HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
HolyCrossHealth.org

Dear Accepted Volunteer or Intern,

Welcome to Holy Cross Health! All Volunteers and Interns must provide the following documentation before entering a Holy Cross Health facility for service. Each is necessary to meet Holy Cross Health and Trinity Health policies, as well as national requirements, for the safety and security of everyone in our facilities.

a. If you received any **COVID vaccinations** (not required): Proof of all COVID vaccinations and boosters by including pictures of original documents that show:
   - Full name
   - Date of birth
   - Manufacturer (Pfizer, Moderna, J&J)
   - Date of administration
   - Lot #

b. **Proof of 1 QuantiFeron Gold blood test or 2 PPD skin tests** that have a negative result for Tuberculosis (TB). The 2-part TB testing required 4 trips to the provider (2 placements, and 2 readings). If positive, you must provide proof of clear chest x-ray or documentation of treatment. TB skin test results must show (not necessary for blood test):
   - Clinician who placed the TB serum & proof of location where you sought services
   - Placement date & Time
   - Place site (which forearm)
   - Lot #
   - Expiration Date
   - Clinician who read the PPD
   - Date and time it was read
   - Result in mm

c. Proof of **current season Influenza vaccination**
   - Date of injection
   - Injection site (which deltoid)
   - Vaccine Manufacturer
   - Vaccine Lot #
   - Vaccine Expiration Date
   - Who administered the vaccine & credentials

d. Proof of **Measles, Mumps, Rubella (MMR)** vaccination (or titer) with dates

e. Proof of **Varicella** vaccination (or titer) with dates

f. All of the **attached Holy Cross paperwork** with highlighted areas completed, including check marks in boxes on the agreements:
   - Volunteer Services Release
   - Photo Consent (Authorization for use or disclosure of personal…)
   - General Agreement
   - Service Excellence Agreement
   - Tuberculosis Risk Assessment (to accompany proof of TB screening)
   - Vehicle Registration Form (only if parking on-site at any Holy Cross facility)
   - Parental Permission form (for Volunteers & Interns under 18)

g. Review the *Volunteer Handbook & Volunteer Orientation* under "Helpful Documents"

h. Complete the *Confidentiality Agreement* and *Orientation Quiz & Checklist* under "Online Submissions"

i. Submit headshot picture as stated at the end of this *Welcome Packet*

I look forward to working with you,

Sarah P. Walker

Sarah Walker, CDVS
Manager, Volunteer Services
Direct for all locations: 301-754-7306
sarah.walker001@holycrosshealth.org

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VOLUNTEER SERVICES RELEASE

I, (PRINT NAME)_____, am choosing to volunteer my services for Holy Cross Health. This Release form must be agreed to and signed, as a condition of my ability to provide volunteer services on the premises. I acknowledge that I must complete all health requirements, education, and releases prior to volunteer service.

I acknowledge that Holy Cross Health has put in place preventative measures to limit the spread of illnesses, however, Holy Cross Health cannot guarantee I will not become infected. Volunteer orientations are designed to educate volunteers on the proper infection control measures to take in various situations around the health system. I agree to follow those measures to enhance my own safety and the safety of others. Additionally, I acknowledge that some illnesses are highly contagious through person-to-person contact. I acknowledge that my service to Holy Cross Health is completely voluntary, and I assume full responsibility for my own welfare and safety while providing volunteer services on behalf of Holy Cross Health.

I acknowledge it is my responsibility to consult a physician prior to, and regarding my volunteer services at Holy Cross Health. I acknowledge that I am required to provide proof of clear tuberculosis screening, Influenza vaccination from the most current year, as well as vaccinations of MMR, Varicella, and Tdap (when applicable) to Holy Cross Health prior to my volunteer service. If I received any COVID vaccination, I agree to provide proof of complete COVID-19 vaccination from a community provider or Holy Cross Health clinic. If I did not received any COVID-19 vaccination, I understand that I must notify Volunteer Services that is the case. I will comply with mandatory health screening at my own expense when not provided by Holy Cross Health. I represent and warrant that I am in proper physical health and that I have no medical condition which would put me at an increased risk of serious, potentially fatal, complications. I understand that Holy Cross Health relies on my representation of health adequate to volunteer for the organization.

I acknowledge that the risk of becoming exposed to or infected by an illness may result from the actions, omissions, or negligence of myself and others, including, but not limited to, employees of Holy Cross Health, other volunteers, and other individuals present in Holy Cross Health. I understand that being completing the health screening prior to service will reduce these risks.

I acknowledge that, while providing services to Holy Cross Health, I may be exposed to illnesses, as well as other risks, which may cause serious injury, the effects of which may include, but are not limited to personal injury, emotional injury, serious illness, paralysis, disability, death, property loss and damage, and economic losses, including medical bills and lost wages. I am fully aware of the potential risks and hazards of agreeing to volunteer at Holy Cross Health and in consideration of being permitted to do so, I voluntarily and knowingly assume full responsibility for any risks, injuries or damages, known or unknown, not limited to infection, which I might incur as a result of volunteering. If I experience any symptoms of illness or injury, I agree to stop serving as a volunteer until my doctor has evaluated my condition.

Initials _____

Initials of Parent/Legal Guardian (if under 18) _____

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In further consideration of being permitted to volunteer, I for myself, my heirs, executors, administrators, agents, and other personal representatives, voluntarily, expressly, irrevocably and unconditionally waive and release forever any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that I may have against Holy Cross Health and its parents, subsidiaries, and affiliates and any of their respective present and former officers, directors, employees, owners, shareholders, agents, attorneys, and assigns; arising from or in connection with my participation in the volunteerism or internship. Without limiting the generality of the foregoing in any way, I specifically understand that I am releasing and holding harmless Holy Cross Health and its member hospitals and related health care entity's respective directors, officers, employees, agents and assigns from financial liability for any economic harm, injury, bodily harm, emotional harm, or illness occurring during, arising from or relating to my participation in the Internship.

The laws of the State of Maryland shall apply to this document.

I HAVE READ THE ABOVE RELEASE AND UNDERSTAND ITS CONTENTS. I VOLUNTARILY SIGN THIS DOCUMENT WITH THE INTENT TO BE LEGALLY BOUND BY THE TERMS AND CONTITIONS STATED ABOVE.

Volunteer's Printed Name _____

Volunteer's Email _____

Volunteer's Current Mailing Address

_____

Volunteer's Home Phone _____

Volunteer's Work/Cellular Phone _____

Volunteer's Signature _____

Date of Volunteer Signature _____

Signature of Parent/Guardian (if volunteer is under 18) _____

Date of Signature of Parent/Guardian _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL INFORMATION OR IMAGE FOR HOLY CROSS HEALTH'S MARKETING AND COMMUNICATIONS PURPOSES

1. I, _____, ☐ **authorize** ☐ **DO NOT authorize**
   Volunteer Name (print)

   the use of my name, likeness, biographical information and/or health information to the Marketing and Media Relations departments of Holy Cross Health as described below. If I am a patient, I acknowledge that the personal information is protected health information (PHI) and is protected by HIPAA.

2. The information will be used or disclosed for Holy Cross Health's marketing and communications purposes and become public information by being included in Holy Cross Health's print publication, display, multimedia production, advertisement, on-line publication and/or the news media's use for a story in a newspaper, magazine, radio or television broadcast, or social media site (including Facebook or Twitter).

   Other (specify): _____ Restrictions (if any): _____

3. Description of information that may be used and/or disclosed:

   Photo/Image: _____ Date of photo shoot: _____
   General description & purpose of photo shoot: Volunteer Orientation-individual and group photos

   Specific biographical health information if any (describe in detail): _____N/A_____

   _____

   _____

I understand that **I may refuse to sign this authorization**. If I refuse to sign this authorization, my refusal will not affect my treatment, payment, enrollment or eligibility for benefits or, in the case of medical staff, my medical staff membership or employment.

I understand that information that is used, based on my signing this form, will be made public and no longer protect by HIPAA or other privacy protection and that a person or entity that receives this may be redisclose, share and distribute the information. Examples of those who may receive and redistribute the information include social media locations (Facebook, Twitter), newspapers, magazines, radio stations, or television broadcasts. I understand that I may revoke this authorization in writing at any time except to the extent that Holy Cross Health has already used my photo and/or health/biographical information in response to this authorization. Revocation requests should be directed to the Media Relations Office or the Marketing Department.

I understand that this authorization for the photograph or image and biographical and health information described above will remain in effect until revoked by me.

_____ Date: _____
Signature of Volunteer or Representative (parent of Volunteer less than 18 years of age)

Phone number: _____ Email address: _____

For questions contact:
Director of Media Relations (301-754-7123) | Director of Marketing (301-754-7718)
Holy Cross Health Marketing Department | 11801 Tech Road | Silver Spring, Maryland 20904

General Agreement

First Name_____ Last Name _____

If I am accepted as a volunteer, I agree to (you must check all):

- ☐ Keep all information regarding patients/clients confidential.
- ☐ Give permission for the Volunteer Services staff to discuss my work history and performance with those I have listed as supervisors and references and with my potential HCH supervisor(s).
- ☐ Sign in and out each day I volunteer according to the protocol set up for my particular area.
- ☐ Promise to volunteer a minimum of 100 hours per program requirements.
- ☐ I understand verbal/written verification of hours or letter of reference/recommendation will only be given after I have contributed the minimum of 50 hours.
- ☐ Always be punctual and regular in attendance.
- ☐ Notify my supervisor(s) in advance if I cannot work my schedule.
- ☐ Wear the hospital I.D. badge while on volunteer duty.
- ☐ Purchase my own volunteer jacket (new $30, used $20) and wear it whenever on duty.
- ☐ I do not expect compensation from Holy Cross or employment as a result of my volunteer work.
- ☐ Provide my own transportation to and from the volunteer work site at my expense.
- ☐ Return my hospital I.D. badge to Volunteer Services on my last day.
- ☐ Abide by Holy Cross Hospital policies and procedures.
- ☐ Have a background check (for 18 years and older).
- ☐ I am at least 16 years old, or will be prior to my orientation date.
- ☐ I am not volunteering as a court requirement or as an attorney referral.
- ☐ I have never been convicted of a crime.

Date_____ Volunteer Signature _____

If I am under the age of 18 and unemancipated, I must have a parent or guardian sign this Agreement on my behalf. Parent or legal guardian of minor 16 to 17 years of age:

- ☐ This applicant has my permission to volunteer for Holy Cross Health.
- ☐ I have read the above Volunteer Agreement and I will support this applicant in fulfilling the above Volunteer Agreement.
- ☐ I give permission for this applicant to receive a TB test (PPD) and/or chest r-ray as required by Holy Cross Health and the Maryland State Health Department regulations for hospital workers.
- ☐ I release Holy Cross Health of any responsibility if the applicant should have an adverse reaction as a result of the skin test.

Date_____ Parent or legal guardian Signature _____

Service Excellence Agreement

First Name_____ Last Name _____

Regarding patient and visitor interactions, I understand and am clear that (you must check all):

- ☐ I will greet each patient, employee or other individual with a pleasant disposition;
- ☐ During my first patient/customer interaction I will introduce myself by name and role;
- ☐ I will clearly explain what they can expect of me during each interaction;
- ☐ I will listen actively and inquire if they have any questions about the interaction and/or the tasks I performed during each interaction;
- ☐ I will close every interaction by summarizing the interaction and asking if there is anything more I can do;
- ☐ If there are subsequent/series visits to the patient I will end the interaction with a positive salutation for example "Have a great evening, we will see you tomorrow."
- ☐ Upon discharge or transfer of care/handoff I will thank the patient for allowing Holy Cross Health to participate in their care.

Regarding all interactions, I understand that the following actions are barriers to Service Excellence overall and to providing patient-centric service excellence in particular, and I commit to not engaging in these behaviors (you must check all):

- ☐ Use of personal electronic devices while in public view (e.g., cell phones, laptops, iPads, MP3 players);
- ☐ Reading of non-work materials while in public view (e.g., magazines, books, Internet);
- ☐ Not adhering to the Appearance Policy (e.g. inappropriate fitting uniform, dirty or with under clothes showing-low waist, inappropriate placement of name badge);
- ☐ Loud or vulgar tone or inappropriate personal communications;
- ☐ Lack of sense of urgency or imparting compassion; and
- ☐ Attitude not respectful of peers.

Date_____ Volunteer Signature _____

Date_____ Parent or legal guardian Signature _____
(if Volunteer is under 18)

Tuberculosis Risk Assessment

Symptom Screen and Education Attestation

Date form completed: _____

Name (Last Name, First Name): _____

Date of Birth: _____

Reason for Completing Survey:

_____ I am new to the organization _____ This is my annual or routine TB update

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Risk Assessment

1. Have you ever tested positive for TB? e.g., TB skin test, TB Blood Test - QuantiFERON TB Gold or T-Spot Test?
   Yes No if Yes when (month/year) _____

2. Have you ever been diagnosed with active TB?

   YES NO If yes, when_____ and what was prescribed and for how long?_____

3. Have you ever been treated for latent TB infection (LTBI)?

   YES NO If yes, when_____ and what was prescribed and for how long?_____

4. Do you have permanent or temporary residence (greater than 29 days) in a country with a high TB rate. (Any country other than USA, Canada, Australia, New Zealand, Northern and Western Europe)?

   YES NO

5. Are you currently or planning to be immunosuppressed including HIV, organ transplant, use of a TNF-alpha antagonist, chronic steroids (equivalent prednisone equal or > 15 mg/d for equal to or> a month, or other immunosuppressives including chemotherapy?

   YES NO

6. Have you had close contact with someone who has had infectious TB disease since your last TB test?

   YES NO

Symptoms of Active TB Disease

Check all that are present:

- ☐ Coughing (> 3 weeks)
- ☐ Chest pain
- ☐ Fatigue
- ☐ Night sweats
- ☐ Coughing up blood
- ☐ Weight loss/poor appetite
- ☐ Fever/chills
- ☐ No symptoms

Risk Factors for the Development of TB

Generally, persons at high risk for developing TB disease fall into two categories:

- Persons who have been recently infected with TB bacteria
  - Close contacts of infectious TB
  - Persons who have immigrated from areas of the world with high rates of TB (any country other than USA, Canada, Australia, New Zealand, Northern and Western Europe)
  - Groups with high rates of TB transmission, e.g. homeless, IVDA, HIV
  - Persons who work or reside with people at high risk of TB, e.g. hospitals, homeless shelters, correctional facilities, nursing homes, and residential homes for those with HIV
- Persons with medical conditions that weaken the immune system, e.g. HIV, substance abuse, diabetes, severe kidney disease, organ transplants

TB Risk Factors | TB | CDC

Infection Control

If a patient has symptoms of TB disease, Airborne Precautions should be instituted:

- Patients with a cough should wear a surgical or procedure mask.
- Place patient in negative pressure room asap
- Healthcare personnel should wear a fit tested respirator (N95 or PAPR) while caring for the symptomatic patient to prevent inhalation of airborne bacteria.

If you develop symptoms of TB disease:

- Put on mask if coughing or other symptoms are present.
- Notify your primary care provider and Colleague Health Services ASAP
- Do not report to work until cleared by Colleague Health Services

I (print name)_____ attest that this information is accurate and complete and I have read and understand Risk Factors for Development of TB and Infection Control sections above.

Signature:_____

HOLY CROSS HOSPITAL

1500 Forest Glen Road
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20910-1484
Phone: (301) 754-7000
www.holycrosshealth.org

VEHICLE REGISTRATION FORM

Bring this form & Photo ID with you to Protective Services when you get your badge.

Section I - This form must be completed for each vehicle you will park at a Holy Cross Hospital facility or off-site parking location.

Name_____ Orientation Date _____
(PLEASE PRINT)

Department Volunteer Services Primary Shift: Day ☐ Evening ☐ Night ☐ Weekend ☐

			To be completed by Security
Vehicle 1 Make	Model	Year	Decal/Tag # Issued
Color	Tag # License Plate #	State	
Vehicle 2 Make	Model	Year	Decal/Tag # Issued
Color	Tag#	State	
Vehicle 3 Make	Model	Year	Decal/Tag # Issued
Color	Tag#	State	

Employee Signature:_____ **Date:**_____
(Volunteer)

Section II – To be completed by Security

Off-site Parking Assignment: _____

Date _____

6/10

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PARENTAL PERMISSION FOR VOLUNTEER LESS THAN 18 YEARS OF AGE

Parent or legal guardian of minor 16 to 17 years of age:

Volunteer's Name: (Please print)_____

1. This applicant has my permission to volunteer at Holy Cross Health.
2. I have read the General Agreement and Service Excellence Agreement, and will encourage the volunteer to abide by the regulations.
3. I will support this applicant in fulfilling the below Volunteer Agreement.
4. I give permission for this applicant to receive a TB test (PPD) and/or chest r-ray as required by Holy Cross Health and the Maryland State Health Department regulations for hospital workers in the event of a contamination. I release Holy Cross Health of any responsibility if the applicant should have an adverse reaction as a result of the skin test.
5. I understand that Holy Cross Health will not provide any medical screening/vaccination for MMR, Varicella, COVID, or TB unless otherwise stated.
6. I understand that my child must receive a flu shot during flu season, as no exemptions are approved for unpaid labor.

I certify that the volunteer:

1. Is at least 16 years old.
2. Is not volunteering as a court requirement or as an attorney referral.
3. Has not been convicted of a crime.

_____ _____ _____

Please **PRINT** Name of Parent/Guardian Signature of Parent/Guardian Date

Time to get famous!!!
Protective Services needs your picture to create a badge for you.

If it isn't right, they will not make a badge for you, so please follow these instructions:
Pictures must have:

1. Hair off your face, not covering your eyes or face too much that we cannot see you (short bangs are fine)
2. Good lighting with minimal shadows
3. A blank background
4. No mask, face covering, sunglasses/tinted lenses
5. Professional dress/appearance
6. A sign with your full name boldly written/printed at chest height (not covering your neck or face) - if you have a professional nickname you prefer to be called rather than your legal first name, please put that in " " on the sheet

Formatting:

- Last Name_First Name headshot
- .jpeg or .png ONLY! NO PDF, .heic, or other format

I look forward to getting your Holy Cross mug shot (hehe)!

Example: