] SCHEDULED
 CORI _____

PERSONAL INFORMATION

First Name _____ Last Name _____
 Street Address _____ Apartment # _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Cell Phone _____ Work phone _____
 Email Address _____ Date of Birth (optional) _____

WORK AND VOLUNTEER EXPERIENCE

Please Select:

[] Employed [] Student [] Retired [] Eucharistic Minister [] MassHire [] Top Notch Scholars

Please list current employer or school _____

Describe current & previous work experience _____

Describe current & previous volunteer experience _____

BACKGROUND

How did you learn about the volunteer opportunities here? _____

Have you ever been employed, volunteered or applied previously at this hospital? _____

List any special skills and interests that you have: _____

INTERN REQUEST - Please complete the Student Application (*students required to provide a certain amount of hours through a school internship*)

JOB SHADOW REQUEST - Please complete the Job Shadow Application

AVAILABILITY AND INTEREST ____ Patient Care Areas ____ Office Support

View Current Volunteer openings on our Website: www.lawrencegeneral.org and search for Volunteer Opportunities – Select the top 3 places to volunteer:

1. _____ 2. _____ 3. _____

Please circle how many times a week you would like to volunteer? **1 day** **2 days** **3 days**

PREFERRED TIMES: [] Mornings 8 or 9am-1pm [] Afternoons 1-3pm [] Evenings 3-7pm
 (under 18, you cannot volunteer past 7pm)

PREFERRED DAYS: [] Sunday [] Monday [] Tuesday [] Wednesday [] Thursday [] Friday [] Saturday

Why do you want to volunteer at Lawrence General? _____

REFERENCES (Please do not include names of relatives)

Name _____ Relationship to you _____
Phone _____ Email _____

Name _____ Relationship to you _____
Phone _____ Email _____

STUDENTS – Please Provide the name of your Guidance or School Intern Coordinator:

Name: _____ Phone _____

Email _____

EMERGENCY CONTACT

Name _____ Relationship to you _____

Phone _____ (This is a: _____ Home _____ Cell _____ Work number)

SIGNATURE

- The information on this application is true to the best of my knowledge. I understand that false statements made as part of this application will be considered cause for dismissal.
- I understand that if I am accepted as a volunteer/intern, I will not be paid for my services.
- I understand that if I am accepted as a volunteer/intern, I will agree to abide by the guidelines of the Volunteer Services Program.
- I grant authorities of this hospital to investigate my references.
- I understand that Criminal Offender Record Information (CORI) checks are required for all applicants over the age of 18. Acceptance to the volunteer/intern program is contingent upon successful clearance of CORI evaluation.

Applicant Signature _____ Date _____

*If you are under 18 years of age, the signature of a parent or guardian is required.

Signature _____ Date _____

Mail or deliver completed Application:

Lawrence General Hospital
Volunteer Department
1 General Street
Lawrence, MA 01841

Name: _____

Date of Birth: _____

Directions: Please take this form to your health care provider for completion. The lab tests needed when immunization records are not available may be costly, and you are responsible for payment. Please be diligent in getting your records from your private physician, school record or previous employer.

For Health Care Provider Completion: For this individual to qualify to volunteer at Lawrence General Hospital, there are minimal infection control standards that need to be met. **A list of the standards is on the next page. Please complete the form below with special consideration to the following:** If there is no evidence of measles and/or rubella immunity, please administer MMR or draw titer(s). For questions on form completion, 978-683-4000, ext. 2645. Thank You.

Signature of Health Care Provider: _____ **Date:** _____

A copy of your immunization records or your school health record is acceptable. In addition, we need a copy of your COVID vaccine card.

Location: _____ **Telephone:** _____

MMR	MMR #1 DATE: _____ or <input type="checkbox"/> Titer, please provide documentation MMR #2 DATE: _____ <input type="checkbox"/> MMR Booster, please provide documentation	
TDAP	TDAP Date: _____	
VARICELLA	History of Chicken Pox: Yes____ No____, If No History: <input type="checkbox"/> Titer, please provide documentation or Vaccination Dates: #1: _____ #2: _____	
HEP B	Hepatitis B Vaccine Date # 1: _____ Hepatitis B Vaccine Date # 2: _____ Hepatitis B Vaccine Date # 3: _____	<input type="checkbox"/> Titer, please provide documentation <input type="checkbox"/> Or Declination Signed: _____
TB	Date Planted: _____ Date Read: _____ Result in MM: _____ <input type="checkbox"/> TB Assessment Risk Form completed and included with application <input type="checkbox"/> Date Q-GOLD TB Blood Test completed, please provide documentation	
FLU	<input type="checkbox"/> Flu Vaccine: please provide documentation	
COVID	<input type="checkbox"/> COVID Vaccine: Include a copy of an official CDC-issued vaccination card	

☐ **Occupational Health**, 2nd Floor, 25 Marston Street, Suite 204
Lawrence, MA Monday – Friday, 8:30am – 4:00pm

Infection Control Standards for Health Clearance

Tuberculosis Screening and Chest X-Rays. *One of the following is required:*

- A. One (1) PPD Skin test within the *past 12 months and complete a TB Risk Assessment Form.*
- B. For individuals known to be PPD test positive, there needs to be a record of a negative chest x-ray report done by your physician.
- C. Receive the IGRA blood test such as the QuantiFERON – TB Gold blood test or T-SPOT TB.

Measles and Rubella Immunity. The following is required:

- A. Documentation of two MMR vaccines, or
- B. Proof of immunity to measles, mumps and rubella by titer (blood test done by your private Physician. Please note that you will be responsible for payment for this test.)

Hepatitis B Vaccine. For individuals who may be exposed to blood or body fluids during their experience at LGH:

- A. Documentation of the Hepatitis B series, or
- B. Positive antibody test for hepatitis B will be done our Occupational Health Department. LGH will provide this vaccine free of charge to individuals who may be exposed to blood or body fluid during their work.

Chicken Pox: Anyone who does not have a history of chicken pox is **strongly recommended** to get the chicken pox (varicella) vaccine from his/her primary care provider. As an adult, chicken pox can be a very serious illness.

Flu Vaccine: 100% compliance during Flu Season, usually October – April of every year.

COVID Vaccine: Fully vaccinated: Individuals are considered fully vaccinated for COVID-19 two weeks or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna) or vaccine authorized by the World Health Organization, or two weeks or more after they have received a single-dose vaccine (Johnson and Johnson [J&J]/Janssen).

To verify COVID-19 vaccination: An official CDC-issued vaccination card (or digital version/photo) with your name and dates of doses, including the date the last dose was administered printed on the card must be provided.

ASSESSMENT OF SYMPTOMS FOR TUBERCULOSIS

Complete this questionnaire:

Annually for any individual working as a volunteer for Lawrence General Hospital
Prior to the start of service for any new volunteer with a past history of positive skin testing or reported history of tuberculosis disease.

Below I indicate if I have any symptoms related to a possible TB infection. Should I now or at any time in the future have these symptoms I will contact the Occupational Health staff. I understand that I may ask Occupational Health staff or my personal physician for any additional information regarding TB.

Symptoms of TB always include a persistent cough and one or more of the following symptoms. I have indicated below if I have any of the following:

YES	NO	
_____	_____	Persistent cough
_____	_____	Unexplained weight loss
_____	_____	Night sweats
_____	_____	Bloody sputum
_____	_____	Loss of appetite
_____	_____	Fever

Signature

(Print your name)

Date

If you are under 18 years of age, the signature of a parent or guardian is required:

Parent / Guardian Signature

(Print your name)

Date