A MESSAGE FROM THE REGINA AUXILIARY

Thank you for your interest in joining the Regina Auxiliary! Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

Here are the steps to sharing your talents, time and energy with us:

Regina Hospital coordinates the application and paperwork on behalf of the Auxiliary; please return your completed application form to:

Pam Kochendorfer, Regina Hospital Volunteer Services
1175 Nininger Road, Hastings, MN 55033
Phone: 651.404.1451
Email: pamela.kochendorfer@allina.com

- An Auxiliary member will contact you to share information about the Auxiliary. All members pay annual membership dues, which can be submitted when you meet with the Auxiliary membership person following your general orientation by Regina Hospital.
- Health – Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, and tuberculosis. If you are not sure about some of your vaccinations, a blood test may be required to verify immunizations at no cost to you. Additionally, if any vaccines are needed, they may also be offered to you at no cost. Regina Hospital will send you forms and information and help you through this process.
- Background Check – Regina Hospital is required to perform a background check on all volunteers.
- Once your application is complete, you will be notified and the Regina Volunteer department will schedule you for general hospital orientation; an Auxiliary member will also be there to provide you orientation to our organization and get you started.

We look forward to your involvement on the Regina campus as an Auxiliary member. Please feel free to contact me or Kathy Horsch, Membership Chair at 651-437-4541, if you have questions.

Sincerely,

Mary Ann Teuber
Phone: 651.437.6022
Email: maryannteuber@gmail.com

Print these forms, complete and mail to the volunteer office. If you wish to have an application mailed to you, Please call Kathy Horsch, membership chair.

REGINA AUXILIARY VOLUNTEER ENROLLMENT FORM

Name							
Street Address							
City				**State**		**Zip**	
Land phone		**Cell Phone**		**Driver's Lic #**		**State**	

WORK STATUS

	Employed		**Retired**		**Unemployed**
Current or last place of employment					

Are you performing this volunteer service because it is required?		**Yes**		**No**
If Yes, Reason hours are needed				
Number of hours required		**Completion deadline**		

INTERESTS, SKILLS, TALENTS (e.g. education, computer, music)

VOLUNTEER EXPERIENCE

Please list any volunteer experiences that you have. Include where, and how long.

AREA(S) OF INTEREST

Please indicate general area(s) that may interest you, keeping in mind that your choices may change as you discover more about us and as additional opportunities are announced.

	Office/Clerical work		**Eucharistic Ministries**		**Gift Shop (Hospital)**
	Country Store (Senior Living)		**Aux Fundraising Events (bazaar, garage sales)**		**Crafts/Quilting**
	Coffee Socials (set up, serving)		**Senior Living Resident Birthday Parties**		**Ice Cream Socials (set up, serving)**
	Where the need is greatest				

ADULT VOLUNTEER REFERENCES

Please list two references. Do not use physicians or relatives. Your reference may provide information in writing (a short form will be sent) or may be contacted by phone.

1. Name		**Daytime Phone**	
Mailing Address			
2. Name		**Daytime Phone**	
Mailing Address			

AVAILABILITY:
Please check all that apply:

	Weekly		**Every other Week**		**Once a month**		**Summer only**

The times you would be available to volunteer:

	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Morning							
Afternoon							
Evening							

Do you have a preference for how many hours you want to work per shift? (shifts usually last 4 or 8 hours)		**Maximum**		**No preference**

Do you relocate seasonally?		**No**		**Yes**	**Leave**		**Return**	

HEALTH INFORMATION

Regina Hospital requires all volunteers serving on campus to complete the health and immunization record. This information is managed by hospital Occupational Health staff. Please complete the form included with the application; information will be kept confidential.

IN AN EMERGENCY PLEASE NOTIFY

Name		**Relationship:**	
Mailing Address			
Phone 1.		**Phone 2:**	

SIGNATURE

My signature below certifies that all statements made on this enrollment form are true, complete and correct tothe best of my knowledge and belief. I understand these statements are subject to verification. I understand that falsification of information can disqualify me from consideration or result in dismissal upon discovery. My signature below provides my authorization for Regina Hospital to check my references listed above to determine my suitability for placement and allows Regina Hospital to share the application information with the Regina Auxiliary.

_____ _____

Signature Date

Return completed application to:

Regina Volunteer Services
Attn: Pam Kochendorfer
1175 Nininger Rd.
Hastings, MN 55033

Background Check Disclosure for Allina Health Volunteers

Allina Health, including its subsidiary and affiliate corporations, may:

- order a consumer report (a background report) on you in connection with your application to volunteer at Allina Health
- order additional background reports on you for purposes of your volunteer role if you become a volunteer, or if you already volunteer for Allina Health.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and criminal history. Information may be obtained from private and public record sources.

The current consumer reporting agencies (CRAs) are:

Verified Credentials, Inc. 20890 Kenbridge Court Lakeville, MN 55044 952-985-7200 Toll free:1-800-473-4934	Bureau of Criminal Apprehension BCA Headquarters – St. Paul 1430 Maryland Avenue East St. Paul, MN 55106-2802 651-793-2400

You have the right in most circumstances to submit a written report to the CRAs for a complete and accurate disclosure of the nature and scope of any consumer report Allina Health ordered about you. The CRAs must provide you with this disclosure form within five business days after its receipt of your request or the report was requested by Allina Health, whichever date is later.

Background Check Disclosure for Allina Health Volunteers

By signing below, I authorize Allina Health, including its subsidiary and affiliate corporations, to obtain a consumer report in connection with my application for a volunteer role, or, as allowed by law, at any timeduring my volunteer role and from a consumer reporting agency (CRA) other than Verified Credentials, Inc.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, andsubject to all laws protecting my information and individual privacy, I also authorize that the following information may be disclosed to the CRA as needed to compile the report: my past and present employers; learning institutions, including colleges and universities; law enforcement and all other federal,state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed tothe CRA, if and only as allowed by law, includes information related to my criminal background, motor vehicle history, employment and earnings history, education, personal references, character, mode of living, credit background, civil judgments or liens, military service, and professional credentials and licenses.

A volunteer opportunity with Allina Health is contingent upon a satisfactory background investigation. If Ibecome a volunteer, I authorize Allina Health to order additional background reports while volunteering with Allina Health related to any of the above issues without asking me for my authorization again.

I may receive a copy of any consumer report obtained by Allina Health at no expense to me. I understand that I may request additional information on the nature of the report upon written request to the CRA. These searches will be conducted by: Verified Credentials, Inc., 20890 Kenbridge Court, Lakeville, MN 55044, 800-473-4934, www.verifiedcredentials.com.

Check this box if you would like a free copy of your background report: ☐ Yes ☐ No

A copy of this authorization has the same validity as the original.

Identity Information and Address History		
First Name	**Middle Name**	**Last Name**
Former name(s) or alias you have used in the past (including maiden name):		
Date of Birth*	**Social Security Number***	
Phone	**Email Address**	
Please list ALL the of the addresses where you have lived during the **last 7 years**		
Current:		
Previous:		
Previous:		
Previous:		
Signature:	**Date:**	

** This information is used for identification purposes only*

(EOH Updated 5/1/2021)

Volunteer Health Clearance Form

Please fill out form completely and <u>return with all required immunization records to your volunteer coordinator.</u>
Any questions in regards to completion of this form, please contact Employee Occupational Health at 612-262-4490.

****Your social security number is required to process health clearance in the Allina Health System****

Name:_____ SSN# (required):_____

Date of Birth:_____ Phone Number (daytime): _____

Email:_____ Volunteer Site: **REGINA CAMPUS**

Places you have lived outside USA: _____

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS.
CHECK ALL ANSWERS THAT APPLY TO YOU.

Tuberculosis (TB)
_____ I have never had a skin test or blood test for TB (Mantoux)
_____ I have had a negative skin test for TB
_____ Approximate date of last test (month and year) _____
_____ I have received BCG vaccine (uncommon in U.S.)
_____ I have had a positive skin test or blood test for TB
_____ not treated _____ treated with isoniazid (INH) or other medication
Dates of treatment: _____ Duration of treatment_____
_____ I have had TB
_____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe:
_____

Current Health Status – Any current symptoms such as:
____ fever ____ cough over 3 weeks ____ bloody sputum
____ night sweats ____ weight loss ____ fatigue
____ poor appetite ____ unexplained chills ____ chest pain

____**No current symptoms**

Mumps

_____ I had Mumps. If yes, have documentation that you had it? yes ☐ no ☐
_____ I have had two Mumps vaccines. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for Mumps antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Mumps or been vaccinated

Rubella (German Measles)
_____ I had German Measles. If yes, have documentation that you had it? yes ☐ no ☐
_____ I had rubella vaccine. If yes, have documentation that you had it? yes ☐ no ☐
_____ I have been tested for rubella antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had German measles or been vaccinated

Measles (Rubeola) (Red Measles)
_____ I had Measles. If yes, have documentation that you had it? yes ☐ no ☐
_____ I have had Measles vaccine. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for rubeola antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Measles (Rubeola) or been vaccinated

Chickenpox

_____ I have had chickenpox/and or shingles (also called Herpes Zoster).
If yes, do you have MD documentation of having the disease? yes ☐ no ☐
_____ I have had chickenpox (Varicella) vaccine.
If yes, do you have documentation of two vaccinations? yes ☐ no ☐
_____ I have been tested for chickenpox immunity.
If yes, do you have documentation of lab titer results? yes ☐ no ☐
_____ I don't know if I have had Chickenpox/and or shingles or been vaccinated

Tetanus / Diphtheria / Pertussis

_____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine:
_____ Date of last tetanus vaccine "booster"
_____ Date of last documented DPT vaccine
_____ I had a single adult does of Tdap vaccine: _____ Date of documented Tdap vaccine
_____Allergy
_____ Unknown

Hepatitis B (required only if your assignments have the potential for blood & body fluid exposure)

_____ I have had Hepatitis B. If yes, date _____.
_____ I have had the Hepatitis B vaccine. If yes, approximate dates:
Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____
Other (describe) _____
_____ I have been tested for Hepatitis B antibody. If yes, date _____.
Where tested _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I have had Hepatitis B surface antigen test. If yes, date _____.
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Hepatitis or been vaccinated.

COVID Vaccine (Not Required)

_____ I have NOT had COVID vaccine.

_____ I have had the COVID vaccine. If yes, dates

Dose 1:_____ Manufacturer_____

Dose 2:_____ Manufacturer_____

Immune Status: People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. Check if you have had the following:

_____ Splenectomy (spleen removed)
_____ Organ transplant
_____ Chronic steroid use (taking Cortisone, Prednisone, etc.). If yes:
Name of medication(s) and dose _____
How long have you been on these medications? _____
_____ Chemotherapy or radiation
_____ Immune deficiency disease: lymphoma ☐ leukemia ☐ HIV infection ☐
Other malignancy or condition (list)_____

CONSENT:

VOLUNTEER NAME (Please Print):_____

VOLUNTEER SIGNATURE_____DATE:_____

☐ By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

PARENTAL CONSENT (required if applicant under 18 years old):

_____ _____

(*parent/guardian signature*) *(date)*

By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.

Please include copies of all prior immunization records and/or lab titers listed below if you have available to you.

- **TB skin test or QFT (TB blood test)**
- **Chest x-ray only if positive TB history**
- **MMR (Measles, Mumps, Rubella)**
- **Hepatitis B**
- **Tdap or TD**
- **COVID**
- **Influenza**
- **Chicken Pox (Varicella)**

Choose the lab you would like to go to. **Wait 3 days to allow your order to be received and set up**. You can report to the lab within 3 to 14 business days after you submit your request. **Please note, all lab tests in which are ordered are FREE of charge.**

Blood tests that may be ordered are:

1. **Tuberculosis screening (QFT-Quantiferon Gold Test)**
2. **Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox**

See next page to select your desired lab location:

Select one location		
Location	**Hours**	**Address**
☐ **Abbott North Western Hosp. (Minneapolis)**	6am-6pm M-F 7am-1:30pm Sat	800 East 28th St Minneapolis, MN 55407
☐ **Abbott Northwestern Center for Out Patient Care EDINA**	8am-5pm **Call For Appointment** 952-914-8046	8100 W. 78th St Suite 110 Edina, MN 55439
☐ **Buffalo Hospital**	7am-3pm M-F **Call For Appointment** 763-684-7855	303 Caitlin St Buffalo, MN 55313
☐ **Cambridge Medical Center**	7am-3pm M-F	701 South Dellwood St Cambridge, MN 55008
☐ **Faribault Allina Health Clinic**	7:30am-4:30pm M-F	100 State Ave Faribault, MN 55021
☐ **Hastings Allina Health Clinic**	8am-3:30pm M-F	1880 N. Frontage Road Hastings, MN 55033
☐ **Mercy Hospital (Coon Rapids)**	6am-6pm M-F 7am-1:30pm Sat	4050 Coon Rapids Blvd Coon Rapids, MN 55433
☐ **New Ulm**	8am-5pm M-F **Call For Appointment** 507-217-5366	1324 Fifth North St New Ulm, MN 56073
☐ **Northfield Allina Health Clinic**	8am-5pm M-F	1400 Jefferson Rd Northfield, MN 55057
☐ **Owatonna Hospital**	8am-2pm M-F Report to Emergency Room Registration Desk	2250 NW 26th St Owatonna, MN 55060
☐ **River Falls Hospital**	6:30am-2:30pm M-F	1629 E. Division St River Falls, WI 54022
☐ **St. Francis Hospital (Shakopee)**	9:30am-4pm M-F	1455 St. Francis Ave Shakopee, MN 55379
☐ **Mercy Hospital—Unity Campus (Fridley)**	6am-6pm M-F 7am-1:30pm Sat	550 Osborne Rd Fridley, MN 55432
☐ **United Hospital (St. Paul)**	6am-6pm M-F	333 North Smith Ave St. Paul, MN 55102
☐ **West Health (Plymouth)**	7:30am-4pm M-TH 7:30am-2pm F	2855 Campus Dr Suite 215 Plymouth, MN 55441