Lawrence General Hospital
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Summer Student Program Application

(If applying for the Shadow-A-Professional – no need to complete this application)

Brenda LeBlanc,
Volunteer Coordinator
978-683-4000 x2645

Office Use Only
Application Received _____ PIN #_____
Interview _____ Jersey Size ____
Orientation _____ [ ] SCHEDULED
CORI _____ TB_____ Immunizations ___

Summer Student Volunteer Program – Must be at least 15 years old to volunteer. Applications will be accepted until the end of April. This six-week program runs from July 10 to August 18, 2023. You will be notified by email for Next Steps! ***Please write your email address legibly. Thank you***!

RETURNING VOLUNTEERS – Please compete the Returning Volunteer Application

PERSONAL INFORMATION

First Name _____Last Name _____
Street Address _____
Apartment # _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Email Address _____

SCHOOL AND VOLUNTEER EXPERIENCE

☐ high school ☐ college: __Freshman __Sophomore __Junior __Senior **__MassHire __Top Notch Scholars**

Please list your current school_____

Describe current & previous work experience_____
_____

Describe current & previous volunteer experience _____
_____

BACKGROUND: How did you learn about the Summer Student Program? _____
Have you ever been employed, or applied previously at this hospital? _____

RETURNING VOLUNTEERS – Please compete the Returning Volunteer Application

AVAILABILITY:

Are you available to attend "virtual" hospital orientation Wednesday, June 14th 3:30 – 5:30 pm?_____

Please provide vacations / camps dates that you will not be available during the 6-week time-frame:
_____

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 is not an option*)? 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

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REFERENCES (*Please do not include names of relatives***)**

Name _____ Relationship to you _____

Phone _____ Email _____

Guidance Counselor_____ 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 Summer Student Volunteer, I will not be paid for my services.
- I understand that if I am accepted as a Summer Student Volunteer, 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 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:

Parent/Guardian Signature:
_____ Date _____

Mail or deliver completed application:
Lawrence General Hospital
Volunteer Services
1 General Street
Lawrence, MA 01841
Brenda.leblanc@lawrencegeneral.org
Fax: 978-946-8338

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Health Screening

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 ☐ Titer, please provide documentation MMR #2 DATE:_____ ☐ MMR Booster, please provide documentation	
TDAP	TDAP Date: _____	
VARICELLA	History of Chicken Pox: Yes____ No____ , If No History: ☐ 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:_____	☐ Titer, please provide documentation ☐ Or Declination Signed:_____
TB	Date Planted: _____ Date Read: _____ Result in MM: _____ ☐ TB Assessment Risk Form completed and included with application ☐ Date Q-GOLD TB Blood Test completed, please provide documentation	
FLU	☐ Flu Vaccine: please provide documentation	
COVID	☐ 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

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Health Screening

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.

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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