HEALTH ASSESSMENT QUESTIONNAIRE -- VOLUNTEER

Nuvance Health and its affiliates, including but not limited to Western Connecticut Health Network, Inc., and its affiliated entities, including but not limited to the Norwalk Hospital Association, Requires that all prospective volunteers obtain medical clearance. This information will be safeguarded as confidential in accordance with all legal requirements. Please affix copies of immunity records and proof of flu vaccination to this form.

A key factor to consider while completing this questionnaire is to understand that a volunteer may be assigned to work directly with patients or in an assignment that would require physical exertion such as pushing or walking. Volunteers should have the stamina to stand for three-four hours.

Name: _____ Date of Birth: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Cell # _____ Business # _____

Email Address: _____

Have you volunteered for the Western Connecticut Health Network before? ☐ Yes ☐ No

If so, when did you last volunteer? _____ Do you have any physical or medical limitations that would affect your performance On the job? Yes: ____ No: ____ If yes, please specify: _____

Mandatory health paperwork that you must obtain and attach to this form before you start

☐ Checklist of Mandated Immunizations. Please have your provider print out your vaccination schedule which must include: **MMR1, MMR2, Varicella1, Varicella 2 (chickenpox) and FLU vaccine proof.** Please attach printout to the back of this form. (note: if you do not have records that indicate you had the above vaccines, you will need to obtain a titer (blood test) demonstrating immunity to Measles, Mumps, Rubella and Varicella and submit with this form

☐ Tuberculosis Test (PPD): Volunteers 18 years of age and older, require a 2 step test. Under 18, requires a 1 step test. Employee Health Services at Danbury Hospital (1st floor Tower) offers the PPD test free of charge. Hours to get test planted: Monday/Tuesday/Wednesday 7:30am – 3:00pm. Hours to get test read: Monday-Friday 7:30am-3:00pm

TO BE FILLED OUT BY PROSPECTIVE VOLUNTEER

I, _____, authorize that my medical information be released for medical reference to the Volunteer Services Department at Western Connecticut Health Network.

_____ _____
PATIENT'S SIGNATURE DATE

To Be Completed by Physician or Nurse Practitioner

I certify that the above volunteer is in good health, is free and clear of communicable disease and is medically able to perform his/her volunteer duties.

_____ _____
CLINICIAN'S SIGNATURE DATE

_____
OFFICE ADDRESS CITY STATE ZIP

_____
TELEPHONE FAX

Apply Office Stamp Here

_____