Cancer Treatment Centers of America®

Winning the fight against cancer, every day.®

Trees

This tree represents every tree growing in our Cancer Survivors Arboretum, as source of inspiration to people who have cancer. One tree is planted there for every patient of Cancer Treatment Centers of America who has survived for at least five years.

There is no more fitting symbol to commemorate all the battles won and all the lives improved. The tree, the boy and his companion speak of the optimism of youth, of new beginnings, soaring spirits, years of love and laughter and loyal friends and the joy of looking forward to life once again.

We have already planted hundreds. Our goal is to plant a forest.

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Volunteer Application

Please print:

First Name.....Last Name .....

Address .....City/State/Zip. .....

Telephone.....Cell Phone.....

E-mail Address.....Birth Date.....

Social Security Number.....

Personal Information (please circle correct response):

Gender: Male Female

Physical Limitations: No Yes

.....

.....

Education (highest level completed)

Grades: High School Associate Degree College Graduate School Technical Vocational

Former work/occupation.....

Most recent employer

.....

.....

.....

.....

List previous volunteer experience.....

.....

Skills (List your skills)

1.....

2.....

3.....

Languages.....

.....

Volunteer availability (List time availability)

Monday	Tuesday	Wednesday	Thursday	Friday	No Preference

Volunteer Placement Preference (Specific Role or Clerical vs. Patient Care):

.....

In an emergency, notify:

First Name.....Last Name .....

Address .....

City/State/Zip.....Telephone.....

References:

First Name.....Last Name .....

Address .....

City/State/Zip.....Telephone.....

First Name.....Last Name .....

Address .....

City/State/Zip.....Telephone.....

I certify that the information I have provided on this application is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration for volunteering, or may result in my termination as a volunteer at the Cancer Treatment Centers of America, Southwestern Regional Medical Center. If accepted as a volunteer, I understand that I must abide by all of the policies, rules and regulations of the Hospital. I authorize Cancer Treatment Centers of America, Southwestern Regional Medical Center Volunteer Services Department to investigate all statements contained in this application and to make inquiries of my personal references and medical history, as well as run a background check, as well as other related matters as may be necessary for determining my eligibility as a volunteer. I hereby release employers, schools or individuals from all liability in responding to inquiries relating to my volunteer application.

Signature.....Date.....

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VOLUNTEER UNIFORM CODE

The following Dress Code is hospital policy:

- Volunteers are expected to maintain a neat, professional appearance and dress to allow safe completion of work duties.
- The supervisor is responsible for evaluating the dress and appearance of employees under his/her supervision.
- Hair. Hair, including sideburns, moustaches, and beards should be clean, combed, and neatly trimmed. In the clinical area, long hair should be pulled back away from the face.
- Personal hygiene. Staff/volunteer must be clean. The use of deodorant is required.
- Make-up. Make-up should be used in moderation. Extreme colors and glitter may not be worn.
- Grooming. Clothes should be clean, pressed and stain-free. Clothing should fit smoothly without seam pulling or gaping open or material clinging to the body. Shirttails should be tucked in unless the top is specifically made to fit over pants.
- Perfume, cologne, aftershave. Should not be worn. Other scents should be mild. Cancer patients are extremely sensitive to odors.
- Jewelry. In addition to a watch and wedding rings, jewelry should be worn in moderation. Earrings should be a maximum of two per ear and may not dangle below the chin. In the clinical areas, jewelry must not interfere with patient care.
- Fingernails. Nails should be clean and manicured and may only extend a maximum of ½ inch beyond the tip of the finger. Polish should not be chipped and without ornamentation. Extreme colors should be avoided.
- Name Badge. The hospital approved and supplied name badge must be worn above the waist at all times.

General clothing requirements for all volunteers include:

- Denim/jeans. No denim garments.
- Shirts. No tube tops, tank tops, revealing necklines, backs, or belly buttons. No T-shirts and sweatshirts or similar styles.
- Slacks. Jeans or leggings are not acceptable. Shorts may not be worn.
- Undergarments. Appropriate undergarments must be worn.
- Stockings. Socks/knee-highs must be worn with slacks.
- Shoes. Shoes must be clean and polished. Open toed shoes, sandals, thongs, canvas or other casual sport or leisure shoes are unacceptable.
- Volunteer jacket. Volunteer jacket should be worn whenever possible.

Off duty, but on premises requirements include:
No shorts, denim clothing, tube tops, crop tops, or halter tops. Also, no T-shirts with objectionable slogans or pictures are allowed. Shoes must be worn.

I have read and agree to comply with the Volunteer Uniform Code.

Volunteer Signature_____

Date_____

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PATIENT RIGHTS

You can protect your patient's rights by focusing on your patient as a consumer of your healthcare services. True False

The Patient's Bill of Rights was adopted to ensure that healthcare facilities and healthcare workers respect and honor their patients' rights. True False

Ethically, you are obligated to protect the privacy and confidentiality of all patient information.
True False

Patients have the right to receive visitors, mail, telephone calls and other communications as long as ongoing treatment is not compromised.
True False

Patients may review records pertaining to their healthcare after obtaining permission and under proper supervision. True False

In order for patients to participate in research conducted at your facility, they must first be fully informed about the research and provide their verbal or written consent. True False

Patients can, to the extent permitted by law, make decisions about the plan of their care prior to and during the course of treatment. True False

You and your facility must honor the intent of a patient's advance directive to the extent permitted by law. True False

Patients must be given impartial access to healthcare regardless of sources of payment.
True False

Patients have a right to obtain an itemized explanation of the total bill for health services rendered.
True False

Since it is impossible to satisfy all patients, refer only those patients who complaints you judge to be a significance to your facility's grievance process. True False

In order to receive optimal care, patients, or other designees, must seek clarification when necessary, to fully understand their health problems and the proposed plan of action. True
False

I have read the above and agree with the Patient Rights statements.

Signature _____

Date _____

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STATEMENT OF CONFIDENTIALITY

I hereby recognize and acknowledge that all information concerning the patients at Cancer Treatment Centers at SOUTHWESTERN REGIONAL MEDICAL CENTER (SRMC) is highly privileged, confidential and protected by law. In the course of my volunteering, I understand that I am likely to become familiar with confidential medical and other information concerning patients. I recognize that as a Volunteer of SRMC, it is my personal and legal responsibility to protect the privacy of its patients. In accordance with this duty, I promise never to place medical information of any patient in the hands of an unauthorized person. In addition, I promise never to discuss medical information concerning a patient with any person who is not specifically authorized to receive patient's protected health information. I understand that all patient medical records are the property of SRMC and are to be maintained solely for the benefit and use of the hospital, its physicians, administrators, medical and technical personnel for the purpose of providing quality care to its patients.

I will not publish, release, broadcast or otherwise disclose either during or after my volunteering any patient information obtained as a result of my volunteering at SRMC. I further agree to conform to all the rules and regulations of SRMC which are now in force, or may be enacted in the future, in regard to the confidentiality of information concerning patients at SRMC.

I hereby recognize and agree that if I shall in any manner disclose any confidential information obtained as a result of my volunteering at SRMC, I will be immediately barred from participating in any programs at SRMC.

I further agree that during the course of volunteering with SRMC, I may be assigned a Username and Password for access into the SRMC computer systems. I declare that I understand it is a breach of trust for me to divulge my computer Username and Password to another, or to use another volunteer or employee's Username and Password. I realize that it is my responsibility to request a new Password if I believe another person has knowledge of my Password. I further agree that if, as a result of my position, I do not use the computer system, I will declare myself as such to the Information Technology Department and my Username and Password will be revoked.

Signature _____ Date _____

Printed Name _____

CANCER TREATMENT CENTERS OF AMERICA
VOLUNTEER MEDICAL HISTORY FORM

Confidential: All information is considered confidential and kept in a confidential medical file in the Employee Health Office.

Objective: To establish a baseline medical history to be used for future reference and in the event of a medical emergency.

Date:_____ SSN:_____

Name: _____ Date of Birth:: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Please Circle: Male Female

Personal MD: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Work: _____

Please List Allergies: _____

Please List Current Medical Conditions: _____

Please List Current Medications: _____

IMMUNIZATION HISTORY: Please list if you have had either the disease or the vaccine for the following communicable diseases:

	Disease	Vaccine
Chicken Pox	_____	_____
Measles (Rubeola)	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Diphtheria	_____	_____
Pertussis	_____	_____
Polio	_____	_____
Tetanus	_____	_____

Hepatitis B Series: (If you have had the series, please provide dates if known.)

_____ _____ _____ _____

1 2 3 Titer (date & results)

I understand that this information is required for this facility to be in compliance with state and federal regulations.

If I have had the Hepatitis B Vaccine, I consent to have a titer for proof of effectiveness of the vaccine.

I hereby agree to abide by any company policies, which may be considered applicable to me, while performing my duties as a volunteer. This includes but is not limited to Annual TB screening and the reporting of communicable diseases.

Signature: _____ Date _____

ONLY FILL OUT IF TB POSITIVE

TUBERCULIN HEALTH QUESTIONNAIRE

Answer if History of Positive TST or if unable to have TST

History of Positive TST ☐ **Yes** ☐ No ♦ **if yes continue ↓** ♦
☐ Information already on file Hx. BCG vaccine? ☐ yes ☐ no
☐ Results in MM_____ Date _____
Last Chest X-ray Date_____ Where_____
Received prophylactic Tx? ☐ yes ☐ no ♦ Given INH? ☐ yes ☐ no
Other treatment?_____ Duration_____
Dx with infectious active TB? ☐ yes ☐ no

Answer the following questions by checking appropriate box

Yes	No	
☐	☐	On Corticosteroids or immunosuppressive agents?
☐	☐	History of untreated or inadequately treated TB disease?
☐	☐	History of close exposure to a case of communicable Pulmonary TB within the last 2 years?
☐	☐	Acquired immunodeficiency syndrome (AIDS), or HIV infection, silicosis, organ transplant, diabetes, prolonged corticosteroid therapy, hematological disease, immunosuppressive disease or treatments, intestinal bypass or gastrectomy, chronic renal failure or end-stage renal disease, Cancer of head, neck or lung?
☐	☐	Foreign-born person or frequent travels in Asia, Africa, Eastern Europe, Russia and Latin America?
☐	☐	Homeless, alcoholic, or IV drug user?
☐	☐	Elderly over 70 years old?
☐	☐	Fatigue and/or chest pain?
☐	☐	Productive cough greater than 3 weeks?
☐	☐	Unexplained weight loss, body weight ≥10% below ideal weight?
☐	☐	Loss of appetite?
☐	☐	Unexplained fever, chills or night sweats greater than 2 weeks?
☐	☐	Bloody sputum, hemoptysis, or unexplained hoarseness?
☐	☐	Resident or employee of high-risk settings – i.e. Correctional facilities, homeless shelter or mental Institution? Hx of migrant farm working in past?
☐	☐	History of high-risk chest x-ray?
☐	☐	Have you been informed about your risks of developing tuberculosis, (It increases if you have any of the above risk factors)?
☐	☐	Do you have understanding of the signs and symptoms to watch for and report if present?

Information on this form is current and correct.

Employee **Date**

PLEASE PRINT

Date_____

Employee Name_____

Dept.. / Occupation_____

Birth Date_____

Employee Tuberculin SKIN TEST(TST)

Test must be read in 48-72 hours
or will have to be repeated

☐ **New employee** ☐ **Annual** ☐ **Post Exposure**
☐ **2nd Step test needed**

By my signature on this form, I give my permission for administration of the tuberculin skin test to me or the person for whom I am authorized to make such decisions. The purpose of the tuberculin test is to detect tuberculosis infection. I acknowledge there is no history of having previous positive Tb skin test. I have been given the opportunity to ask questions and they have been answered to my satisfaction

_____

Employee Signature for consent to be tested **Date**

Date Given_____

Site R L Forearm	Amt. Given 5 Units TST Lot # C3949AA Exp: 5-26-14	Nurse Signature
Date Read	Results in MM	Nurse Signature

Induration ♦ Neg. < 5 MM ♦ Pos. if post exp. MM >10 ♦ Pos. MM >15

☐ **2nd Step Test** ☐ **10-week post exposure test**

Date Given_____

Site R L Forearm	Amt. Given 5 Units TST Lot #	Nurse Signature
Date Read	Results in MM	Nurse Signature

Induration ♦ Neg. < 5 MM ♦ Pos. if post exp. MM >10 ♦ Pos. MM > 15

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ACKNOWLEDGE/ DECLINATION FORM
HEPATITIS B VACCINATION
OSHA BLOOD-BORNE PATHOGEN REGULATION

Pursuant to federal law, employers are required to offer the Hepatitis B vaccine free of charge to current personnel at risk of exposure to blood and blood products by July 6, 1992 and to new employees within ten (10) days of beginning employment. Occupational exposure means reasonably anticipated skin, eye, mucous membrane or parenteral (i.e. -needlestick) contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

I have had access to handout literature, lecture and/or video presentation on the disease Hepatitis and Hepatitis B vaccine. I am aware of the possible side effects and adverse reactions (soreness at injection site, arthralgia, neurological reactions such as Guillain-Barre' Syndrome, and other illnesses). I am aware that the Hepatitis B vaccine is given in a series of three (3) injections over six (six) months and that it is my sole responsibility to complete the series as directed by Employee Health (i.e.-initial dose followed by the second dose in one month then the third dose in six months from the first).

I wish to take the series of Hepatitis B vaccine being offered me by Cancer Treatment Center. I shall report any side effects immediately to the Employee Health Department.

_____ _____ _____

Employee Signature Employee # Date

_____ _____

Witness Signature Date

HEPATITIS B VACCINATION DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____ _____

Employee Signature Employee # Date

_____ _____

Employee Name Printed Witness Date

Reason Refused:

____ Have had vaccine. Titer ____ Yes ____ No

____ Not interested at this time.

____ Other (fear of needles, fear of vaccine, etc.)

CLASS B EMPLOYEES – MRI EDUCATION

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The MRI department wants to thank all those employees for taking the time to fill out and return the Patient Survey Safety Sheet. All forms were evaluated for unsafe metallic conditions and are kept in the employee health files as confidential information.

Rather than address each one individually, we are generalizing the information. If you have a specific question we would be happy to help you with that information individually and privately.

The most popular items: piercing and transdermal patches depend on the metal or composition of the item. Generally, you are safe to go into the room but for your safety we would most likely have you remove these items if being scanned.

Most tattoos are safe, it is the ink that may heat up due to the inks metal content causing a warming and eventually possible burn potential. Each person entering MRI with a tattoo will be monitored for safety.

External devices, pumps, hearing aides, etc., are to be removed prior to entering the scan room.

IUDs, carotid clips, cochlear implants, ocular implants, penile implants, tissue expanders and other mechanical implants are rarely safe to have a scan but you can enter the room. Again, we would have to check these items out individually by manufacturer. These are magnet strength dependant; CTCA's current magnet is a 1.5 Tesla and has the potential to do harm.

Surgical clips, staples, wires, stents etc. are safe **after 6 to 8 weeks** after surgery. Orthopedic hardware, hips, knees once any surgical staples are removed these are MRI safe although they will cause an artifact of that specific area.

Internal pumps, pacemakers and aneurysm clips are still on the "do not scan" list, although there are some manufacturers that are beginning to come out with MRI compatible or MRI safe devices that are being tested.

For those who have some unknown metallic foreign body, we determine that individually with the help of a Reference Manual for Magnetic Safety, a book that is in every MRI department and is updated yearly.

I have received a personal copy of the Class B Employee MRI Education form. I understand that now, or at any time during my employment at Southwestern Regional Medical Center, I can make an appointment with the employee Health Nurse to discuss my personal MRI safety and have my questions fully answered.

_____ _____

Employee Name (print) Employee Signature

Date:_____

Employee Health

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MRI QUESTIONNAIRE

Please indicate if you have any of the following

☐ Yes	☐ No	Aneurysm clip(s)
☐ Yes	☐ No	Cardiac Pacemaker
☐ Yes	☐ No	Implanted cardioversion defibrillator (ICD)
☐ Yes	☐ No	Electronic implant or device Magnetically-activated implant or device
☐ Yes	☐ No	Neurostimulation system
☐ Yes	☐ No	Spinal cord stimulator
☐ Yes	☐ No	Internal electrodes or wires
☐ Yes	☐ No	Bone growth/bone fusion stimulator
☐ Yes	☐ No	Cochlear, otologic, or other ear implant
☐ Yes	☐ No	Insulin or other infusion pump
☐ Yes	☐ No	Implanted drug infusion device
☐ Yes	☐ No	Any type of prosthesis (eye, penile, etc.)
☐ Yes	☐ No	Heart valve prosthesis
☐ Yes	☐ No	Eyelid spring or wire
☐ Yes	☐ No	Artificial or prosthetic limp
☐ Yes	☐ No	Metallic stent, filter, or coil
☐ Yes	☐ No	Shunt (spinal or intraventricular)
☐ Yes	☐ No	Vascular access port and/or catheter
☐ Yes	☐ No	Radiation seeds or implants
☐ Yes	☐ No	Swan-Ganz or thermodilutoin catheter
☐ Yes	☐ No	Medication patch (Nicotine, Nitroglycerine, Duragesic)
☐ Yes	☐ No	Any metallic fragment or foreign body
☐ Yes	☐ No	Wire mesh implant
☐ Yes	☐ No	Tissue expander (e.g., breast)
☐ Yes	☐ No	Surgical staples, clips, or metallic sutures
☐ Yes	☐ No	Joint replacement (hip, knees, etc.)
☐ Yes	☐ No	Bone/joint pin, screw, nail, wire plate, etc.
☐ Yes	☐ No	IUD, diaphragm, or pessary
☐ Yes	☐ No	Dentures or partial plates
☐ Yes	☐ No	Tattoo or permanent makeup
☐ Yes	☐ No	Body piercing jewelry
☐ Yes	☐ No	Hearing aid (remove before entering MRI system room)
☐ Yes	☐ No	Other implant _____
☐ Yes	☐ No	Claustrophobia

Name: _____ Date _____

Hazardous Drug Questionnaire

Name_____ Date_____

Job Title_____ Dept._____

This questionnaire will aid us in surveillance of healthcare workers who handle hazardous drugs.

Please answer the following questions:

Do you have any new and unexplained medical problems? □ YES □ NO

If yes, please describe:_____

History of: Malignancy □ YES □ NO Blood disorders □ YES □ NO Reproductive disorders □ YES □ NO

Present Work History

Hazardous drug handling □ YES □ NO Years_____ Hours per Week _____

Number of drug preparations/administrations per week _____

PPE provided □ YES □ NO Type _____

Description of Job Duties: _____

Past Work History

Hazardous drug handling □ YES □ NO Years _____ Hours per Week _____

Number of drug preparations/administrations per week _____

PPE provided □ YES □ NO Type _____

Description of Job Duties: _____

Use of Acronym: BE SAFE

- Be familiar with safety precautions for all hazardous drugs.
- Equip yourself with all recommended Personal Protective Equipment (PPE).
- Side-effects: Know which are exposure-related from handling hazardous drugs.
- Always use appropriate universal precautions.
- Follow all departmental policies and procedures.
- Exposures: Report all exposures immediately to your supervisor.