Dear Volunteen:

Thank you for your interest in Froedtert Menomonee Falls Hospital’s 2020 summer Volunteen program from Monday, June 15, 2020 through Sunday, August 16, 2020. The program gives you the opportunity to gain experience volunteering at least one day a week for a 3-4 hour shift. To be eligible, you must be at least 15 years old and have completed your freshman year of high school by the start of the summer program. There are a few steps involved in participating in this program. These steps include the application process, registration and orientation. Please complete the new Volunteen application online. The application can be found here: https://www.volgistics.com/ex/portal.dll/ap?ap=1760996572

- Registration for RETURNING VOLUNTEENS will take place from Monday March 9, 2020 through Friday, April 3, 2020. Please call or email to make an appointment with Paige Siehr to register. When you come to register in the Volunteer Services Office, please bring your completed forms with you, and be prepared to select a service area.

- Registration for NEW VOLUNTEENS is Tuesday, April 7, 2020 from 3:00pm to 4:30pm in Treiber Conference Center. Please bring the completed forms with you, and be prepared to select a service area. The TB (tuberculosis) test will be administered that afternoon. The entire process should take approximately 20-30 minutes. Please see the additional document regarding TB testing.

For registration, Volunteers under 18 years must be accompanied by a parent or legal guardian for the application materials to be accepted. Please bring the following completed forms with you:

1. Volunteer Commitment/Vacation Schedule (commitment of 25 hours of service)
2. Consent for Interviews/Photographs
3. Background Information Disclosure
4. Volunteer Form – Internal Occupational Health (New Volunteers Only)
5. Copy of your immunization record from your Health Care Provider and/or a copy of your WI Immunization Registry (New Volunteers Only)

- Volunteer Orientation is Wednesday, May 20, 2020 from 3:00pm-4:30pm in Treiber Conference Center. In order to participate in the 2020 Summer Volunteer Program, you must attend. You will meet your unit leader, pick up your uniform and badge, and attend an orientation session. If there are Volunteer assignments still available and you are interested in a second one, you will be able to sign up at that time.

Please contact Paige with any questions. We look forward to having you volunteer at Froedtert Menomonee Falls Hospital!

Sincerely,

Paige Siehr
Volunteer Services Coordinator
262-257-3310
paige.siehr@froedtert.com
Volunteer Commitment Statement and Time-Off Schedule

I understand that in order to participate as a Froedtert Menomonee Falls Hospital 2020 Summer Volunteen, I must commit to 25 hours of service. The program will be held from Monday, June 15, 2020 through Sunday, August 16, 2020.

I understand that absences are allowed for vacations, camps (band, sports, etc.), classes, and work schedules. However, I agree to inform my employer of my Volunteer schedule so that he/she can plan my work schedule around my Volunteer assignment.

I understand that participating for less than 25 hours this summer may affect future participation in the program.

I understand I must attend the required Volunteer Orientation on Wednesday, May 20, 2020, from 3:00 pm to 4:30 pm.

I understand that in order to attend the Volunteer Orientation this Commitment Statement and Time-off Schedule must be completed and submitted at the time of registration.

Please list any dates that you know you will be absent: _______________________

Please check here if dates unknown at this time: ______

Volunteer Signature: _____________________________________________

Date: __________________

Volunteer Printed Name: __________________________________________

If you are under the age of 18, parental/legal guardian signature is required.

Parent/Legal Guardian Signature: ______________________________________

Date: __________________
1. I, ________________________, consent to the release of my name as a:
   □ patient □ staff member □ family member, guardian or support person □ affiliate (such as donor or board member) □ model
   of any of the following Froedtert or the Medical College of Wisconsin entities or affiliates: Community Memorial Hospital,
   Froedtert Hospital, Medical College of Wisconsin, St. Joseph's Hospital or another entity of Froedtert Health, Inc. or the
   Medical College of Wisconsin, Inc.
   I grant my permission for authorized Froedtert or the Medical College of Wisconsin staff to release medical information
   concerning my case. I also give my permission for members of Froedtert Health or the Medical College of Wisconsin
   staff to interview and/or photograph me. I understand my permission and/or restrictions may be changed or revoked by
   me at any time.

2. I further authorize the use and reproduction by Froedtert Health, Inc. or the Medical College of Wisconsin Inc. of
   photograph(s) and/or interview(s) of me, in whole or in part, limited to the following Froedtert Health or Medical College of
   Wisconsin activities:
   □ advertisements □ fundraising publications □ news media*
   □ publications □ social media sites □ internet properties
   □ other publicity, educational or marketing purposes
   *Name and address of news media organization authorized to receive this information:

   I further understand that no payment has been promised or is anticipated.

3. I hereby release Froedtert Health, Inc. and the Medical College of Wisconsin, Inc. and its employees, officers and agents
   and any other authorized persons associated with Froedtert Health or the Medical College of Wisconsin from any and
   all liability and/or claims which may or could arise while being photographed and/or interviewed or from the release of this
   information or interviews and/or photographs.

4. Permission for the release of my name or information about my care, or Froedtert Health or the Medical College of Wisconsin
   interviews/photographs of me may be subject to the following restrictions: __________________________

   Witness Signature ____________________________________________________________
   Subject Signature ____________________________________________________________
   Date _________________________________________________________________________
   Street Address __________________________________________________________________
   City/State/Zip/Phone ___________________________________________________________________

   In the event the above named patient is a minor of ____ years of age or is unable to sign, this consent is given on the
   patient's behalf by:
   ________________________
   Patient/Guardian/Family Member

   Please return this consent form to:
   Froedtert Health Marketing Or Fax to 414-777-7055
   Attn: Administrative Assistant
   400 Woodland Prime
   N74 W12501 Leatherwood Court
   Menomonee Falls, WI 53051

   For Office Use Only:
   Photographer/Event/Date/Other Metadata
   __________________________________________________________

   Consent for Interviews/Photographs for
   Marketing and Communications - Item # 50802
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 Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

CAREGIVER BACKGROUND CHECK LAW
In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., 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. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. 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 http://OHS.wisconsin.gov/caregiver/StatutesINDEX.HTM.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as “Entities”):

Programs Regulated under Chapter 48, Wis. Stats.:
- Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.

Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.:
- Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.

Others:
- Child Care Providers contracted through Local School Boards

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 is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- 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 who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- 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, Chapters 111.31 – 111.395, Wis. Stats., 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)

For Instructions, see F-82064A.
Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. 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 the instructions (F-82064A) on page 1 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.

PLEASE PRINT OR TYPE YOUR ANSWERS.

Check the box that applies to you.

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

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DOA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name - (First and Middle) Name - (Last) Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)

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

Race
- [ ] American Indian or Alaskan Native
- [ ] Asian or Pacific Islander
- [ ] Black
- [ ] White
- [ ] Unknown

Social Security Number(s)

Home Address City State Zip Code

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

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

1. Do you have any criminal charges pending against you or 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.

2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.)
   - [ ] If Yes, list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.

3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?
   - [ ] A response is required if the box below is checked:
     - [ ] (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.)
     - [ ] If Yes, explain, including when and where it happened.

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, explain, including when and where it happened.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, explain, including credential name, limitations or restrictions, and time period.</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION B – OTHER REQUIRED INFORMATION

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, explain, including when and where it happened.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, explain, including when and where it happened and the reason.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Have you been discharged from a branch of the US Armed Forces, including any reserve component?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If yes, indicate the year of discharge: ______</td>
<td></td>
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<tr>
<td></td>
<td>▶ Attach a copy of your DD214 if you were discharged within the last 3 years.</td>
<td></td>
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<tr>
<td>4.</td>
<td>Have you resided outside of Wisconsin in the last 3 years?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, list each state and the dates you lived there.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Have you had a caregiver background check done within the last 4 years?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ 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.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>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?</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>▶ If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.</td>
<td></td>
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</tbody>
</table>

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

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHIS 12.05 (4), Wis. Adm. Code.

SIGNATURE  

Date Signed
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>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address:</th>
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<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>Daytime Phone:</th>
<th>Evening Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Last 4 digits of SS #:</th>
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<tbody>
<tr>
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<td></td>
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<table>
<thead>
<tr>
<th>Email Address:</th>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Emergency Contact Relationship</th>
<th>Emergency Contact Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</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></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 doses of MMR vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MMR Dose #1</td>
<td>__ / __ / __</td>
<td>[ ]</td>
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<tr>
<td></td>
<td>MMR Dose #2</td>
<td>__ / __ / __</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>
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</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>2 doses of vaccine or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>positive serology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measles Vaccine Dose #1</td>
<td>__ / __ / __</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>Measles Vaccine Dose #2</td>
<td>__ / __ / __</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>Serologic Immunity (IgG, antibodies, titer)</td>
<td>__ / __ / __</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

| Mumps    |                       |                       |               |
|          | 2 doses of vaccine or |                       |               |
|          | positive serology     |                       |               |
|          | Mumps Vaccine Dose #1 | __ / __ / __          | [ ]           |
|          | Mumps Vaccine Dose #2 | __ / __ / __          | [ ]           |
|          | Serologic Immunity (IgG, antibodies, titer) | __ / __ / __ | [ ] |

| Rubella  |                       |                       |               |
|          | 1 dose of vaccine or  |                       |               |
|          | positive serology     |                       |               |
|          | Rubella Vaccine       | __ / __ / __          | [ ]           |
|          | Serologic Immunity (IgG, antibodies, titer) | __ / __ / __ | [ ] |

**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>
<td></td>
</tr>
</tbody>
</table>
### Varicella Vaccination

- **Option 1**: Varicella Vaccine #1
  - Date: __/__/__
  - Copy Attached: □
- **Option 2**: Varicella Vaccine #2
  - Date: __/__/__
  - Copy Attached: □
- **Option 2**: Serologic Immunity (IgG, antibodies, titer)
  - Date: __/__/__
  - Copy Attached: □

### Tuberculosis Surveillance

- **Section A**: Negative Skin or Blood Test History - Last two skin tests or one IGRA required
  - Option 1: Tuberculin Skin Test #1 (dated within 12 months of program start)
    - Date Placed: __/__/__
    - Date Read: __/__/__
    - Result: _____ mm
    - Copy Attached: □
  - Option 2: Tuberculin Skin Test #2 (dated within 90 days of program start)
    - Date Placed: __/__/__
    - Date Read: __/__/__
    - Result: _____ mm
    - Copy Attached: □
  - Option 2: Interferon gamma releasing assay (IGRA) Blood Test (dated within 90 days of program start)
    - Date: __/__/__
    - Result: _____
    - Copy Attached: □

- **Section B**: History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test
  - Option 1: Positive Tuberculin Skin Test
    - Date: __/__/__
    - Result: _____ mm
    - Copy Attached: □
  - Option 2: Positive IGRA Blood Test
    - Date: __/__/__
    - Result: _____
    - Copy Attached: □
    - Chest X-ray (dated within 6 months of program start)
      - Date: __/__/__
      - Result: _____
      - Copy Attached: □
    - Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health
      - Date: __/__/__
      - Copy Attached: □
    - 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: __/__/__
  - Chest X-ray (dated within 6 months of program start)
    - Date: __/__/__
    - Result: _____
    - Copy Attached: □
  - Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health
    - Date: __/__/__
    - Copy Attached: □

### 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: __________________________ Date: __/__/__

Signature of Volunteer: __________________________

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

Cleared to Volunteer by: __________________________ Date: __/__/__
TB Testing and Volunteer Registration— Tuesday, April 7, 2020

- A two-step TB skin test or a TB QuantiFeron blood draw test is required before volunteering at the hospital. Froedtert Menomonee Falls Hospital Internal Occupational Health Department team members will administer and provide clearance for the test. Returning Volunteers will NOT need a TB test and can disregard this information.

- The TB skin test or the TB QuantiFeron blood draw test will be given at the Volunteer Registration Open House on Tuesday, April 7, 2020 from 3:00-4:30 pm. Volunteers can choose which TB test they would like to receive. At the time of the test, please advise the Internal Occupational Health staff member if your son or daughter has a fear of needles.

- If receiving the two-step TB skin test, the Volunteer must return to Froedtert Menomonee Falls Hospital to have the TB skin test read on Thursday, April 9, or Friday, April 10, 2020 in the Internal Occupational Health Department on the 3rd floor of the Heart and Vascular Center, (enter main entrance) anytime between 7:00 am to 3:45 pm.

- Volunteers that choose to have the two-step TB skin test must return for a second TB skin test between April 14 - May 5, 2020 and have it read 2-3 days after the date administered. The second test will be scheduled by Internal Occupational Health on April 9 or April 10 during the first TB skin test reading.

- If receiving the TB QuantiFeron blood draw test at registration, Volunteers do not need to return back for a TB reading, or a second TB skin test, and reading.

- Volunteers who have a known previous history of a positive reaction to a TB skin test or a Quantiferon test, or who test positive, should contact Internal Occupational Health: 262-257-3340

If you have any questions, please reach out to Internal Occupational Health at 262-257-3340.