REGINA AUXILIARY MEMBERSHIP INFORMATION

Thank you for your interest in joining the Regina Auxiliary and helping to support the United Hospital – Hastings Regina Campus and Benedictine Senior Living! Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

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

1. Complete the Volunteer Enrollment Form.

2. Complete the Health Certification Form. Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, tuberculosis and other vaccination status. 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. Auxiliary members are required to follow hospital policies for immunization and vaccination including the flu vaccine. The Volunteer Services can help you through this process if needed.

3. Complete the Background Check Form. Regina is required to perform a background check on all volunteers.

4. Return the completed Auxiliary Volunteer Enrollment form, the Volunteer Health Clearance form, and Background Check disclosure:

   Joanne Peters, Volunteer Services
   1175 Nininger Road, Hastings, MN 55033
   Phone: 651.404.1454
   Email: joanne.peters@allina.com
   (Regina Volunteer Services coordinates the application and paperwork on behalf of the Auxiliary)

5. Once your application is complete, an Auxiliary member will contact you to share information about the Auxiliary. Also, the Regina Volunteer Services will schedule you for general hospital orientation; an Auxiliary member will attend to provide orientation specific to the Auxiliary to get you started.

We look forward to your involvement as an Auxiliary member! Please feel free to contact Kathy Horsch, Auxiliary Membership Chair, at 651.437.4541 with questions about the Auxiliary, or Joanne Peters, Regina Volunteer Services, at 651.404.1454 with questions about the application process.

REGINA AUXILIARY VOLUNTEER ENROLLMENT FORM

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

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.

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

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**	

BACKGROUND CHECKS: Regina Hospital is required to perform background on anyone volunteering for the organizations associated with Regina. You will be sent a form to complete after your application has been received.

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. You will be sent forms from the Volunteer office for completion. Please note the annual flu shots are required to volunteer on the Regina campus.

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 listedabove to determine my suitability for placement and allows United Hospital Hastings – Regina Campus to share the application information with the Regina Auxiliary.

_____ _____

Signature Date

Return completed application to:

Volunteer Services
Attn: Joanne Peters
1175 Nininger Rd.
Hastings, MN 55033
email: joanne.peters@allina.com

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, LLC. 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 time during my volunteer role and from a consumer reporting agency (CRA) other than Verified Credentials, LLC.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, and subject 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 to the 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 I become 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, LLC. 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*

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:_____ Previous Name(s):_____ SSN(required)_____

Date of Birth: _____Phone Number (daytime): _____Email:_____

Volunteer Site: _____ 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). (If you have never had a test, Allina will order proper testing free of charge as part of your on-boarding)
_____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 (Include a copy of proof of required vaccination if available)

_____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) (Include a copy of proof of required vaccination if available)

_____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) (Include a copy of proof of required vaccination if available)

_____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 (Include a copy of proof of required vaccination if available)

_____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 (Include a copy of proof of vaccination, if available)

_____ 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 (Include a copy of proof of vaccination, if available)

_____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 **(Include a copy of proof of vaccination if available)**

_____I have NOT had the COVID vaccine.

_____I have had the COVID vaccine(s). If yes, please include all dates you have received.

Vaccine Date 1:_____Manufacturer_____

Vaccine Date 2:_____Manufacturer_____

Vaccine Date 3:_____Manufacturer_____

Vaccine Date 4:_____Manufacturer_____

Vaccine Date 5:_____Manufacturer_____

Influenza Vaccine – **For current flu season (September-March). (Include a copy of proof of vaccination if available)**

_____I have NOT had the Influenza vaccine.

_____I have had the Influenza vaccine. If yes, date

Date:_____
Location received:_____

Applicant Name:_____

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:***

_____Uncontrolled HIV with CD4 count <200 or HIV patients not on antiretroviral medication
_____Currently receiving cancer treatment
_____With solid organ transplant on anti-rejection medication
_____Recent bone marrow transplant recipients with <500 absolute neutrophil count
_____With genetic immune deficiencies
_____On 30mg prednisone for 30 or more days
_____On immunosuppressants (mycophenolate, sirolimus, cyclosprine, tacrolimus, etanercept, rituximab, daclizumab, basiliximab, ocrelizumab, ofatumumab, obinutuzumab)

CONSENT:

VOLUNTEER NAME (Please Print): _____

VOLUNTER 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:**

_____ DATE: _____
(*Parent/guardian signature*)

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.

VOLUNTEERS please provide copies of all prior immunization records and/or lab titers listed below if you have available to you. Copies of your immunization record(s) should be sent along with this completed form to your volunteer coordinator. Record(s) may be obtained from the following sources: personal medical provider/public health clinic, the school district in which you attended grade school/high school, the college you attended, your parent/guardian. Please ensure your full name is visible on your documentation.

- **COVID**
- **Influenza**
- **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**
- **Chicken Pox (Varicella)**

Blood tests that may be ordered are:

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

See last page for location and hours of operation for Allina outpatient labs.

Applicant Name:_____

AUTHORIZATION TO ACCESS AND USE IMMUNIZATION RECORDS

As a benefit to you, Employee Occupational Health (EOH) will obtain your immunization information directly from state immunization registries on your behalf with your consent. If you would like to take advantage of this service, please complete the below Authorization to Access and Use Immunization Records form. Completing this authorization is not required for employment and/or volunteering, but without this authorization, you will need to obtain all of your immunization records on your own. If EOH does not receive your immunization records in a timely manner, your start date maybe delayed.

I, _____, understand that I am required to provide immunization records for required immunizations to Allina Health System ("Allina Health") as a condition of employment and/or volunteering at Allina Health to protect patients, health care workers, visitors and the community. Allina Health's Employee Occupational Health Department provides a service to Allina Health employees and volunteers by offering and coordinating immunizations for Allina Health employees and other workforce members. To aid in this process, I authorize Allina Health and its Agents to obtain immunization information for me on my behalf from state immunization registries, including, but not limited to, the Minnesota Immunization Information Connection (MIIC) and the Wisconsin Immunization Registry (WIR).

First and Last Name:_____ **Signature:**_____

Signature of Parent/Guardian(Parental Consent is required if under 18 years old): _____

Date of Birth (MM/DD/YYYY): _____

Date:_____

This consent will continue forever unless I cancel it in writing by:
Email
employeeoccupationalhealthserv@allina.com OR
By Mail:
Employee Occupational
Health 3960 Coon Rapids
Blvd NW Suite 315
Coon Rapids, MN 55433

If I cancel my consent, it will not apply to releases that have already been made.