



Shriners Hospitals for Children

Dear Volunteer Applicant:

Thank you for your interest in Shriners Hospitals for Children in Galveston. We are pleased that you would like to volunteer your time assisting us with our efforts to care for children with burn injuries. Volunteers play an important role. We are confident the time you spend at Shriners Hospital in Galveston will be rewarding and satisfying. By volunteering at our hospital, you can make a real difference in the lives of others.

Shriners Hospital in Galveston is one of 22 hospitals in the Shriners Hospitals for Children system and one of only four in the system specializing in burn care. Shriners Hospitals is supported by the Shriners, fraternity, their families & friends, and donations from the community. Because of this support, Shriners Hospitals is commonly referred to as the "World's Greatest Philanthropy."

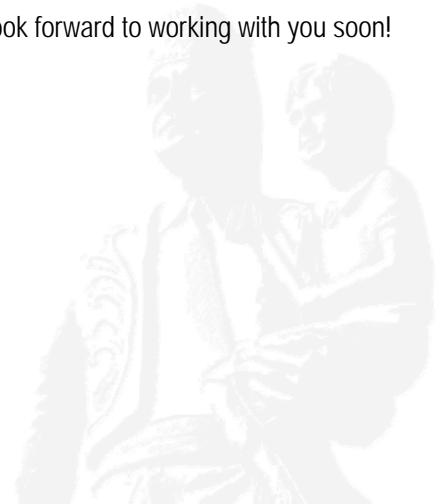
Volunteer candidates must be at least 16 years of age, and able to make an ongoing commitment to the hospital. Please complete the enclosed volunteer application, including the Pre-Voluntary Disclosure & Release. Our application process has a variety of steps: Upon receipt of your completed application, we will review your interests and qualifications, submit your Pre-Voluntary Disclosure & Release form to our Human Resources Department and wait for confirmation. Once an application has been reviewed, we will send a letter of confirmation along with details about the next steps in the process. *Any volunteer service will be contingent upon the satisfactory completion of a background clearance and health screening.*

Potential volunteers are responsible for submitting a copy of their TB skin test, and immunization record from their physician along with their application; TB skin test immunizations should not exceed a six month period. This will help to expedite the volunteer process. Drug screens are scheduled Monday thru Friday between the hours of 7:30am and 2:30pm, our Human Resources will notify you of the process.

Applications can be dropped off or mailed to the address below, or faxed (though we must have an original on file before you begin volunteering) to 409.770.6563. Please understand that the volunteer process can take up to 2-3 weeks to process completely. If you have any questions regarding this process, or the status of your application, please call 409.770.6600 and ask for Volunteer Services.

Again, thank you for your interest in the "*Shriners Hospitals for Children*" We look forward to working with you soon!

Clemmie White
Public Relations
& Volunteer Services
cjwhite@shrinenet.org



CURRENT EMPLOYMENT STATUS

Current Employment Status (check only one)

- Work Full-Time Work Part-Time Student Unemployed Retired

Employer _____

Supervisor Name _____ Phone Number (_____) _____

Your Title _____

Brief Description of Duties _____

EXPERIENCE/SKILLS

Check highest level of education completed:

- | | |
|---|---|
| <input type="checkbox"/> Did not complete high school | <input type="checkbox"/> High school graduate or GED |
| <input type="checkbox"/> Some college | <input type="checkbox"/> Associate's Degree / Completed 2 Yrs College |
| <input type="checkbox"/> 4-year Degree | <input type="checkbox"/> Advanced Degree |

Have you ever volunteered before? Yes No

If yes, please provide:

Organization _____ How long? _____ Yrs _____ Mths

Brief description of duties/responsibilities: _

Can you use a computer? Yes No

If yes, with what computer programs are you familiar:

- MS Word Excel PowerPoint Outlook Access

Other _____

If no, would you like to learn the computer? Yes No

Would you be comfortable answering the telephone? Yes No

Are you fluent in any language(s), other than English?

SPEAK

- Spanish
 Vietnamese
 French
 Other _____

WRITE

- Spanish
 Vietnamese
 French
 Other _____

List any other skills, interests, certifications, or special abilities we should take into consideration.

INTERESTS & AVAILABILITY

Please indicate the type of service(s) you would most prefer to do in our hospital:

- | | | |
|---|---|--|
| <input type="checkbox"/> Office Assistant | <input type="checkbox"/> Clinical Care Areas | <input type="checkbox"/> Pet Partners Program |
| <input type="checkbox"/> Child Life Areas | <input type="checkbox"/> Greeter / Tour Guide | <input type="checkbox"/> Special Events (Seasonal) |

* If interested in the Pet Partners Program please list type of pet, and provide a copy of your Pet's Certificate of Training. List type of pet here: _____

Check days and provide specific times you are available to work for each.

<u>DAY</u>	<u>MORNING</u>	<u>AFTERNOON</u>	<u>EVENING</u>
<input type="checkbox"/> Monday	_____	_____	_____
<input type="checkbox"/> Tuesday	_____	_____	_____
<input type="checkbox"/> Wednesday	_____	_____	_____
<input type="checkbox"/> Thursday	_____	_____	_____
<input type="checkbox"/> Friday	_____	_____	_____
<input type="checkbox"/> Saturday	_____	_____	_____
<input type="checkbox"/> Sunday	_____	_____	_____

How long do you expect to be a volunteer for Shriners Hospitals for Children – Galveston?

- Seasonal Summer Only Less than six months Winter Texan Duration

Why do you want to volunteer at Shriners Hospitals for Children – Galveston? _____

How did you learn about Shriners Hospital volunteer services? _____

MEDIA CONSENT

I understand and hereby consent that my photograph may be taken for the purpose of promotion of services at Shriners Hospitals for Children. I am aware that I will not receive payment of any kind for my participation and grant Shriners Hospitals for Children the rights to their use for my future association with the hospital and for an unrestricted time.

AUXILIARY APPLICATION

I am interested in joining the Shriners Hospitals for Children – Galveston Auxiliary. **I understand that the Auxiliary requires an initial membership payment of \$5.00, due prior to starting your first work day.** After which a vote of approval will take place during the next Board Meeting. The Auxiliary board meets the 1st Wednesday of each month. Upon approval, annual dues of \$5.00 will be expected. Additionally, I understand that certain rules & regulations, separate from those of the hospital, are to be adhered to as a member of the Auxiliary.

I certify that all information contained in this application is true and authorize its investigation, and hereby release all parties from any liability arising from such investigation. I also agree that any false statement, misrepresentation, or omission of facts on this application, regardless of when discovered, will result in immediate dismissal.

Should I be accepted as a Shriners Hospitals for Children - Galveston Volunteer, I have no expectation of remuneration for the services I will provide.

Signature

Date

**TUBERCULOSIS SKIN TEST
DOCUMENTATION**

Employee / Volunteer Name: _____

Social Security Number: _____

**Tuberculin Purified Protein Derivative (PPD)
for intracutaneous (Mantoux) tuberculin testing:**

Date Administered: _____ Site: _____ Rt. _____ Left (forearm)

Dose/Route 0.1 ml of 5 Tuberculin Units, intradermal (intracutaneous) or otherwise as follows:

Name of Person Applying Test:

Print Name Signature and Title

Interpretation of Tuberculin PPD Skin Test:

Date of Reading: _____ Millimeters (MM) Induration: _____

Vesiculation/Ulceration/or Necrosis at Test Site _____ Yes _____ No

Name of Person Who Read Test:

Print Name Signature and Title

Name of Institution

Street City State Zip Code

Phone: Fax:

Return Documentation form to:

Shriners Hospitals for Children – Galveston (Volunteer Department)

815 Market Street, Galveston, TX 77550

Phone: (409) 770-6520

Fax: (409) 770-6547

**SHRINERS HOSPITALS FOR CHILDREN-GALVESTON
OCCUPATIONAL HEALTH HISTORY QUESTIONNAIRE**

Name: _____ Date: _____ SS#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ DOB: _____ Age: _____
 Personal Physician/Provider: _____ Phone: () _____
 Emergency Contact: Name _____ Relationship: _____ Phone: () _____

PERSONAL HEALTH HISTORY

Have you ever had, or do you have, any of the following? If yes, please indicate the year in which it occurred.

Skin problems or chronic rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver trouble/hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain/injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Eye problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent/persistent diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Sciatica/disc problem <input type="checkbox"/> Yes <input type="checkbox"/> No
Wear glasses/contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight problems/changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/tightness in legs/feet <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss/ear trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Knee injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent colds <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes simplex or zoster <input type="checkbox"/> Yes <input type="checkbox"/> No	Foot problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia/rupture <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe/unusual headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol/drug problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness/fainting spells <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Shoulder/elbow/hand pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Lung problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Sever weakness/tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Carpal tunnel syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression/anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tendonitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional/nerve problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble/attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/tightness in arms/hands <input type="checkbox"/> Yes <input type="checkbox"/> No	Bruising of unknown cause <input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No	Discoloration of joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune suppression <input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Broken bones <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke or paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Bone/joint problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach/duodenal ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Yellow jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Neck pain/injury <input type="checkbox"/> Yes <input type="checkbox"/> No	

51. Have you ever had a motor vehicle accident resulting in injury? Yes No
52. Have you ever had a work related injury or illness? Yes No
53. Have you ever had
- a) Needle sticks/blood or body fluid exposures Yes No
 - b) Rash or symptoms related to glove use Yes No
 - c) Pain, numbness, or tingling related to repeated hand/wrist motions or keyboard use Yes No
54. Are you presently under a health provider's care of any condition? Yes No
55. Please list the dates and reason for your last medical examination _____
56. Have you ever had an illness or injury since your last medical examination? Yes No
57. Have you ever been hospitalized or had an operation? Yes No
58. Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants, animals, latex gloves, or any other substances? Yes No

Please describe any YES answers from questions 51-58. Include dates: _____

59. What medications do you regularly or frequently take? _____
 60. _____
 61. _____

I HERBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS HEALTH QUESTIONNAIRE FOR EMPLOYEMENT UIS TRUE AND CORRECT AND ANY OMISSION OR MISREPRESENTATION OF FACTS WILL BE A BASIS FOR IMMEDIATE DISMISSAL.

Signature: _____ Date: _____

OCCUPATIONAL HEALTH NOTES: _____

Occupational Health Nurse Signature: _____ Date: _____

SHRINERS HOSPITALS FOR CHILDREN-GALVESTON

NATURAL RUBBER LATEX (LATEX) SCREENING FOR EMPLOYEES AND STAFF

The questions in the questionnaire may identify food allergies, medications or medical and surgical history that are sometimes found in people who have latex allergy. A positive response to any of the following questions means additional information may be needed to make a determination whether you should avoid contact with latex. The Employee Health Nurse will evaluate your responses and make any recommendations regarding latex that you may need. Answer each question. If a question does not apply to you, leave the field blank.

DEFINITIONS FOR WORDS IN THE TOOL

Anaphylactic: An allergic reaction so severe it may be life-threatening. These occur very rarely.

Congenital Abnormalities: A deformity or skeletal problem you are born with. The most important are those that require surgery to correct. E.g. spina bifida (sometimes called "open spine.")

Latex Birth Control Devices: Condoms and Diaphragms.

Dental Cofferdams: A latex (rubber) barrier (sometimes called "dam") placed in the mouth during procedures, e.g. when capping teeth.

FURTHER QUESTIONS

Why is it important if I am on specific medications? The listed medications are beta-blockers. If a person is on a beta-blocker medication and has a mild natural latex rubber allergy, the beta-blocker medication could cause the person to have an allergic asthmatic attack because the medication and the allergy both cause the lung to tighten up.

This tool is not intended to be all-inclusive. Individuals who are uncertain whether they are or may be sensitive to natural rubber latex should consult their physician.

Employee Name: _____ Dept/Rm: _____

1. Have you ever had an anaphylactic reaction to latex device/products? _____
If yes, under what circumstances did it occur? _____

2. Have you ever been told by a doctor that you have an allergy to any latex product? _____
If yes, what specifically did the doctor say you were allergic to? _____

3. Do you have any congenital abnormalities (i.e. spina bifida, myeloma, myelodysplasia)? _____

4. Have you had a reaction to the following personal sources of latex?

- Balloons, Rubber gloves, Hot water bottles, Rubber bands, balls, Foam pillows, Baby bottles, nipples, Pacifiers, teething rings, Belts, bras, suspenders, Rubber grips, Latex birth control devices, Dental cofferdams, Erasers, Face masks, Elastic bandages, Elastic cuffs/waistbands, Ostamy bags, Shoewear, Other

5. After handling latex products, have you experienced any of the following?

- Difficulty breathing, Chapping or cracking of hands, Runny nose/congestion, Itching (hands, eyes), Redness, Selling, Hives, Other

6. Do you have a history of the following?

- Contact dermatitis, Asthma, Hay fever, Eczema, Autoimmune Disease, Lupis

7. Do you have any food allergies? If yes, are you allergic to the following?

Table with columns for food items (Banana, Avocados, Tomatoes, Kiwis, Peaches, Papaya, Potatoes, Chestnuts, others) and sub-columns for 'Recent onset' and 'Long-standing' with checkboxes.

If yes, describe the reaction:

8. Do you take any of the following medications? _____

propranolol (Inderal), atenolol (Tenormin), acebutolol (Sectral), betaxolol (Kerlone), bisoprolol (Zebeta), carteolol (Cartrol), carvedilol (Coreg), esmolol (Brevibloc), labetolol (Trandate, Normodyne), metoprolol (Lopressor), nadolol (Corgard), penbutalol (Levatol), pindolol (Visken), sotalol (Betapace), and Timolol (Blocadren).

9. Have you had any previous surgeries? _____ How many before the age of one year? _____ Types of surgical procedures: _____

10. Have you ever had extensive dental work? _____ Define "extensive" _____

11. Does your occupation involve contact with products containing latex? _____ If yes, which products? _____