Community Outreach
HEALTH CLINIC
Froedtert & Community Health

BRIEF JOB DESCRIPTION OF CLERICAL/PHARMACY

POSITIONS AT THE

COMMUNITY OUTREACH HEALTH CLINIC

Medical Records Receptionist

Greeting patient, assist with patient registration and scheduling, medical records preparation and filing and is responsible for the organization and patient flow throughout the clinic evening.

Computer knowledge is required to do minimal computer entry.

Screener/Discharge Assistant

Screen new patients for financial eligibility, assist with referrals to appropriate community agencies, and assist with sub-specialty medical follow-up.

Computer knowledge is required to do minimal computer entry.

Pharmacy Assistant

Gather and package patient’s medications and complete prescription label for dispensing by pharmacist, physician or nurse practitioner. Organize medications in Med. Room.

Take out outdated medications monthly.

Training is provided for all positions.
FROEDTERT HEALTH | CONFIDENTIALITY & ELECTRONIC SECURITY AGREEMENT

RELATIONSHIP TO FROEDTERT HEALTH:
- [ ] FROEDTERT HEALTH STAFF MEMBER
- [ ] VOLUNTEER
- [ ] TEMPORARY EMPLOYEE
- [ ] FROEDTERT HEALTH STUDENT
- [ ] MEDICAL STAFF
- [ ] RESIDENTS
- [ ] MCW STUDENT:
- [ ] MCW STAFF:
- [ ] OTHER:

DEMOGRAPHIC INFORMATION: (PLEASE PRINT CLEARLY)

FIRST NAME:       LAST NAME:

FH EMPLOYEE ID:

JOB TITLE:

DEPARTMENT:

ENTITY LOCATION:

GENERAL CONFIDENTIALITY REQUIRED BY ALL:

As a condition of my use, access, and/or disclosure of confidential Froedter Health or any Froedter Health Affiliate (collectively FH) information, I understand that I am responsible for my actions and agree to protect and secure confidential information and will abide by the requirements set forth in this Agreement. I understand that the obligations under this Agreement will continue even after my employment or business relationship has ended with FH. I agree to the following:

1. I will protect and secure confidential information. Confidential information includes patient information, workforce information and/or any business related information that is not publicly available.

2. I will only access, use, disclose, copy, review, alter, remove or destroy confidential information as authorized to carry out approved and legitimate job functions, and in accordance with applicable policies and procedures and State and Federal regulations.

3. I will not access, use and/or disclose my own Protected Health Information (PHI) or the PHI of my family, friends, co-workers, neighbors, media story patients or any other patients for personal reasons or for any other non-job duty related purpose. (Examples of PHI include: all patient information medical record information, appointment date/time, demographics, billing, room number, etc.)

4. I understand that if I or my family members need information about an appointment, care or services with any FH Affiliate, the approved process is to obtain this information from the provider, MyChart, or to request information from the Health Information Management Department.

5. I will exercise extreme caution when discussing confidential information to prevent others from overhearing and will do so only when there is a legitimate business need. I agree not to gossip or talk inappropriately about patients.

6. I will prevent accidental release of confidential information by validating patient identifiers (name, DOB, address) and double checking my work to assure I have the correct information prior to disseminating confidential information. I will also be careful not to leave confidential information in unsecure areas such as conference room, restroom, cafeteria, etc.

7. I understand and agree that I have no individual rights to, or ownership of any information accessed or created by me during my relationship with FH.

8. I will immediately report to the FH Corporate Compliance Department, any actions or activities that I suspect may compromise the confidentiality of patient, workforce or other confidential business information.

CONFIDENTIALITY REQUIREMENTS FOR THOSE WITH ELECTRONIC ACCESS:

I understand that my userid/password is my personal access code for my electronic system access. It acts as my personal signature when performing electronic activities, and I agree to the following:

1. I will follow the FH Information Technology (IT) security policies and will only access or use systems or devices, including portable devices and USB media that I am properly authorized to use and will do so in the appropriate manner identified.

2. I will keep my userid/passwords secure and will not disclose them to anyone or allow others to use my workstation when I am logged in. I will not request access to any other person’s passwords or access codes nor will I use a workstation that is logged in under someone else’s unique access code.

3. I will secure the computer workstation when it is left unattended and I accept responsibility for all activities under my access code. If the security of my access codes has been compromised, I will immediately change my password and report it to the FH IT Department.

4. I will keep mobile devices password protected and will take precautions to keep the device from being lost or stolen.

5. I will not make any unauthorized transmissions, inquiries, modifications or purging of confidential information. I will not modify the workstation configuration or use or add software to it without prior authorization from the FH IT Department.

6. I understand that FH has the right to maintain system audit trails and that it may conduct audits at any time and without notice, of any use, activity or access by me within the IT environment, or within any FH facility.

7. I understand that FH may revoke my userid/passwords at any time.

By signing this document, I agree with the terms and I understand that violation of any part of this agreement may result in corrective action, including termination of employment or business relationship with Froedter Health. Additionally, certain violations may be subject to external agency enforcement. (e.g. State Licensing Boards, Law Enforcement, or civil and/or criminal penalties.)

Signature

Date
BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

- The Background Information Disclosure (form F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions.
- Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.
- NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064, and the BID Appendix, F-82069, and submit both forms to the address noted in the BID Appendix Instructions.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Wis. Stat. § 50.065, for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity.
   *Note: Employers and Care Providers are referred to as "entities."
2. An entity may not employ, contract with, or permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at https://www.dhs.wisconsin.gov/caregiver/statutes.htm.

The Caregiver Law covers the following EMPLOYERS / CARE PROVIDERS (aka ENTITIES) regulated under Wis. Stat. §§ 50, 51, and 146:

- Adult Family Homes (3-4 Bed)
- Ambulance Service Providers
- ACODA Services
- Community Based-Residential Facilities
- Community Mental Health Programs
- Community Support Programs (CSP)
- Developmental Disabilities
- Emergency Mental Health Service Programs
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Home Health Agencies, including those that provide personal care services
- Hospices
- Hospitals
- Mental Health Day Treatment Services for Children
- Nursing Homes
- Residential Care Apartment Complexes
- Rural Medical Centers

The Caregiver Law covers the following PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone certified by DHS.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin’s Fair Employment Law, Wis. Stat. §§ 111.31 – 111.395, prohibits discrimination because of a criminal record or pending charge. However, it is not discrimination to decline to hire or license a person based on the person’s arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services’ Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client’s property.
BACKGROUND INFORMATION DISCLOSURE (BID)

- **Penalty:** Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

**PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

- [ ] Employee / Contractor (including new applicant)
- [ ] Applicant for a license, certification, or registration (including continuation or renewal)
- [ ] Household member (lives on premises, but is not a client)
- [ ] Other – Specify:

**Note:** If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the *Appendix, F-82065*, and submit both forms to the address noted in the Appendix Instructions.

<table>
<thead>
<tr>
<th>Full Legal Name – First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

Position Title (Complete only if a prospective or current employee or contractor.)

<table>
<thead>
<tr>
<th>Birth Date (MM/dd/yyyy)</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
</tbody>
</table>

Any Other Names By Which You Have Been Known (Including Maiden Name)

<table>
<thead>
<tr>
<th>Race / Ethnicity (Check ONLY one.)</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] American Indian or Alaskan Native</td>
<td></td>
</tr>
<tr>
<td>[ ] Asian or Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>[ ] Black</td>
<td></td>
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<tr>
<td>[ ] White</td>
<td></td>
</tr>
<tr>
<td>[ ] Unknown</td>
<td></td>
</tr>
</tbody>
</table>

Home Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Business Name and Address – Employer or Care Provider (Entity)

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A “NO” answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

**SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION**

1. **Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?**
   - If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   - You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   - Yes  No

2. **Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?**
   - If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   - You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   - Yes  No
3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. “All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential.” Reports and records may be disclosed only to the persons identified in this section.

☐ If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?

**If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.**

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?

**If Yes, explain, including when and where it happened.**

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?

**If Yes, explain, including when and where it happened.**

6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?

**If Yes, explain, including when and where it happened.**

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?

**If Yes, explain, including credential name, limitations or restrictions, and time period.**
### SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?
   - Yes
   - No
   If Yes, explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?
   - Yes
   - No
   If Yes, explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?
   - Yes
   - No
   If Yes, indicate the year of discharge: __________
   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years?
   - Yes
   - No
   If Yes, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
   - Yes
   - No
   If Yes, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years?
   - Yes
   - No
   If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.
7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?  
   If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.

   Yes  No
   □  □

**Read and initial the following statement.**

_________ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today’s date.

<table>
<thead>
<tr>
<th>Name – Person Completing This Form</th>
<th>Date Submitted</th>
</tr>
</thead>
</table>
Volunteer Health Evaluation

Name ____________________________ Birthdate ____________ Sex ☐ M ☐ F
Address ____________________________ Social Security Number ____________
Phone Number (H) ____________________________ Alternate Phone ____________________________
Emergency Contact ____________________________ Contact’s Phone ____________________________
Name of Healthcare Provider ____________________________ Phone ____________________________

1. Are you currently taking any medications? Yes ☐ No ☐ (List): _______________________________________________________________________
2. Do you have any allergies (latex, drug, food, chemical, or seasonal)? Yes ☐ No ☐ (List): _______________________________________________________________________
3. Do you currently have any temporary or permanent, physical limitations? Yes ☐ No ☐ if yes, what accommodations are necessary for these limitations: _______________________________________________________________________

4. Hospitalizations/Surgeries:
Year ____________ Reason _______________________________________________________________________

<table>
<thead>
<tr>
<th>Have you ever had, or now have:</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Headaches / Migraines</td>
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<tr>
<td>Sinus problems</td>
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<tr>
<td>Visual problems</td>
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<tr>
<td>Difficulty hearing, Cochlear implants</td>
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<tr>
<td>Ringing/buzzing in ears</td>
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<tr>
<td>Motion sickness</td>
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<tr>
<td>Frequent sore throats</td>
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<tr>
<td>Concussion / Head injury</td>
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<tr>
<td>Fainting / Dizzy spells</td>
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<tr>
<td>Seizures (Epilepsy)</td>
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<tr>
<td>Chronic cough</td>
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<tr>
<td>Colds (frequent)</td>
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<tr>
<td>Asthma/wheezing</td>
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<tr>
<td>Breathing difficulty</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Stroke / CVA</td>
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<tr>
<td>Heart trouble</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Cancer</td>
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</table>

Also included:
- Anemia
- Liver disease / Jaundice
- Hernia
- Arthritis
- Joint Replacement
- Metal Implants
- Back / neck injury or pain
- Shoulder / knee injury
- Swollen legs / feet
- Foot trouble
- Broken bones / Sprains / Strains
- Skin trouble
- Recurring infections
- Weakened Immune System
- History of alcohol/drug dependence
- Mental or nervous disorder
- Lack of concentration / memory
- Injuries from car accident
- Other

Please provide documentation of your immunizations.
- 2 MMR Vaccines (Measles, Mumps, Rubella) or proof of a positive titer (a lab test that shows proof of immunity).
- 2 Varicella Vaccines (Chicken Pox) or proof of a positive titer (a lab test that shows proof of immunity).
- Influenza Vaccine* (Current Season; Sept-June) *Influenza vaccine is required to participate in the Volunteer Program. If there is a medical or religious reason for exemption, please tell the nurse at the time of your visit.

An immunization record from the Wisconsin Immunization Registry will be accepted. If the immunizations are not supplied to us, we will do a blood draw to check immunity. A two-step tuberculosis skin test will also be required. This is supplied to you by the Internal Occupational Health Department.

I have reviewed the above statements and I certify that the information is true to the best of my knowledge.

Signature ____________________________ Date ____________________________

Signature ____________________________ Date ____________________________

(Parental/Legal Guardian if under 18 years of age)

Examiners Signature ____________________________ Date ____________________________

CMH-F-0231 (R 02/15)
Volunteer Form

This form is to be completed prior to volunteering.

Please print legibly

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address:</th>
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<table>
<thead>
<tr>
<th>Daytime Phone:</th>
<th>Evening Phone:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Last 4 digits of SS #:</th>
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<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Emergency Contact Relationship:</th>
<th>Emergency Contact Phone:</th>
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</table>

Purpose of Visit

- [ ] Volunteer
- [ ] Transplant peer mentor
- [ ] Other: ____________________________

Froedtert Health Facility - Please check one:

- [ ] Froedtert Hospital
- [ ] Community Memorial Hospital
- [ ] St. Joseph's Hospital

Department / Area Requested for Volunteering: ____________________________

Health Requirements

**MMR (Measles, Mumps, Rubella)** – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; OR serologic proof of immunity for Measles, Mumps, and/or Rubella

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Vaccine</th>
<th>Date</th>
<th>Copy Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>MMR Dose #1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>MMR Dose #2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 2</th>
<th>Vaccine or Test</th>
<th>Date</th>
<th>Copy Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>Measles Vaccine Dose #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles Vaccine Dose #2</td>
<td></td>
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<tr>
<td></td>
<td>Serologic Immunity (IgG, antibodies, titer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Mumps Vaccine Dose #1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Mumps Vaccine Dose #2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Serologic Immunity (IgG, antibodies, titer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Rubella Vaccine</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Serologic Immunity (IgG, antibodies, titer)</td>
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<td></td>
</tr>
</tbody>
</table>

Influenza Vaccination – Only required September - March

<table>
<thead>
<tr>
<th>Influenza Vaccine</th>
<th>Date</th>
<th>Copy Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A – not flu season</td>
<td></td>
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</tbody>
</table>


### Varicella Vaccination – 2 doses of vaccine or positive serology

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella Vaccine #1</td>
<td>/ / /</td>
<td>□ Copy Attached</td>
</tr>
<tr>
<td>Varicella Vaccine #2</td>
<td>/ / /</td>
<td>□ Copy Attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 2</th>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serologic Immunity (IgG, antibodies, titer)</td>
<td>/ / /</td>
<td>□ Copy Attached</td>
</tr>
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</table>

### Tuberculosis Surveillance – Complete Section A, B, OR C

#### SECTION A: Negative Skin or Blood Test History - Last two skin tests or one IGRA required

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Tuberculin Skin Test #1 (dated within 12 months of program start)</th>
<th>Date Placed</th>
<th>Date Read</th>
<th>Result: ______ mm</th>
<th>□ Copy Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Placed</td>
<td>Date Read</td>
<td>Result: ______ mm</td>
<td>□ Copy Attached</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tuberculin Skin Test #2 (dated within 90 days of program start)</td>
<td>Date Placed</td>
<td>Date Read</td>
<td>Result: ______ mm</td>
<td>□ Copy Attached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 2</th>
<th>Interferon gamma releasing assay (IGRA) Blood Test (dated within 90 days of program start)</th>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date</td>
<td>Result: ______</td>
<td>□ Copy Attached</td>
</tr>
</tbody>
</table>

#### SECTION B: History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Positive Tuberculin Skin Test</th>
<th>Date Placed</th>
<th>Date Read</th>
<th>Result: ______ mm</th>
<th>□ Copy Attached</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Option 2</th>
<th>Positive IGRA Blood Test</th>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chest X-ray (dated within 6 months of program start)</td>
<td>Date: ______ / ______ / ______</td>
<td>Result: ______</td>
</tr>
<tr>
<td></td>
<td>Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health</td>
<td>Date: ______ / ______ / ______</td>
<td>□ Copy Attached</td>
</tr>
</tbody>
</table>

Was prophylactic medication taken for latent TB? □ Yes □ No

If prophylactic medication was taken, total duration of prophylaxis ______ Months

#### SECTION C: History of Active Tuberculosis

Date of Diagnosis: 

Date Treatment Completed: 

<table>
<thead>
<tr>
<th>Chest X-ray (dated within 6 months of program start)</th>
<th>Date: ______ / ______ / ______</th>
<th>Result: ______</th>
<th>□ Copy Attached</th>
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</thead>
<tbody>
<tr>
<td>Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health</td>
<td>Date: ______ / ______ / ______</td>
<td>□ Copy Attached</td>
<td></td>
</tr>
</tbody>
</table>

### Volunteer Signature

I certify that the information in this document and any attached documents are true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after volunteer status has been awarded to me, may lead to termination of my participation in the volunteer program.

Printed Name of Volunteer: 

Signature of Volunteer: 

If under 18, signature of parent or legal guardian and relationship: 

Cleared to Volunteer by: 

Date:
Authorization for Disclosure of
Protected Health Information - Form # 37976
Health Surveillance Process

To ensure your ongoing health and safety, OSHA and the Center for Disease Control have established health requirements that may include baseline and periodic health surveillance monitoring.

**Baseline** monitoring includes:

- Health Evaluation through the Internal Occupational Health department
- Proof of immunity to Measles, Mumps, Rubella and Varicella*
- Proof of Hepatitis B vaccination or record of declination (for direct caregivers)
- Tuberculosis screening with TB skin testing prior to placement. Documentation of a check x-ray is required for positive Quantiferon blood test or TB skin test.

*Please be prepared to provide Internal Occupational Health with medical documentation of immunity from your physician.

**Periodic** monitoring: The frequency may vary based on TB exposure and/or risk assessment.

**Information for employees of Froedtert Menomonee Falls Hospital or Medical Staff:**

The Community Outreach Health Clinic is a separate organizational entity and in order to obtain medical information of immunity from Froedtert Menomonee Falls Hospital Internal Occupational Health or Froedtert Menomonee Falls Hospital medical staff office, your written permission is necessary.

For your confidentiality, Froedtert Menomonee Falls Hospital’s Internal Occupational Health Department will conduct health screening and keep all medical information in a separate Community Outreach Health Clinic file.

If you have any questions or concerns, please contact Linda Smith, APNP, Clinic Nurse Practitioner Coordinator at 262-257-3394.