SECTION II. MEDICAL REQUIREMENTS

**** **PLEASE READ CAREFULLY** ****

FOLLOW ALL STEPS/INSTRUCTIONS TO AVOID A DELAY IN PROCESSING YOUR APPLICATION

Below is a list of medical records all prospective volunteers are required to furnish to Mercy Medical Center Employee Health Services Department before they may be cleared to volunteer:

1. **Volunteer Self-Assessment/Evaluation - Medical History** – Self Assessment/Evaluation. This is a medical self-assessment to be completed by the applicant. Complete this page in its entirety. Sign and date the attestation at the bottom of the page.

2. **PPD/Physical Exam/Medical Provider Certification**. This page must be completed in its entirety by your physician/healthcare provider. Proof of two (2) PPD Tests administered within the past 12 months must be provided (w/Manufacturer, Lot # and Expiration Date.

3. **TITERS / Proof of Immunity (Lab/Blood Work)**. Your provider will need to furnish you with a prescription for lab work called "titers."

   Mercy Medical Center requires documented proof of immunity in the form of quantitative titers (providing copy of your immunization history is not acceptable). Each volunteer must have quantitative titers drawn, and provide copies of the official laboratory printouts containing the numerical values for Mumps, Measles, Rubella, Varicella and Hepatitis B (surface antigen and surface antibody) and Hepatitis C (*see page 3*).

4. **Flu Vaccine**. *Only required during flu season (generally September – June).*

SUBMISSION INSTRUCTIONS: (EMAIL / HAND-DELIVERY)

1. **EMAIL ALL MEDICAL DOCUMENTATION (1 pdf file)**: Requested MEDICAL documentation must be completed in its entirety and FIRST submitted by email to the Mercy Medical Center Employee Health Services Department at the addresses listed below. All completed medical forms and supporting documentation (lab results) must be **attached to your email as ONE (1) complete pdf file** and sent to:

   Mirna.Labissiere@chsli.org; Valerie.Pierre@chsli.org

2. **HAND-DELIVER ORIGINAL DOCUMENTATION**: Original documentation (all medical records with original provider signatures/stamp, lab titers, etc.) must be submitted directly to the Employee Health Services Department before you can start volunteering. You may bring these documents with you on your starting date (if assignment begins Monday-Friday, 9:00 a.m. – 4:00 p.m.).

* DO NOT SEND ANY MEDICAL RECORDS TO THE VOLUNTEER SERVICES DEPARTMENT *

Mirna.Labissiere@chsli.org
Valerie.Pierre@chsli.org

Mercy Medical Center
Catholic Health Services
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1. VOLUNTEER SELF-ASSESSMENT/EVALUATION

COMPLETED, SIGNED AND DATED BY VOLUNTEER

Name: ______________________ Date: ______________________

Address: ______________________ Date of Birth: ______________________

______________________ Sex: ☐ Female ☐ Male

Phone: ______________________ Email: ______________________

Emergency Contact: ______________________ Contact's Phone: ______________________

MEDICAL HISTORY

Do you have or have you ever had (or been told you have):

Condition	No	Yes	Condition	No	Yes
Mumps Disease			History of Back or Neck Problem(s)		
Rubella Disease			Fractures		
Rubeola Disease			Loss of Limb		
Varicella (Chicken Pox) Disease			Joint Disease		
Tuberculosis/TB Disease			Carpel Tunnel		
Hepatitis B, HIV, Hepatitis C, or Liver Disease			Seizure Disorder		
Asthma			Mental Illness		
Hypertension			Stroke/Neurological Disease		
Heart Disease/Pacemaker			Migraines		
Renal/Kidney Disease			Glasses/Contacts		
Thyroid Disease			Hearing Impairment		
Cancer			Varicose Veins		
Diabetes			Hernia		
Skin Disorders			Drug or Alcohol Addiction		
Anemia			Other such as fainting, exposures		

If YES to any of the above, please explain:

____

Surgical History (including C-Sections): ☐ None

____

History of Injuries/Illness ☐ None

____

Current Medications (including over-the-counter medications and herbal supplements) ☐ NONE

____

Allergies (drug, food, environmental, seasonal, latex, other) ☐ NONE

____

Have you ever had a positive/reactive PPD (TB) Skin Test? ☐ YES ☐ NO

Do you require any medical accommodations to assist you in your job? ☐ YES ☐ NO

If yes, please state: ____

This evaluation is for the purpose of determining your ability to perform volunteer service and is not considered a substitute for your total medical care by your private physician. I have read the above and declare that I have had no injury, illness or ailment other than specifically noted. I understand that any falsification or misrepresentation will be sufficient grounds for my release from volunteering. I attest to the fact that I am free from a health impairment which is a potential risk to patients or which might interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter my behavior (per N.Y.S. Code 405.3).

VOLUNTEER SIGNATURE: ______________________ DATE: ______________________

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VOLUNTEER APPLICATION
EMPLOYEE HEALTH SERVICES

Mirna.Labissiere@chsli.org
Valerie.Pierre@chsli.org

VOLUNTEER (PATIENT) NAME: ______________________________________ Date: ___________________________

DATE OF BIRTH: ____ Sex: ☐ Female ☐ Male

2. PPD / PHYSICAL EXAM – COMPLETED BY HEALTHCARE PROVIDER (SIGNED/DATED/STAMPED)

TWO (2) PPD TESTS must be administered within the last 12 months. Manufacturer, Lot #, expiration date, provider's signature and results are required.

Test 1 PPD 5 TU 0.1 cc ID __________________ __________________ ______________ LFA/RFA/LUE/RUE
Manufacturer Lot # Exp. Date

Administered by: _______________________________________ Date: ________________________

Date Evaluated: _______________________________________ Result: ____________ mm induration

Test 2 PPD 5 TU 0.1 cc ID __________________ __________________ ______________ LFA/RFA/LUE/RUE
Manufacturer Lot # Exp. Date

Administered by: _______________________________________ Date: ________________________

Date Evaluated: _______________________________________ Result: ____________ mm induration

XRAY (Chest X-Ray only if new POSITIVE) Date Ordered: ___________________ TB Symptom Sheet: _______________

PHYSICAL EXAMINATION - The above-named individual would like to volunteer services not requiring medical training. N.Y.S. Department of Health Code 405.3 requires the following tests be completed before the individual starts volunteering. An accurate and honest evaluation of your patient's medical status is most important. Please complete all sections. This evaluation will become part of their confidential file. If you have any questions, please contact the MMC Employee Health Services Department at the email addresses listed at the top of this page.

Height: _________ Weight: ____________ B/P: ____________ Pulse: _______ Resp: _________

	Comment / unremarkable-normal		Comment / unremarkable-normal
Head		Lungs	
Eyes		Heart	
Ears		Abdomen	
Nose		Extremities	
Throat		Back	
Neck		Skin	
Chest			

PROVIDER ATTESTATION: (REQUIRES HEALTHCARE PROVIDERS SIGNATURE AND STAMP):

A physical examination was performed on the above patient on ___________________ and there is no evidence of communicable disease or any disability that would interfere with his/her anticipated responsibilities as a volunteer.

☐ At this time, my patient **HAS NO** restrictions to perform volunteer service
☐ At this time, my patient **HAS** restrictions to perform volunteer service.

_________________________________ _________________________________ ___________________
PHYSICIAN/PRACTICE STAMP Examiner's Signature Date

3. TITERS – PROOF OF IMMUNITY FROM DISEASES

BLOOD DRAWN - LAB RESULTS REQUIRED

Copy of immunization history is NOT acceptable

Your provider will need to furnish you with a prescription for lab work called "titers."

Mercy Medical Center requires documented proof of immunity in the form of quantitative titers (copy of your immunization history is not acceptable).

TITERS are blood tests that measure whether or not you are immune to a given disease. More specifically, a quantitative serum titer is a **titer with a numerical value** indicating your actual degree of immunity to a disease.

Each volunteer must have quantitative titers drawn, and provide MMC Employee Health Services with copies of the official laboratory printouts containing the numerical values for **ALL OF THE FOLLOWING**:

- Rubeola (Measles) — Documentation of Immunity with copy of lab titer/report
- Mumps — Documentation of Immunity with copy of lab titer/report
- Rubella (German Measles) — Documentation of Immunity with copy of lab titer/report
- Varicella (Chicken Pox) — Documentation of Immunity with copy of lab titer/report (proof of vaccination x 2 is also acceptable)
- Hepatitis B Virus Testing — Hepatitis B Surface Antibody Immunity, Quantitative Surface **antigen** and surface **antibody.** Copy of lab titer/report rquired
- Hepatitis C — Viral Hepatitis C Antibody Screen. Copy of lab titer/report required

LABORATORY REPORTS FOR ALL OF THE ABOVE MUST BE PROVIDED.

If you or your healthcare provider have any questions, please contact the MMC
EMPLOYEE HEALTH SERVICES DEPARTMENT
BY EMAIL:
Mirna.Labissiere@chsli.org; Valerie.Pierre@chsli.org