



APPLICATION FOR  
VOLUNTEER SERVICES  
Tel: (617) 243-6048 Fax: (617) 243-5363  
<http://www.nwh.org/>



NAME: \_\_\_\_\_  
Last, First, MI Social Security # Database #  
(Office use only)

Street Address (Local): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
(Home) (Work or Cell)

In an emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel #: \_\_\_\_\_

PLEASE CHECK:

(\*Needs parental consent form)  14-15\*  16-17\*  18 and over

EDUCATION:

High School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

College: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Area of Study: \_\_\_\_\_ Degree: \_\_\_\_\_

Graduate School: \_\_\_\_\_ Degree: \_\_\_\_\_

Other Schools or Special Training: \_\_\_\_\_

EMPLOYMENT:

1. Present / last employer: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Position held: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

2. Previous Employer: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Position held: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

Foreign languages spoken fluently: \_\_\_\_\_

REFERENCES:

Two persons other than relatives. If student, give advisor or faculty member and one other person.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Tel #: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Tel #: \_\_\_\_\_

Previous volunteer experience and/or community activities (where, when, what kind of work):

\_\_\_\_\_

Are you doing this for course/community service? \_\_\_\_\_

If yes, how long and /or how many hours? \_\_\_\_\_

Contact person at school/community center/other: \_\_\_\_\_

Tel #: \_\_\_\_\_

Please list any special skills, interests and/or other hobbies: \_\_\_\_\_

\_\_\_\_\_

Why do you want to volunteer at Newton-Wellesley? \_\_\_\_\_

\_\_\_\_\_

What type of volunteer work are you interested in? \_\_\_\_\_

\_\_\_\_\_

Days and times, you are available?

\_\_\_\_\_

I understand that my placement as a volunteer will be dependent upon demonstration of my ability to perform the duties required in the specific department to which I am assigned, and that I must comply with all Hospital policies, including, but not limited to, protection of patient privacy and confidentiality.

I affirm that all information provided on this application and accompanying material is complete and true. I understand that my acceptance into the volunteer program is contingent of satisfactory results of my health screening, criminal history check (CORI), and other information provided by me. I understand that the hospital reserves the right to terminate my service as a volunteer when, in the opinion of Volunteer Services, such action is in my best interest and/or that of the hospital.

**By checking this box, I hereby authorize the use and reproduction by Newton-Wellesley Hospital of any and all photographs or video taken of me for the purpose of general marketing communications, promotion or advertising, without compensation to me. All photographs and video shall constitute the property of Newton-Wellesley Hospital.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

.....  
\*\*\* FOR OFFICE USE ONLY \*\*\*

Area: \_\_\_\_\_

Schedule: Day: \_\_\_\_\_ Time: \_\_\_\_\_

Orientation Date: \_\_\_\_\_ Start Date: \_\_\_\_\_

Training: \_\_\_\_\_ Training Date: \_\_\_\_\_

M / F

A / M

Affiliation: \_\_\_\_\_

Limitations: \_\_\_\_\_

Interviewer's Comments:

Interviewer's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

## NEWTON-WELLESLEY HOSPITAL VOLUNTEER HEALTH SCREENING REQUIREMENTS

As part of your volunteer health screening, you will need to bring in written documentation of all your vaccinations and/or blood tests/titers listed on the checklist below.

\_\_ Documentation of one **tuberculosis (TB)** skin test (within the past three months) OR if you have a history of a past positive skin test, written documentation of your last skin test result and chest x-ray evaluation report. *\*Some volunteer positions require a two-step TB skin test as part of the pre-placement health screening. TB screening may be performed at your pre-placement health screening. Please be aware that TB skin tests planted in OHS require reading of the test in 48-72 hours.*

\_\_ Documentation of two **Measles, Mumps, and Rubella (MMR)** vaccines OR written documentation of blood test/titer for measles (Rubeola), mumps, AND German measles (Rubella).

\_\_ Documentation of two **Varicella (chicken pox)** vaccines OR written documentation of blood test/titer for varicella. If you were not vaccinated and you had the disease, please disclose this during your appointment.

\_\_ Documentation of latest influenza vaccination.

Coming prepared with this documentation **at your volunteer interview** will help to expedite the volunteer health screening process. If you are unable to provide this written documentation, you will need to be re-vaccinated or have blood work drawn during your health screening appointment.

Please note that the health screening process cannot be scheduled until you have been offered a volunteer position.

IF YOU ARE UNDER 18 YEARS OF AGE, PLEASE HAVE A PARENT OR GUARDIAN COMPLETE THE MINOR'S AUTHORIZATION FORMS.

**AUTHORIZATION FOR MINOR'S VOLUNTEER SERVICES**

By my signature below, I give my permission for \_\_\_\_\_  
to serve as a volunteer at Newton-Wellesley Hospital ("NWH").

If in the course of his/her volunteer services, \_\_\_\_\_ requires emergency  
treatment, I consent to such treatment as deemed necessary by NWH.

Our family physician is: \_\_\_\_\_

He/she is located at: \_\_\_\_\_

And the telephone number is: \_\_\_\_\_

In the event I cannot be reached, I authorize NWH to contact the following person and to release such  
information as necessary to obtain his/her assistance:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

By checking this box, I give permission for my child to have a **criminal background check (CORI)**  
conducted by NWH for volunteer placement.

By checking this box, I hereby authorize the use and reproduction by Newton-Wellesley Hospital of  
any and all photographs or video taken of my child for the purpose of general marketing  
communications, promotion or advertising, without compensation to my child. All photographs and  
video shall constitute the property of Newton-Wellesley Hospital.

\_\_\_\_\_  
Print Name of **Parent** or **Guardian**  
(Please circle relationship)

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

Please direct any questions to NWH's Volunteer Services Department, at (617) 243-6048



Consent to Provide Pre-Placement Screening to a Minor

Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_
Job Title: \_\_\_\_\_ Department: \_\_\_\_\_
Current Date: \_\_\_\_\_

I am the parent or legal guardian of \_\_\_\_\_ and as such I authorize the Partners Occupational Health Services to provide medical care to my child for the purpose of screening my child for placement as either an employee or volunteer. I understand this care may include 1) drawing blood and testing it for immunity to measles, German measles, mumps, chickenpox, and Hepatitis B; 2) vaccinations against the infections listed and during flu season influenza vaccination; 3) a skin or blood test to check for tuberculosis infection; and/or 4) a chest x-ray if my child has had a positive skin test for tuberculosis in the past or during the pre-placement screening. I fully understand that if my child is being screened for employment (please note that this does not apply to students and volunteers), he/she is subject to the Pre-Hire Drug Testing Policy. My signature on this form serves as consent for my child to undergo pre-hire drug testing.

I understand that if my child requires vaccination I will be provided with a Vaccine Information Sheet by fax or email. I understand by law, all vaccines given by OHS or documented by OHS will be electronically sent to the MIIS (Massachusetts Immunization Information System) and that I have the right to limit who can see these records by completing the online "MIIS Objection Form" at www.mass.gov/dph/miis (also available at Occupational Health). By signing this form, I acknowledge that I have read and understand this consent. I also understand that if I have any questions I can contact the Occupational Health Service at the number listed below so that my questions are fully answered prior to signing this consent.

Print Your Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_
I understand this consent is good for 1 year unless otherwise specified

Please provide contact information as we must forward you a Vaccine Information Sheet if your child requires any vaccines:

Email Address: \_\_\_\_\_
Fax: \_\_\_\_\_
Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_

MGH: (617) 726-2217 | BWH: (617) 732-6034 | BWFH: (617) 983-4628 | MCL: (617) 855-2438 | NWH: (617) 243-6181  
NSMC Union: (781) 477-3211 | NSMC Salem: (978) 354-4466 | RCI: (508) 833-4178