Mason General Hospital
& Family of Clinics

Dear Volunteer / Job Shadow Applicant,

Thank you for your interest in Mason General Hospital & Family of Clinic's volunteer / job shadow program. I hope that you decide to join our wonderful group of volunteers! We have numerous opportunities, and I am certain we can find one that fits your interests.

Please complete the attached application and return it to:

Lonnie Hatman
Volunteer Services Coordinator
Mason General Hospital & Family of Clinics
901 Mountain View Drive
P.O. Box 1668
Shelton, WA 98584-8614
lhatman@masongeneral.com

When I receive your paperwork, we will schedule an interview to explore your interests, talents and the hospital needs. At that time, I will provide you with additional paperwork to complete and schedule you for an orientation.

If you have further questions or concerns, I can be reached at (360) 427-3621 or lhatman@masongeneral.com

We value the dedication and hours of service our volunteers give each year. Again, thank you for your interest in being part of our team!

Sincerely,

Lonnie Hatman | Volunteer Services Coordinator
Mason General Hospital
& Family of Clinics
901 Mountain View Drive POB 1668
Shelton, WA 98584
Phone: 360-427-3621 | Ext. 28899 | Fax: 360-432-3267
www.masongeneral.com

Mason General Hospital & Family of Clinics

Volunteer / Job Shadow Application

Mason General Hospital & Family of Clinics

901 Mt. View Drive/PO Box 1668◦ Shelton, Washington 98584 ◦ (360) 426-1611

Please Print Clearly

PERSONAL DATA

Last Name _____ First Name _____M.I._____

Address _____ City _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Email _____ **Position Applying for**: **Volunteer** _____**Job Shadow** _____

How do you prefer to be contacted? (circle one) Phone ☐ or by ☐ Email or by ☐ Text Msg.

Have you ever been convicted of a felony or misdemeanor? Yes _____ No _____
(A "yes" answer to this question will not necessarily bar the applicant from volunteering)

If yes, explain fully _____

_____

Are you at least 18? Yes _____ (Skip to Emergency Contact Section)

No _____ (Complete Parental Consent Section)

PARENTAL CONSENT

A junior volunteer must be at least 15 years of age. They must maintain an overall grade point average of at least 2.5; a letter of recommendation from a school counselor or teacher; a copy of your school transcripts; and verification of vaccination for Measles, Mumps & Rubella (MMR) and the annual flu immunization.

TO BE SIGNED BY PARENT(S) AND/OR GUARDIAN:

I GIVE CONSENT FOR MY SON/DAUGHTER TO VOLUTNEER/JOB SHADOW AT MASON GENERAL HOSPITAL. I UNDERSTAND THAT VOLUNTEERING CAN LEAD TO EXPOSURE TO A VARIETY OF INFECTIOUS DISEASES. THESE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING; HEPATITIS A, B, C, D, E, G, AND SIN-V, TUBERCULOSIS, HIV/AIDS, MENINGITIS, INFLUENZA AND OTHER BACTERIAL AND VIRAL INFECTIONS.

_____ HAS MY (OUR) CONSENT TO PARTICIPATE IN THE VOLUNTEER PROGRAM. I (WE) UNDERSTAND THAT TRANSPORTATION TO AND FROM THE HOSPITAL IS OUR RESPONSIBILITY. I (WE) UNDERSTAND I (WE) NEED TO PRODUCE VERIFICATION OF THE VARICELLA (CHICKEN POX) VACCINE AND THE MEASLES, MUMPS, AND RUBELLA VACCINE OR THAT OUR CHILD HAS BEEN SCREENED.

_____ _____

(Parent and or Guardian's Signature) (Date)

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____ PHONE _____

NAME: _____ RELATIONSHIP: _____ PHONE _____

REFERENCE INFORMATION

Please provide three professional or personal references who are not family members:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

EDUCATION & EMPLOYMENT HISTORY

High School _____ Graduated ☐ Yes ☐ No

If No: Present Grade_____ Present GPA:_____ Are you involved in after school activities the might conflict with participation in the program? ☐ Yes What:_____ ☐ No

College _____ Graduated ☐ Yes ☐ No

Degree(s): _____Professional licenses held: _____

Current or last place of employment: _____

City / State: _____ Phone: _____

Job title: _____

Job duties: _____

Supervisor's name: _____ May we contact? ☐ Yes ☐ No

Special Skills and/or hobbies: _____

Past or current volunteer experience: _____

POSITION PREFERENCE

Please list the departments that interest you:_____

What interests you about those departments? _____

_____

What skills do you have that would make you a good candidate for positions in the above departments?

_____

_____

APPLICATION QUESTIONNAIRE

1. Why do you want to Job Shadow / be a hospital volunteer? _____

_____

2. Describe your formal/informal training and experience pertinent to your application?

_____

_____

3. What do you hope to gain from volunteering/Shadowing?

_____

4. Other organizations to which you have provided volunteer services or Job Shadowed:

_____

Volunteer Position: _____ Dates: _____

5. Are you willing to make a 6 month commitment? Yes _____ No _____

6. Which days/hours are you available? (i.e. Mondays 8–12, Thursday 12-4, Sunday 6-10)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

7. Are hours required for: Community Service ☐ School Classes ☐ Other ☐

8. How does a Job Shadow / Volunteer job fit in with your present life situation? _____

_____

9. What personal traits do you possess that would help make you successful in Job Shadowing / Volunteering?

_____

_____

HEALTH

I UNDERSTAND THAT VOLUNTEERING/JOB SHADOWING CAN LEAD TO EXPOSURE TO A VARIETY OF INFECTIOUS DISEASES. THESE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING; HEPATITIS A, B, C, D, E, G, AND SIN-V, TUBERCULOSIS, HIV/AIDS, MENINGITIS, INFLUENZA AND OTHER BACTERIAL AND VIRAL INFECTIONS.

_____

(APPLICANT'S SIGNATURE) (DATE)

Have you any physical, mental or sensory limitation that would prevent you from performing as a Volunteer/Job Shadow?

YES ☐ NO ☐ PLEASE EXPLAIN: _____

You will be required to have a Tuberculin Skin Test (T.S.T.). Our Employee Health Nurse will administer this on the first day of orientation **free of charge** along with the annual flu immunization if you haven't already been vaccinated. **If you are a minor, your parents will have to sign a TB consent form and a consent form for the Influenza Vaccine.** You will also be required to show verification of having received the Measles, Mumps and Rubella vaccine, or that you have gone through M.M.R. screening.

CERTIFICATION, CONFIDENTIALITY AUTHORIZATION & RELEASE

I UNDERSTAND THAT ALL THE INFORMATION WHICH I MAY HEAR DIRECTLY OR INDIRECTLY CONCERNING A PATIENT, DOCTOR, OR STAFF MEMBER, WILL BE CONSIDERED *STRICTLY CONFIDENTIAL,* AND I WILL NOT SEEK INFORMATION IN REGARD TO ANY PATIENT.

ALL STATEMENTS IN THE APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ANY INFORMATION SUBMITTED PROVES TO BE FALSE, IT SHALL BE CAUSE FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION.

I certify that the information given by me to Mason General Hospital & Family of Clinics (MGH&FC) is true and complete to the best of my knowledge. I understand that, if I am accepted as a hospital volunteer and it is discovered that I gave false, incomplete or if I omit information, it may result in my immediate dismissal. I also understand that if I am hired, my volunteer position is conditioned on your receipt of a satisfactory report from the Washington State Patrol, according to the position for which I am applying.

I authorize MGH&FC to solicit information regarding my character, general reputation, previous employment and similar background information, and to contact any and all references I have given on my application. I hereby release all parties and persons connected with any such request for information from all claims, liabilities and damages for any reason arising out of the furnishing of such information. If I am accepted as a volunteer, I release MGH from any liability for future reference it may provide regarding my volunteer history at MGH&FC.

Applicant's Signature: _____ Date: _____

FOR OFFICE USE ONLY

Interviewed by _____ Date: _____

Assigned position: _____ Department: _____

Orientation date: _____ Department date training: _____

RESET

(Clears all Fields in the Form)

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633
(360) 534-2000
http://watch.wsp.wa.gov

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

INSTRUCTIONS: PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION BASED ON NAME AND DATE OF BIRTH. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH $16.00 CHECK OR MONEY ORDER. FOR REQUEST BASED ON FINGERPRINTS, MAIL A COMPLETED FINGERPRINT CARD AND FEE OF $38.00. YOU MAY ALSO COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. ***NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST BY NAME AND DATE OF BIRTH FOR $12.00 USING A CREDIT CARD.***

NOTARIZED LETTERS ARE AN ADDITIONAL $10.00 PER NOTARY SEAL ____ **Notarized Letter(s)**

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

A SUBJECT INFORMATION: (Please type or print clearly)

Applicant's Name: _____ (Last) _____ (First) _____ (Middle)

Alias/Maiden Name: _____

Date of Birth: _____ (Month/Day/Year) Sex: _____ Race: _____

B REQUESTOR INFORMATION: (Please type or print clearly)

DATE: ____ / ____ / ____ (Mo. / Day / Yr.) _____ (print) Name/Title of Requestor _____ Requestor's Signature

Provide e-mail to receive background results electronically. Phone No. ( ) _____

_____ E-mail address _____ Password (must be at least 8 characters)

REQUESTOR'S ADDRESS: (type or print clearly)

_____ Name

_____ Address

_____ City _____ State _____ ZIP Code

Subject's Right Thumb Print (Optional)

MASON GENERAL HOSPITAL DISLOSURE
APPLICANT DISCLOSURE, PURSUANT TO RCW 43.43.830 - 43.43.840
CHILD AND ADULT ABUSE INFORMATION ACT

Answer YES or NO to each listed item. If the answer is YES to any item, explain in the area provided, indicating the charge or finding, the date, and the other court(s) involved.

1. Have you ever been convicted of any crimes against children or other persons, as follows: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second or third degree assault; first, second or third degree rape; first second or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution?

   Answer_☐__ IF YES, EXPLAIN BELOW

   _____

   _____

2. Have you ever been convicted of crimes relating to financial exploitation if the victim was a vulnerable adult, as follows: first, second, or third degree extortion: first, second, or third degree theft; first or second-degree robbery; forgery?

   Answer_☐__ IF YES, EXPLAIN BELOW

   _____

   _____

APPLICANT DISCLOSURE, PURSUANT TO RCW 43.43.830 - 43.43.840
CHILD AND ADULT ABUSE INFORMATION ACT (continued)

3. Have you ever been found in any dependency action under RCW 13.34.030(2) (b) to have sexually assaulted or exploited any minor or to have physically abused any minor?

   Answer_☐__ IF YES, EXPLAIN BELOW

   _____

   _____

4. Have you ever been found in any domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor?

   Answer_☐__ IF YES, EXPLAIN BELOW

   _____

   _____

5. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult?

   Answer_☐_ IF YES, EXPLAIN BELOW

   _____

   _____

6. Have you ever been found in any protection proceeding under chapter 74.24 RCW to have abused or financially exploited a vulnerable adult?

   Answer_☐_ IF YES, EXPLAIN BELOW

   _____

   _____

APPLICANT DISCLOSURE, PURSUANT TO RCW 43.43.830 - 43.43.840

CHILD AND ADULT ABUSE INFORMATION ACT (continued)

7. Have you ever been convicted of crimes related to drugs as defined in RCW 43.43.830?
   This includes manufacturing of a controlled substance, possession with the intent to manufacture a controlled substance, delivery of a controlled substance, and possession with the intent to deliver a controlled substance.

   Answer _____ IF YES, EXPLAIN BELOW

   _____

   _____

Pursuant to RCW 9A.72.085, I certify under penalty of perjury under the laws of The State of Washington that the foregoing is true and correct.

Applicant Name (print)_____

Applicant Signature_____

Date and Place_____

Witness_____

Business or Organization_____

Address_____

PUBLIC VENUE RELEASE FORM

The undersigned hereby consents to the use of their personal information as identified below, by Public Hospital District No. 1 *(doing business as: Mason General Hospital & Family of Clinics)* and waives the right to inspect or approve such photos, stories, etc. or to receive any monetary compensation for this photo, story, etc. The following personal information about myself or child may be used:

- ☐ Name
- ☐ Work Address
- ☐ Name of Baby (Please print)
- ☐ A letter I have sent to the hospital (copy of the letter attached)
- ☐ A photograph (picture) of myself
- ☐ A photograph (picture) of child
- ☐ The following information (attach a separate sheet if needed)
- ☐ Date of Birth:
- ☐ Internet-District Web Page
- ☐ Internet White or Yellow Telephone Pages
- ☐ Newspapers (list exceptions)
- ☐ Radio (list exceptions)
- ☐ Television (list exceptions)
- ☐ Scope, Grapevine, Making the Rounds or other District Publications
- ☐ Reader Board
- ☐ Digital Stories, DVD's, as well as any and all social media and web based (and other) media outlets
- ☐ Telephone Pages
- ☐ Happening Boards
- ☐ Medical Directory
- ☐ Individual Physician or Allied Health Profiles
- ☐ Educational material, i.e. flyers, banners, pamphlets
- ☐ Any Years-of-Service recognition for duration of employment

Please provide your address and phone number so we may contact you if necessary.

Address Phone number Email

Revocation of Public Venue Release (a copy is provided upon request)

If, in the future, you no longer want Public Hospital District No. 1 to use your information in a public venue you need to contact Mason General Hospital & Family of Clinics and sign a revocation statement. This can be done in person or via a fax notice to 360-427-1921. I no longer want my personal information used in a public venue; I understand that it may take up to 60 days for this revocation to be put into effect.

Signature Date

Mason General Hospital

Formulated 3/01

All Departments

Revised 10/02. 3/04
Reviewed 10/2007

CONFIDENTIALITY STATEMENT
HR Policy # 4516

Statement:
Under Federal and State Laws as well as Public Hospital District Policies all information regarding patients to be treated as confidential. Confidential information includes both medical data as well as demographic data. Medical information regarding employees is also considered confidential. Confidential information may be revealed to certain individuals or agencies in order to provide medical care to the patient or to receive payment for the care and in certain circumstances to Public Health Agencies; Patient Privacy Act requirements will be followed for releasing confidential medical information.

All employees, volunteer's students and job shadow participants must maintain patient confidentiality, if they fail to do so they may be disciplined, up to and including termination of employment.

Type of information considered to be confidential includes, but is not limited to, the following data:

Patient Name, Age, Sex, Race, Religion, Social Security Number, Address, Phone number, Financial data, Insurance information
Health History
Diagnosis
Test or Procedure results

In addition to patient confidentiality all employees and volunteers are expected to maintain the confidentiality of Public Hospital District No.1's (PHD No.1) business information or information relating to our vendors, suppliers, providers or customers. Employees and volunteers shall not seek to improperly obtain or misuse confidential information. Please review the Hospital's Code of Conduct for details.

By signing below the employee/volunteer agrees to comply with this policy and all other patient privacy policies, and will not, in any format (oral, written or electronic) reveal patient, employee, or Public District No. 1 confidential information to any individual, or agency which does not have a legal right to this information.

I hereby agree to follow all patient, employee and PHD No. 1 confidentiality policies and procedures.

_____
Signature

Print Name_____ Date

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CONSENT FORM FOR INFLUENZA VACCINE FORMULA

Influenza Vaccine is recommended for the following persons:

- Persons age 50 or older
- Residents of nursing homes or other care facilities
- Adults & children with chronic disorders
- Adults & children with chronic metabolic disorders i.e., diabetes, renal failure
- Children & teenagers on long-term aspirin therapy
- Women in the second or third trimester of pregnancy at flu season
- Health care workers and volunteers

Your signature on this consent signifies the following:

- I am not allergic to chicken eggs, gentamicin sulfate, other aminoglycosides (streptomycin, neomycin, tobramycin) or thimerosal (mercury derivative)
- I have never had Guillain-Barre' Syndrome.
- I am not pregnant.
- I am not currently ill with a temp above 99º
- I may have temporary adverse effects including: fever, headache, malaise, myalgia or soreness at the site of the injection for 1-2 days.
- I have never had a serious problem or allergic reaction to this or any other medication. That allergic reaction may include hives (rash), angioedema (swelling), allergic asthma (difficulty breathing), or systematic anaphylaxis (inability to breath and possibly cardiac arrest).
- I agree to remain at MGH for 30 min. following the influenza injection.

CONSENT:

I consent to have 1 dose of the current Influenza Virus Vaccine (0.5ml) given IM in the Deltoid (shoulder) muscle. I do not hold Mason General Hospital or any of its employees responsible for any possible untoward effects related to this vaccine administration.

Please complete the information below:

Name:_____Signature:_____ Dept:_____
Print Last First

For MGH use only

Administered by: _____ Date/Time Vaccine administered:___/___/___ ___:____ Site of Injection: L/Delt___ R/Delt___

Lot # _____ Exp Date: _____ Manufacturer: _____

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PARENTAL CONSENT FORM FOR INFLUENZA VACCINE FORMULA

Influenza Vaccine is recommended for the following persons:

- Persons age 50 or older
- Residents of nursing homes or other care facilities
- Adults & children with chronic disorders
- Adults & children with chronic metabolic disorders i.e., diabetes, renal failure
- Children & teenagers on long-term aspirin therapy
- Women in the second or third trimester of pregnancy at flu season
- Health care workers and volunteers

Your signature on this consent signifies the following:

- I am not allergic to chicken eggs, gentamicin sulfate, other aminoglycosides (streptomycin, neomycin, tobramycin) or thimerosal (mercury derivative)
- I have never had Guillain-Barre' Syndrome.
- I am not pregnant.
- I am not currently ill with a temp above 99º
- I may have temporary adverse effects including: fever, headache, malaise, myalgia or soreness at the site of the injection for 1-2 days.
- I have never had a serious problem or allergic reaction to this or any other medication. That allergic reaction may include hives (rash), angioedema (swelling), allergic asthma (difficulty breathing), or systematic anaphylaxis (inability to breath and possibly cardiac arrest).
- I agree to remain at MGH for 30 min. following the influenza injection.

CONSENT:

I consent to have 1 dose of the current Influenza Virus Vaccine (0.5ml) given IM in the Deltoid (shoulder) muscle to my son/daughter. I do not hold Mason General Hospital or any of its employees responsible for any possible untoward effects related to this vaccine administration.

Please complete the information below:

Name:_____Signature:_____ Dept:_____
Print Last First

Signature: _____ Date :_____
Parent or Guardian

Name: _____
Print Your Name and Relationship to the Junior Volunteer

For MGH use only

Administered by: _____ Date/Time Vaccine administered:___/___/___ ___:____ Site of Injection: L/Delt___ R/Delt___

Lot # _____ Exp Date: _____ Manufacturer: _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____
Last First Middle

Home Telephone: _____ Department: _____

Position: _____

Immunization and Infection History: Your history of immunizations and past infections will guide us in offering you immunizations and may be important if you should be exposed to infection during employment. This information is used to guide employment decisions such as hiring, firing, or promotions. Please note which infections and immunizations you have had and supply dates as accurately as possible.

Infection or Disease	Year of Clinical Disease	Date of Immunization	Date and Result of Antibody Test
Diphtheria/Tetanus			
Mumps			
Measles (Rubeola, Red Measles)			
Rubella (German Measles)			
Chicken Pox (Varicella)			
Pertussis (Whooping Cough)			
Polio			
Hepatitis B		#1 #2 #3	

IF PROVIDING PROOF OF IMMUNIZATIONS, PLEASE TAKE THE TIME TO FILL IN THE APPROPRIATE DATES IN THE TABLE PROVIDED ABOVE.

Date of last TB skin test: _____ Result: Negative _____ Positive _____
If TB skin test is positive, date of last chest x-ray _____
Where _____
Was it normal? (check one) Yes ____ No ____
Were you ever treated with anti-TB medicine? Yes ____ No ____
If yes, what medicine? _____ Dates of treatment: From _____ to _____

Do you have allergies to: latex ____ Other: _____

Are you color blind? Yes ☐ No ☐ Color Vision Test Pass ☐ Fail ☐

To prevent exposure of patients and other staff to communicable diseases, we request that you report to Occupational Health staff directly should you develop any of the following conditions: (you can report any of these conditions by using the 24-hour illness reporting form provided on the hospital intranet, calling ext. 3442 and leaving a message, or report in person to the Employee Health/Infection Control Office.)

A. Viral Hepatitis (you or your immediate family)

B. Parasitic infections (you)

C. Measles, Rubella, Chicken Pox, Herpes Zoster (Shingles), Pertussis (Whooping Cough) (you or your immediate family)

D. Salmonella, Shigella, Campylobacter, or Yersinia Infections (you or your immediate family)

E. Tuberculosis

F. Staphylococcal infections such as boils

G. Streptococcal infections such as Strep Throat, Scarlet Fever

H. Oral Herpes infections (Cold Sore or Fever Blisters Or Whitlow (Herpes of the hand)

I. Scabies

J. Body lice

K. Skin rash, lesions, or dermatitis

L. Fever (while at work of if missing work)

M. Conjunctivitis or red eyes

N. Gastrointestinal illness including diarrhea or Vomiting (while at work or if missing work)

O. Respiratory illness (while at work or if missing work)

P. Immune suppression

If you are immune-compromised , some need to modify your assignment to minimize risk of infection may rarely arise.

Has your physician informed you that you are immune-suppressed for any reason? Yes ☐ No ☐

DECLARATION: The above answers are correct to the best of my knowledge.

_____ _____

Signature Date

Mason General Hospital has completed an annual assessment for Tuberculosis risk and this year we have been classed as "**LOW RISK**". As such, we are not required to do annual skin testing. However, every employee must complete and return to Employee Health a "**Symptoms Evaluation**" form.

Print Name: _____

Date of Birth _____/_____/_____

Department: _____

Signature: _____ Date: ___/___/_____

Please check any of the following signs and symptoms of tuberculosis that you may be experiencing at this time:

I currently have the following signs and symptoms:

Productive cough lasting 3 weeks or more

- ☐ Coughing up bloody sputum
- ☐ Night sweats (not related to temperature or hormones)
- ☐ Fever of unknown origin
- ☐ Unexplained weight loss (not related to dieting)
- ☐ Loss of appetite
- ☐ I have been exposed to someone with active TB in the past year

☐ I am **NOT** experiencing **ANY** of the above signs and symptoms

If you are concerned at any time that you may have TB symptoms, or been exposed to TB contact Employee Health at ext. 28851 M-F 7am-3:30pm or the House Supervisor ext. 27000

MASON GENERAL HOSPITAL
Volunteer Services
Infection Control/Employee Health

Formulated 9/90
Revised: 3/95; 9/04; 7/07
Reviewed: 5/98

CONSENT FOR TUBERCULOSIS TESTING

In accordance with Washington State Law which requires screening of all Healthcare facilities for detection and prevention of Tuberculosis, I give my consent for Mason General Hospital to give my son/daughter a Tuberculin Skin Test (TST) as a part of the Junior Volunteer Program.

I understand that this test involves a prick under the skin of the forearm with a needle to inject a protein that is sensitive to the Tuberculosis germ. I also understand that 48 to 72 hours later a local reaction to this test may indicate that my son/daughter has at some time in the past been exposed to Tuberculosis. This test is for ***screening purposes only*** and does not diagnose any specific disease.

This baseline test is required for ALL individuals working in or around Mason General Hospital. Volunteer testing will be done on Orientation Day and annually thereafter. The tests will be read at the hospital on the second or third day after being administered. Your child will be tested in a two-step method, which requires a second TST 1 to 3 weeks after the first test.

Further explanation of hospital infection control and employee health issues will be provided during orientation. Any questions concerning this program may be addressed to the Employee Health Nurse (360) 426-1611, extension 28851, or the Volunteer Coordinator at (360) 427-3621.

_____
Minor (Print Name)

_____ _____
Parent or Guardian Signature Date

_____
Print Your Name and Relationship to the Junior Volunteer