BETHEL HEALTH CARE CENTER

Who……. Volunteers must be 12 years or older. Any volunteer under 18 years of age must have parental (guardian) written permission to participate.

When……<u>Wednesday , July 3, 2019-Friday, Aug. 23, 2019.</u>
Volunteers may choose to work a two or three day work week.
Volunteers may choose to work a 2.5 or 3-hour shift.

Where……... Bethel Health and Rehabilitation Center, 13 Parklawn Drive, Bethel, CT. 06801 Located in the Berkshire Corporate Park.

Orientation…….. <u>Monday, July 1st , 2019 (Mandatory Orientation).</u>
(9:00am-11:30am).

Purpose…… To provide young adults in the community an opportunity to Experience a variety of positions in the health care field.

How can I sign up? Mail or bring it to Bethel Health Care Center.
Volunteers will be accepted based upon interest, availability, and commitment.
<u>Telephone Bethel Health and Rehabilitation Center (203-830-4180 Ext. 343) by Wednesday, June 26 ,2019 to confirm you will attend the orientation. (It is not necessary that the adult attend the orientation but must be present to complete the required paperwork).</u>

Requirements……... No volunteer may begin working without an orientation. A Parental Permission form must be completed prior to working. All volunteers must have a PPD Skin Test done prior to working or present a doctor's note that one was given within a one year period of the first day the volunteer begins to work.
(PPD tests are given at our facility free of charge during orientation upon signed permission from a parent).
All volunteers must return to the facility to have the TB test read by a nurse on Wednesday, July 3rd , 2019

Volunteers are asked to make a commitment to the hours they agree to work. Please submit written vacation/days off on this original application. Residents and staff depend on their visits. Volunteer hours may apply to the community service, school requirements, religious service requirements, Scout requirements, etc…

A letter of recommendation and total number of hours worked is available upon <u>written request</u>. (Please allow on week notice)

All students may be dropped off no earlier than 9:00am and leave no later than 3:00 pm.

PARENTAL SIGNATURE:_____Date:_____

If your child has special needs, please attach a note stating how we can best work with him/her.

JOIN US!! VOLUNTEERING IS A GREAT WAY TO ENRICH THE LIVES OF OTHERS!

2019 Bethel Health and Rehabilitation Center Summer

Volunteer Application

NAME:_____TELEPHONE:_____

ADDRESS:_____

Parent/Guardian Name:_____(Work Phone):_____

Emergency Contacts other than Parent/Guardian: (In the event of an emergency situation we will make every effort to contact your Parent/Guardian. If we are unsuccessful please list two names of people we may contact:

1)NAME:_____TELEPHONE:_____

2)NAME:_____TELEPHONE:_____

Days & Times Available: (check three in the order of priority: "1", "2", "3".

___Monday 1:00pm-3:00pm; Working as a Physical Therapy Department transport only.

___Tuesday and Thursday 1:00pm – 4:00pm.

___Wednesday 1:00pm-4:00pm.

___Friday 9:00am-11:30am (Working as Physical Therapy Transporter only).

___Friday 1:00pm-4:00pm.

Due to the busy morning hours, volunteers are not allowed to be in the facility prior to 9:00am. Saturday, Sunday, and evenings are unavailable at this time.

Interests: (Please Check:)

OFFICE:	__typing/filing	
	__secretarial skills	
DIETARY:	__deliver menus	
	__fold napkins	
LAUNDRY:	__fold clothing	
MAINTENANCE:	__sweeping/raking	
	__odd jobs	
RECREATION:	__deliver books/mail	__hand massages/manicures
	__book cart	
	__activity assistant	__decorating/arts& Crafts
	__private reading	__religious service aide
	__friendly visitor	__water plants/gardening
	__outdoor walks/rides	__filing/secretarial/computer work
TRANSPORTER:**	__to therapy transporter*	__Humor/Curiosity Cart

indicates the position most in demand

Vacation: Please indicate the times you will not be available to work:

_____

_____

_____

Please note: Candy Stripe Program runs from Wednesday July 3- Friday, August 23, 2019. .Please mail the completed application (with signed Parental/Guardian signature) to: Dana Dinho, Bethel Health Care Center, 13 Parklawn Drive, Bethel, CT. 06801.

TB TESTING

The TB Test is a requirement to volunteers by the State of Connecticut Department of Health. The TB test is done at Bethel Health Care & Rehabilitation Center administered by a Nurse.

If you did not have a TB test during your orientation, please telephone the Center to make an appointment.

You must return to the Center 48-72 hours after the test to have your arm checked by a Nurse. The Nursing Supervisor must sign the results of your test on a note and give it to Dana Dinho to be placed in your records.
You may not work until the test has been completed.

If you have had the test within a one year period you may submit a Doctor's note to Dana Dinho with the results of the test to be filed.

If you have any questions, please telephone Dana Dinho (Director of Volunteers & Recreation)-830-4180 X343.

VOLUNTEER
BETHEL HEALTH CARE CENTER
TB (PPD) TEST QUESTIONNAIRE

Name: _____

Position: _____ Date of Birth: _____

Volunteer Signature: _____ Date: _____

Parent/Guardian Consent if a minor: _____

NOTE: If a health practitioner has told you that your immune system is suppressed or compromised, please notify the person administering the TB test. Some medical conditions may cause a TB skin test to be negative even when TB infection is present.

1. Were you born in the United States? ☐ Yes ☐ No
2. Have you ever received the BCG vaccine? ☐ Yes ☐ No
   - If 'Yes', in what year was your most recent BCG vaccine? _____
3. Have you had a positive PPD in the past? ☐ Yes ☐ No

If you answered 'No,' to question 1 <u>or</u> 'Yes' to questions 2 or 3, then Quantiferon blood test will be administered; if positive, Chest X-ray will be done.

- ***Quantiferon done on _____; Chest X-ray done on _____***

4. Have you traveled overseas in the past year? ☐ Yes ☐ No
5. Have you had exposure to a known case of TB in the past year? ☐ Yes ☐ No
6. Have you ever had any of the following symptoms for more than three weeks at a time?
   - Excessive sweating at night? ☐ Yes ☐ No
   - Persistent coughing? ☐ Yes ☐ No
   - Excessive fatigue? ☐ Yes ☐ No
   - Coughing up blood? ☐ Yes ☐ No
   - Unexplained weight loss? ☐ Yes ☐ No

Individuals with a positive PPD: If your new PPD is positive, the Quantiferon blood test will be administered; if positive, a chest X-ray will be done.

Documentation of INH therapy: _____

1st Step PPD

Date Administered: _____ By: _____ Title: _____	
Site: ☐ RA ☐ LA Lot #: _____	Exp. Date: _____
Date Read: _____	mm induration: _____
By: _____	Title: _____