Broward Health

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VOLUNTEER APPLICATION

Date: ___________

Last Name: ________________________ **First Name**__________ **Middle Initial**_____

Date of Birth___________________**Age - Under 18 years** ____ **Over 18 years**___

Address:_______________________**City**___________**State**______**Zip**____________

Home Phone:_____________**Cell Phone:**___________**Bus. Phone:**______________

Email Address:________________________________ **Shirt Size:**________________

Language Skills:____________________ **Computer Skills:**_______________________

Special Skills:____

Emergency Contact:

Name:________________________________ **Relation:**________________________

Emergency Contact Phone Number:_______________________________________

Availability

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
AM							
PM							
EVE							

Please indicate hours and time

How were you referred to the Volunteer program?:______________________________

If employee referral, list the Employee name:________________________________

I agree to abide by all policies and procedures of the Volunteer Department and those of Broward Health.
I agree to complete all required orientation and trainings as needed.

Signature______________________ Date:_______________

Broward Health

Volunteer Medical Clearance

To be completed by applicant

Name: ____Date of Birth:__________ Last 4 digits of SS#_______

Address:_____________________________City________________Zip____________

Phone:______________________________

I understand that providing documentation of the health information below is a condition of being permitted to volunteer at a Broward Health Facility. I authorize, my physician,

__________________________________, to provide such documentation and to provide any vaccines and/or TB skin tests necessary to complete my orientation requirements.

Applicant Signature__________________________ Date:________________

If Applicant is under 18 years of age, parent or legal guardian signature is required.

Parent/Guardian ___________________________Print Name:___________________

To be completed by Provider__________________________ (Printed Name)

Due to infection control policies, volunteer applicants for (enter Medical Center)_______, must provide documentation of compliance for the following (copies may be attached to this form).

- **Chicken Pox. Has the applicant had chicken pox? No___ Yes___**
- **If yes, date of disease________ OR date of positive titer __________attach lab report**
- **If no, provide documentation of vaccination (2 doses of varicella) __________date of first dose,**

  Date of second dose____________ .
- **MMR (measles, Mumps and Rubella)**

  Date of 2 MMR vaccines (both must be AFTER 1st birthday.

  Dates_________________(first vaccine) _________________________second vaccine OR

  Date of positive titer___________________(Measles – attach lab report)

  Date of positive titer___________________(Mumps – attach lab report)

  Date of positive titer___________________(Rubella – attach lab report)
- **See attached TB Skin tests or recent Chest X-Ray completed by Broward Health.**
- **If the applicant had a TB skin test within the past 12 months, another skin test is required no more than 30 days prior to volunteering. ______________________**
- **If applicant has had a positive skin test, please advise if latent TB treatment is recommended.**

  Yes ○ Indicate Medication ____________________

  No ○
- **Covid 19 Vaccination Y N If yes, Date of Vaccination___________**
- **Is applicant able to ambulate more than 1500 feet independently Y N**
- **If no, can the applicant ambulate with assistive devices Y N**
- **Specify device and/or any restrictions; ____**

Certification:

The applicant to my knowledge does not have any medical or cognitive condition what would affect their ability to perform volunteer duties within a hospital or office setting. The above information has been provided by me, the undersigned.

Signature of Provider____________________________________Title______________Date______________

Printed Name of Provider______________________________ Phone_____________________

Location of Practice:____________________________________City________________Zip____________