



Department of Volunteer Services

Orientation _____

Computer No. _____

Area _____

UNC HOSPITALS VOLUNTEER APPLICATION FORM

Mr. _____ Date _____
Name: Mrs. _____
Ms. Last First Middle Initial

Date of Birth: _____

Home Address: _____ How Long _____
Street City State Zip

Previous Address: _____ How Long _____
(If present address is less than 7 years, please furnish us with a previous address of at least 7 years)

E-mail address: _____

Home Telephone No. _____ Business or Mobile No. _____

Present Occupation: _____ Employer: _____

Previous Occupation: _____ Employer: _____

Highest Education Completed: (circle one)
High School - Professional School
College: Degree _____ Major _____
(Please specify if current student)

Volunteer Service Area Preferred (1) _____ (2) _____ (3) _____

Languages: _____ () Speak () Write () Read

Days & Hours Available: _____

In case of emergency call (local): _____ Telephone No. _____

Do you have relatives employed at UNC Hospitals? () Yes () No If yes, name _____

How did you learn about UNC Hospitals Volunteer Services? _____

Community Affiliations (service, social, etc.) _____



Occupational Health Services

Phone: 919-966-4480
Fax: 919-966-6326
UNC Health Care

Today's Date: _____

Volunteer

Immunization Review Form

All information must be completed (Print or type)

Name (Last, First, MI) **Medical Record Number**

Date of Birth (Mo/Date/Year) **Home Phone** **Orientation Date**

Age **Gender** **Weight** **Height**

Street Address **City** **State** **Zip**

Job Title **Department Name** **Location**
Volunteer Volunteer Services UNC Hospitals

Telephone #
Memorial Hospital location – 919-966-4793 NC Cancer Hospital Location – 919-445-5305

PROOF OF IMMUNIZATIONS IF REQUIRED!!

This Required Immunization and Screening Form must be completed and returned to the Volunteer Coordinator.

The immunization section must be completed and signed and you need to provide personal documentation of immunizations (school transcript, vaccine history card, etc.). If you cannot get records from your own health care provider, required immunizations will be provided to you, free of charge, by the OHS nursing staff.

Required Immunization and Screening

1. MEASLES, MUMPS AND RUBELLA (MMR) **If you were born before 1/1/1957, you are age exempt from MMR vaccines and/or titers.**

MMR #1 _____ MMR #2 _____

MEASLES (Vaccine or titer) _____

MUMPS (Vaccine or titer) _____

RUBELLA (Vaccine or titer) _____

Provide documentation of two (2) live measles, two (2) mumps and one (1) rubella immunization (or serological evidence)

2. CHICKEN POX (VARICELLA)

Yes No Unknown Known serologic immunity _____
Received Varicella Vaccine Dates #1 _____ #2 _____

3. HEPATITIS B (Must be offered to persons potentially exposure to bloodborne pathogens)

Dates of Hepatitis B immunizations #1 _____ #2 _____ #3 _____
Serology (Anti-HBs) Yes No Unknown
History of Disease Yes No Unknown

4. TETANUS/DIPHTHERIA (Td)

Primary series as a child Yes No Last Booster Date _____

5. Tetanus/Diphtheria, ACELLULAR PERTUSSIS (Tdap) - This will be given to all Volunteers unless medically contraindicated or proof of Td booster within the past two years (11 – up years of age)

Yes No Date _____

NOTE: Section 15A NCAC 19A.0207: HIV and Hepatitis B chronically infected Healthcare workers who perform invasive procedures must report themselves to the NCHD (North Carolina Health Department).

TUBERCULOSIS SKIN TESTING

One TB skin test within the past 12 months unless contraindicated.

PPD #1 _____ PPD #2 _____
Placed _____ Strength _____ Lot # _____ Placed _____ Strength _____ Lot # _____
Result _____ mm of induration Result _____ mm of induration

If you have had a reactive PPD please provide the following information:

Size of induration of last PPD _____ Date _____

Chest Xray documentation _____ Date _____

Treatment with INH or other TB medications _____ How long? _____

Please sign this form and return with your application, "Authority for Release of Information" form and your two (2) reference forms.

Name (Please Print)

Signature

Date

If you are using the services of another Health Care Provider (someone **other** than UNC Occupational Health), please have this form filled in and signed by the Provider below.

Name and Title (Please Print):

Date:
