MedStar Health

Medstar National Rehabilitation Network

Volunteer/Shadow Observer Forms

It's how we treat people.

Please read requirements before completing the application

Step 1: Complete the Applicable Forms

Volunteers
- Application Form
- Parent/Guardian Consent Form (if 16-18yo)
- Background Check Authorization Form (if over 18)
- Health Clearance Form
- Code of Conduct Attestation
- Confidentiality Statement
- Commitment of hours and personal statement

Step 2: Please submit the completed forms along with the required documentation to: mnrnvolunteerprogram@medstar.net

or mail to
MedStar Health National Rehabilitation Network
Support Services Office
102 Irving St., NW
Washington, DC 20010

Step 3 : Attend Orientation

Our Volunteer Coordinators will work with the Director of your site to arrange for your orientation.

Step 4 : Obtain and wear a Volunteer Name Tag at all times

A name badge will be made for you and must be worn at all times.

Step 5 : Begin your scheduled volunteer assignment on time and in the appropriate attire.

Volunteer Application Form

Please print legibly except where signature is required.

Last Name _____First Name_____ Middle Initial_____

Address _____

(Street, Apt #, City, State, Zip)

Phone (daytime)_____E-mail address_____

Contact Name and Phone Number of Current Employer: _____

Position Held with Current Employer: _____

Duties and Responsibilities _____

Please list your talents and skills _____

_____

Area of interest (Select a program)

- Career Exposure
- Student Program
- Community Volunteer Program

Dept/ Position _____

Number of hours to complete_____

Days/ Hours you are available _____

Transportation: Metro / Car / Carpool / Other _____

Do you require a workplace accommodation in order to perform duties associated with this role?

Emergency contact

Name _____Relationship_____

Daytime Phone _____Evening Phone_____

Address _____

Family Physician _____

Address/ Phone Number _____

Personal statement

By signing this volunteer application, I certify the information I have provided is true and complete. I understand that any misrepresentation, willful emission, false or misleading information may disqualify me from further consideration for volunteering or may result in my removal as a volunteer at the MedStar National Rehabilitation Network.

If accepted as a volunteer, I understand that I must abide by all policies, rules and regulations of the MedStar National Rehabilitation Network. I authorize the MedStar National Rehabilitation Network to investigate all statements contained in this application, check personal references, review medical history, and conduct a criminal background investigation in accordance with the separately completed Authorization Form. I also release employers, schools or individuals from liability in responding in inquiries relating to my volunteer application.

Applicant Signature _____Date_____

Parent/guardian consent (required for applicants ages 16-18)

In order for your child to participate in the MedStar National Rehabilitation Network unpaid volunteer program, we need your consent and involvement in helping your child have a productive and safe experience.

In connection with and consideration of my child's (named above) participation in the unpaid volunteer program at MedStar National rehabilitation Network, I, on behalf of my child and myself, hereby represent and agree as follows:

- I understand that my child has applied for an unpaid volunteer position in the MedStar National Rehabilitation Network and I hereby give permission for him/her to serve in that capacity at MedStar National Rehabilitation Network.
- I understand that my child will be provided with the orientation and training necessary, and as needed, for the safe and responsible performance of the duties assigned. He/she will be expected to meet all the requirements of the volunteer activity, including regular attendance and adherence to hospital, and department policies and procedures.
- I understand that as an unpaid volunteer, my child may participate in physical activity. I represent and warrant that my child is in good physical condition, and has no physical, health related or other problems which would preclude or restrict his/her participation in this program or related activities or otherwise render his/her participation dangerous or harmful to him/her or others, and that he/she is allowed to participate in physical activity.
- I authorize MedStar National Rehabilitation Network to publish or release to the media any pictures of my child during his/her time as a participant in an approved unpaid volunteer program for promotional or recognition purposes only.

  ☐ Please check box if you do not consent to this statement. This box, if left unchecked, means that you do consent to any publications or media release. Note: The statement regarding the publishing or releasing to the media your child's photograph does not hinder the process of your child from becoming an unpaid volunteer.

I, the undersigned, certify that I am the parent or legal guardian of the child (named above) and that I have the right to make decisions for my child that effect his/her well being. I recognize and acknowledge that physical injury, accident, illness, death, loss of personal property, or other contingencies may befall my child as a participant in the program and related activities. I understand that my child is not in any way required to participate in the program and related activities, and despite these risks, I want him/her to participate in the preceding. In light of the preceding and with sufficient knowledge of my child's physical and other conditions and limitations, if any, I voluntarily assume all responsibility and risk of loss, damage, illness and/or injury to person or property which my child may, in any way, sustain in connection with his/her participation in the program and related activities. In consideration of my child's participation in the program and related activities, I agree to release MedStar National Rehabilitation Network and its trustees, officers, employees, agents and volunteers from any and all liabilities, damages, losses and/or causes of action (collectively, "Claims") that I or my child may suffer or have, including without limitation, to our persons or property or both, which arise out of, are related to or in connection with, or occur during, my child's participation in or attendance at the program and related activities except to the extent any such claims are caused by the gross negligence or willful misconduct of the employees of MedStar Health. I further agree to indemnify and hold harmless MedStar Health and its trustees, officers, employees, and volunteers from any and all Claims arising out of, related to, or in connection with the program or related activities that are caused by my or my child's negligent or intentionally tortuous acts and/or omissions.

I agree that this agreement shall be governed by the laws of the State of Maryland, District of Columbia, and Virginia without giving effect to any choice or conflict of law principles of any jurisdiction, and if any portion of this agreement is held invalid, the remainder of the agreement shall continue in full force and effect.

I certify that I am 18 years of age or older and that I have read, fully understand and agree to the terms of this agreement, and I sign it voluntarily with full knowledge of its significance.

Parent/Guardian's Full Name (please print): _____

Parent/Guardian's Telephone No: _____

Parent/Guarding Signature:_____Date: _____

Authorization to treat (all applicants)

This is to certify that, if injured on the job, I consent to any treatment which may be deemed necessary or advisable during the time _____(*applicant name*) is serving as a volunteer. Should _____(*applicant name*) require emergency medical treatment, first aid, or transportation to a hospital or medical facility as a result of illness or injury associated with participation in the volunteer program or related activities, I consent to any such treatment, first aid and/or transportation that may be provided, and understand that MedStar National Rehabilitation Network will not be responsible for any costs associated with any of the foregoing.

Applicant Name (print) _____

Applicant Signature_____Date_____

Parent/guardian consent (applicant ages 16-18)

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____Date_____

Address (Street, Apt #, City, State, Zip) _____

_____

Daytime Phone _____Evening Phone_____

Please print legibly except where signature is required

Request for Background Check

Social Security Number

☐☐☐-☐☐-☐☐☐☐

Date of birth

☐☐-☐☐-☐☐☐☐

First Name _____Middle Name_____Last Name_____

Other Names Used (maiden name, AKA names, etc.)

_____

Current Residential Address _____

City _____State_____Zip Code_____

List each CITY, STATE and ZIP CODE (if known) where you have lived during the past seven years:

City _____State_____Zip Code_____From date_____To date_____ ☐

City _____State_____Zip Code_____From date_____To date_____ ☐

City _____State_____Zip Code_____From date_____To date_____ ☐

City _____State_____Zip Code_____From date_____To date_____ ☐

City _____State_____Zip Code_____From date_____To date_____ ☐

Disclosure regarding background investigation

MedStar Health (“the Company”) may obtain information about you from a third party consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification. The investigations will be conducted by First Advantage

P.O. Box 105292, Atlanta, GA 30348 USA. 1.800.845.6004 www.fadv.com.The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature_____Date_____

Signature of parent or guardian(if applicable) _____Date_____

Acknowledgment and authorization for background check

I acknowledge receipt of the separate document entitled DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by MedStar Health ("the Company") at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by First Advantage P.O. Box 105292, Atlanta, GA 30348 USA. 1.800.845.6004 www.fadv.com., and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Washington State applicants only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. A CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Signature	Date
Driver's License Number	State of Issuance - Driver's License
Full Name (First/Middle/Last)	Social Security Number (SSN)*
Email Address & Telephone Number	Date of Birth*
Current Address	City, State and Zip Code

*SSN and DOB will be used for identification purposes and will not be used as selection criteria.

Volunteer health clearance requirements.

All volunteers working in MedStar National Rehabilitation Network are required to meet all the health requirements outlined below. Please provide documentation of vaccinations and most recent TB test (T-spot, TB quantiferon, or two step PPD) or have your physician nurse practitioner complete and sign the Volunteer Health Clearance Form.Required immunizations Requirements

MMR	• **2 MMRs are required**
Measles (Rubeola) Mumps Rubella	Two vaccinations or positive titer for Measles, Mumps and rubeola
Varicella (Chicken Pox)	1. Two vaccinations or positive varicella titer.

Tuberculosis skin testing (TST)

- IGRA (QuantiFERON or Tspot) blood test within the past 3 months OR
- Two-step (TST) PPD within the past 3 months. **If providing a PPD, you will require TWO tests with the second test placed at least 7 days after the reading of the first PPD.** The TST reports from your provider must include date of implant, read and results (including millimeters of induration)

If you have a Negative PPD test within the last year, only one PPD test within the past 90 days is required

If history of a POSITIVE TEST, a negative chest X-ray report after the date of positive test completed within prior FIVE (5) years.

COVID-19	Primary vaccination recommended, but not required

What tests am I required to complete every year?

- A TB questionnaire is required of all volunteers with a history of positive test every year.
- Seasonal Flu Vaccination (required during the current Flu Season (Oct. through March)

Volunteer health clearance form

Name: Last _____First _____MI _____Date of Birth: _____

Home phone: _____Cell phone:_____ ID# or SS#_____

Address:_____City/State/ZIP:_____

Email: _____

I. TB Testing

- **TB Test result is required within 3 months of this application.**

—Documentation of IGRA (T-Spot or QuantiFERON TB Gold (blood test) OR Tuberculin Skin Test (TST/PPD) is accepted.
—Previous POSITIVE candidates DO NOT REQUIRE current TESTING. Report date of previous Positive Test only.

IGRA TEST—T-Spot or QuantiFERON TB Gold (blood test)

Date_____Result_____Type (T-Spot or QuantiFERON)_____

TB SKIN TEST (PPD) (If you have documentation of prior negative PPD, complete Step 1 PPD within 12 months of this application, Step 2 is required with no prior negative PPD test)

Prior negative TB test ☐ **No** ☐ **Yes Date of Negative test** _____**(complete Step 1 or IGRA TEST)**

Step 1 PPD-TST Administration PPD STEP 1

Date/time _____Lot #_____Planted by:_____Result _____

MM Induration_____ ☐ Negative ☐ Positive

Step 2 PPD-TST

Date/time _____Lot #_____Planted by:_____Result _____

MM Induration _____ ☐ Negative ☐ Positive

Positive TB Result (Complete if Positive Test only)

Date of positive test _____Date of chest X-Ray_____Result_____

Treatment for llatent TB_____Not completed _____Completed date _____

II. Flu Vaccination (Required during the current Flu Season (Oct. through March)

Date of Flu Vaccine_____Manufacturer_____Lot # _____

III. Measles, Mumps, Rubella, Varicella (Chicken Pox) History

Provide documentation of your MMR/Varicella (Chicken Pox) vaccination record OR titer results (immune or non-immune).

Vaccine date		**Titer date/Results**	
#1 MMR	Date given _____	MMR	Date_____Result_____
#2 MMR	Date given _____		
#1 Varicella	Date given _____	Varicella	Date_____Result_____
#2 Varicella	Date given _____		

This form must be completed and signed by your medical provider.

Provider Name (printed) _____Address_____Phone _____

Signature _____

Code of conduct attestation

By signing below, I acknowledge that I have received, read, understood, and will abide by MedStar Health's Code of Conduct. I understand that adherence to the Code of Conduct is a requirement and failure to adhere to it can result in disciplinary action up to and including termination of employment and/or affiliation.

Print legal name: _____
Please print clearly)

Signature: _____

Date: _____/_____/_____

Facility: MedStar National Rehabilitation Hospital
Department: Volunteer Services

Upon completion, please return to:

Volunteer Coordinator
MedStar National Rehabilitation Network
P 202-877-1949
102 Irving St. NW
Washington, DC 20010

Please keep a copy for your records.

Volunteer services commitment of hours and personal statement.

Applicant name: _____

Commitment of hours.

If accepted as a MedStar National Rehabilitation Network Volunteer, I commit to volunteer at MedStar National Rehabilitation Network for a minimum of four hours a week for a total of 100 hours as a year-round volunteer (64 hours for summer volunteers).

Personal Statement.

In choosing to apply to become a MedStar National Rehabilitation Network volunteer, I am interested in donating my time and effort to MedStar. I understand that in order to become a MedStar Volunteer, if I qualify, I will need to complete the application process, including the completion of a Volunteer Orientation that emphasizes key components of the MedStar National Rehabilitation Network Volunteer Program.

I hereby certify that I have read and understood all the statements and questions on this application and that my responses are true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from volunteer service. I recognize that inappropriate behavior will result in immediate dismissal from the program.

Applicant signature _____Date_____

High school applicant parental/guardian consent.

As parent/guardian, I have read and understood the requirements and commitments for my son/daughter to volunteer at MedStar National Rehabilitation Network. I hereby grant full permission for his/her participation in the program as a High School Volunteer.

Parental/guardian signature _____Date_____

Printed name _____Phone _____

Confidentialty statement.

Confidential information.

I understand that the patient expects to communicate with health care practitioners with confidence that none of the information communicated will be released without appropriate authorization. I have read and understood Policy number 456 “Confidential Patient Information and Patient Privacy,” which outlines my duties under HIPAA regulations.

I understand that the information considered confidential involves all reports within medical records, employee health records, and/or automated information systems concerning examinations, tests, treatments, observations, and diagnosis of the patient/employee. It also includes information I learn in conversations with the patient/employee. I understand that patient demographic information, including all financial data, is private.

I understand that information about physician credentialing, quality improvement, utilization management, risk management, and business information of the organization are to be treated as confidential and may only be released by those authorized to do so.

Duties and obligations.

I understand and agree that as an employee of MedStar National Rehabilitation Network, I must hold certain confidential information in strict confidence, regardless of the method of communication, including but not limited to hard copy, faxed electronically transmitted, oral conversations, or any printed data. This confidence must be kept when performing my duties, as well as during breaks, rest periods and time away from work. I understand that I may not seek access to or release written or computerized confidential information unless my work assignment specifically authorizes me to do so.

I understand that discussions concerning confidential information are not to occur in hallways, elevators, or other public areas where confidential information can be inadvertently overheard by someone not authorized to receive the information. I understand that when I discuss confidential information, I must take precautions so that unauthorized persons will not overhear my discussion

Consequences.

I understand that violation of the terms of this statement may result in disciplinary action up to and including dismissal. In addition, I understand the civil and criminal sanctions that may be imposed by the Department of Health and Human Services.

Volunteer name (please print): _____

Volunteer signature: _____Date_____

Volunteer Services Coordinator Signature: _____Date_____