

Dear Community Member:

We are delighted that you have expressed an interest in becoming a Main Line Health volunteer!

Volunteers are our most valuable asset performing a variety of non-medical services in both patient and non-patient departments. Main Line Health volunteers come from all walks of life in the surrounding community, but all share the common goal of assisting our professional staff in providing the excellent patient care for which our facilities are known. They also enable us to provide services for both the patients and the community that could not be provided otherwise.

Our volunteers are an integral part of the Main Line Health family, and an assignment and schedule will be worked out for you depending upon your interests, skills, time availability and the needs of the hospital. We prefer our volunteers commit to at least 3 months of weekly volunteer service, however any offer of service will be considered and valued.

To facilitate your application, please follow these guidelines:

1. Fill out the application and return it to the Department of Volunteer Services at your desired location.
2. High school students are asked to give their references to a teacher, guidance counselor or someone who has supervised you. Please ask your references to return the forms to the Department of Volunteer Services at your desired location.

Once your application and both references are received and reviewed, the volunteer office will call you to schedule an appointment to discuss your interests and develop a placement.

We will look forward to meeting you and having you become a member of the MLH team!

Bryn Mawr Hospital, MLHC Newton Square

484-337-3058
BMHVolunteers@mlhs.org
130 S. Bryn Mawr Ave.
Bryn Mawr, PA 19010

Paoli Hospital, MLHC Exton, Collegeville, King of Prussia

484-565-1099
PHVolunteers@mlhs.org
255 W. Lancaster Ave.
Paoli, PA 19301

Bryn Mawr Rehabilitation Hospital

484-596-5599
BrynMawrRehabVolunteers@mlhs.org
414 Paoli Pike
Malvern, PA 19355

Riddle Hospital, MLHC Concordville

484-227-3170
RHVolunteers@mlhs.org
1068 W. Baltimore Pike
Media, PA 19063

Lankenau Medical Center, MLHC Broomall

484-476-2138
LMCVolunteers@mlhs.org
100 E. Lancaster Ave.
Wynnewood, PA 19096

Lankenau Institute for Medical Research

484-476-3440
Olshefskit@mlhs.org
100 E. Lancaster Ave
Wynnewood, PA 19096

Volunteer Office Requirements:

Clearances: All required clearances must be completed prior to your start date. Any potential cost will be the responsibility of the volunteer.

- Background Check*
- Child Abuse History Clearance Go to: www.compass.state.pa.us/CWIS/Public/Home to complete this requirement.*
- FBI Fingerprinting or attestation form. Your volunteer coordinator will notify you if you are expected to complete this requirement.*

Occupational Health Requirements:

Minor volunteers (15-17 years old) must complete the attestation of vaccination and have it signed by your physician or advanced practice provider. Please note, proof of vaccination must be readily available, if requested by the volunteer department. If minor volunteers commit to volunteering past the 3 month requirement, they will need to provide documentation of all required vaccinations to the volunteer office.

All minor volunteers are required to have the following:

- Send a copy (not the original) of your COVID 19 vaccination card.**
 - You must be fully vaccinated. To be fully vaccinated, one must be at least 2 weeks from their last dose in the series (if one dose required, then two weeks from that vaccination).
- You must comply with MLH TB screening process: QuantiFERON Gold Blood Test (QFT), Tuberculosis Form, and/or Positive TB Test Forms.** You are required to obtain a QFT. MLH will not accept PPD skin test. Testing can be facilitated through your primary care office or urgent care.
 - If a chest x-ray is needed, applicant will be asked to obtain this through their PCP.
- Physician Signed Attestation of Immunity**—Your primary care provider is required to attest that you have been fully vaccinated for Measles, Mumps, Rubella (German Measles), Varicella (Chicken Pox), Tdap, and Hepatitis B viruses. In addition, you provider must attest that you have been vaccinated for Influenza for the current flu season September – March 31st and has completed at least the primary series of covid-19 vaccination, as defined by the CDC and will be able to provide proof of vaccination or immunity status if requested.

Minor Volunteer Application

Please print all required information

Please select a preferred location:	<input type="checkbox"/> Bryn Mawr Hospital <input type="checkbox"/> Bryn Mawr Rehab Hospital <input type="checkbox"/> Lankenau Medical Center <input type="checkbox"/> Paoli Hospital <input type="checkbox"/> Riddle Hospital	<input type="checkbox"/> MLHC Broomall <input type="checkbox"/> MLHC Collegeville <input type="checkbox"/> MLHC Concordville <input type="checkbox"/> MLHC Exton Square <input type="checkbox"/> MLHC King of Prussia <input type="checkbox"/> MLHC Newtown Square
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Personal Information <input type="checkbox"/> Adult <input type="checkbox"/> College <input type="checkbox"/> High School <input type="checkbox"/> Court Directed				
Last Name	First Name	MI	Date of Birth / /	
Street Address		City	State	Zip
Home Phone	Cell Phone	Work Phone	Email Address	
Preferred method of communication <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Other (please specify)				
Have you ever been convicted of, or pled guilty to, a felony or misdemeanor? Conviction includes a guilty plea. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give exact details of conviction, offenses, where committed, sentencing court, date of sentence and nature of sentence. Please provide these details under separate cover. <i>Please note: A conviction will not necessarily disqualify you from volunteering but will be considered in relation to specific assignment.</i>				

Volunteer Experience:	Work Experience:
Why are you interested in becoming a volunteer at MLH? To facilitate the application process, please indicate if you have applied or volunteered at another facility within the Main Line Health System. <input type="checkbox"/> Yes (if so, where) _____ <input type="checkbox"/> No	Job Skills: _____ _____ _____ _____

Emergency Contacts		
Name	Relationship	Phone
Personal Physician	Phone	Address

Availability						
Available hours***	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat. - Sun.
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***Shift times fluctuate upon facility and departments

Attestation of Vaccination Applicants for Observing/Shadowing Experiences and Minor Volunteers

Applicant's Name: _____ DOB: _____

I attest that _____ (name of Applicant), has been fully vaccinated (per the CDC guidelines) OR has laboratory proof of immunity for the following. Please note, all observers and minor volunteers <18 years old may be required to provide documented proof of immunity to MLH, if requested.

- *Measles, Mumps, Rubella (German Measles)*
- *Varicella (Chicken Pox)*
- *Tdap*
- *Hepatitis B vaccination series (three documented vaccines and a titer > 10 mIU/mL)*
- *Tuberculosis QFT Test Compliance (See next page for documentation)*

I also attest that the above applicant has been **vaccinated for:**

- *Influenza for the current flu season September – March*
- *the primary series of Covid-19 vaccination, as defined by the CDC.*

I understand that these are requirements of Main Line Health for the above patient to participate in a shadowing/observation experience as defined as follows:

I certify that this statement about my patient's vaccination/immunity status is true and accurate. I understand that knowingly providing false information on this form regarding my patient's vaccination status may subject him/her/them to immediate dismissal from Main Line Health shadowing/observation opportunities.

Signature of Physician/Advanced Practice Provider

Date

Print Name

Physician/APP License Number

For Volunteer Coordinator Use Only

____ Main Line Health or Main Line Health Care premises (includes all minors < 18 years old)

____ Per an academic agreement, contract or understanding with Main Line Health System

____ Applicant observations (Human Resources and Department Manager Arrangement)



Main Line Health®

TUBERCULOSIS FORM

INFORMATION

Last Name:	First Name:	Middle Initial:
	DOB:	Date:

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS

Interferon Gamma Release Assay (IGRA)

Date Obtained <i>(Attach results of laboratory test):</i>	Please check one:	Result:	IF POSITIVE RESULT: See Chest X-Ray Information below.
	<input type="checkbox"/> T-Spot	<input type="checkbox"/> Negative	
	<input type="checkbox"/> Quantiferon	<input type="checkbox"/> Positive	
		<input type="checkbox"/> Indeterminate	

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS

Chest X-Ray Information: required if tuberculin skin test or IGRA test is positive. *(Copy of X-ray or IGRA must also be attached.)*

Date of Chest X-Ray <i>(must be done in the United States):</i>	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date treatment started: <i>(if abnormal results)</i>	Date treatment completed: <i>(if abnormal results)</i>
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HEALTH CARE EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this page (2) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	Phone:
Signature of Health Care Examiner:	Date:



Main Line Health®

Positive TB Test Symptom Screening Form

Full Name: *(Please print)* _____ Date: _____

DOB: _____

It is mandatory that this form be completed and kept in your clinical compliance file if you have a current or prior positive QFT. Please check either “Yes” or “No” to the questions below.

Please place a check (✓) your response.

Night Sweats (not related to heat or hot flashes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue/Tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough (productive or dry)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Loss (unplanned or greater than planned)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Signature: _____ Date: _____

Volunteer Application Agreement

Are you or have you ever been employed by any Main Line Health entity? Yes No

I certify that the information contained in this application is true and correct to the best of my knowledge and understand that any falsification, misrepresentation, or omission on this application is grounds for rejection of this application or for dismissal if such statement is discovered subsequent to an assignment.

I authorize a criminal background check to be conducted on me with the report to be provided to Main Line Entities (applicants over the age of 18 only)

I authorize any of the persons or organizations referenced in this application to give to Main Line Hospitals any and all information concerning my previous volunteer service, criminal background, or any other information they might have, personal or otherwise, with regard to any of the subjects covered by this application and release all such parties, Main Line Hospitals, Inc., its parent, affiliates, and their respective officers, trustees, directors, agents, and employees from any and all liability for damages for or in connection with the collection, use, release or disclosure of such information. I authorize Main Line Hospitals to request and receive such information.

I agree that if offered an assignment, I will consent to a health screening, including, but not limited, to Tuberculosis testing. I understand that my assignment is conditional upon the satisfactory results of this screening. I also understand I must comply with Main Line Hospitals' policy requiring an annual influenza vaccination.

I understand that I must be punctual and regular in attendance, helpful in my assignment and careful to honor the confidential nature of what I observe. I agree to comply with the rules, regulations, and policies of Main Line Hospitals and the Volunteer Services Department and acknowledge that these rules, regulations and policies may be changed, interpreted, withdrawn, or supplemented at any time, and without prior notice to me. I understand that my service as a volunteer is conditional based on need and satisfactory service, and that either I or Main Line Hospitals may terminate my volunteer service at any time, with or without notice, for any reason. I understand that I will not be compensated for my volunteer service and that being accepted for volunteer service does not give rise to or create an employment relationship with Main Line Hospitals.

Signature

Date

MAIN LINE HEALTH PROVIDES OPPORTUNITIES FOR VOLUNTEERISM WITHOUT DISCRIMINATION DUE TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, ANCESTRY, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENETIC INFORMATION OR HANDICAP.

STATEMENT OF RESPONSIBILITY AND CONFIDENTIALITY

I, _____, the undersigned, am the parent or legal guardian of _____ (minor's name), a minor, and for and in consideration of the benefit provided to _____ (minor's name) in the form of experience in the health care field at Main Line Hospitals, Inc., Riddle Memorial Hospital and/or any of their affiliates (hereinafter collectively referred to as "Facility"), I and my heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury, illness or loss sustained by _____ (minor's name) while they are participating in the experience at Facility unless such injury, illness or loss arises solely out of Facility's gross negligence or willful misconduct.

I and _____ (minor's name) hereby acknowledge that _____ (minor's name) has a responsibility under applicable state and Federal law and this Agreement to keep confidential a) any information regarding the patients of Facility, b) any sign on and password assigned to undersigned by Facility, and c) all confidential information of Facility. _____ (minor's name) agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility.

The following shall bind the person who has signed below. The undersigned agrees that this Statement of Responsibility and Confidentiality may be electronically signed and that any such electronic signature shall have the same legal effect as a handwritten signature. In addition, the undersigned agrees that when they sign and deliver this form to Facility, whether by hand delivery, email, fax, scan or any other means, this form becomes binding irrespective of whether Facility is in possession of the original signed copy.

Dated this ____ day of _____, 20__

Signature of Parent/Legal Guardian

Signature of Minor

Print Name

Print Name

Applicants Age 18 and Under

**INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORTS ONLY
(to be used for no other purposes)**

Please write legibly:

Full Name: _____

Date of Birth: ____/____/____ Social Security #----- _____

Primary Phone Number: _____ Email Address: _____

Driver's License Number: _____ State of Issue: _____

Current Address: _____
(Number and Street, Apt # if applicable)

City

State

Zip Code

List all Residence Addresses in Past Seven Years (attach additional sheets if necessary)

Please be advised that this sample form that we have provided is intended as general guidance and not legal advice. Please consult competent counsel for specific legal advice. We assume no legal liability for any use or reliance upon any of the information or documentation provided.

BACKGROUND SCREENING DISCLOSURE FORM [FOR EMPLOYMENT PURPOSES - MINORS]

Please be advised that a consumer report may be obtained on you for employment purposes (which includes independent contractors under the Fair Credit Reporting Act (FCRA)).

Consumer reports may be obtained at any time after the company receives your written authorization, including during the hiring process; and, during any subsequent period of employment you may have with the company, where permitted by law. *[Note to Drafter: California requires that a new background check authorization form be signed each time a consumer report is requested]*

Under the FCRA, consumer reports include any written, oral or other communication of information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or is expected to be used for employment purposes. Consumer reports may include credit reports, criminal records and driving records, among other forms of information obtained from private and public record sources.

By signing below, I acknowledge that I have read the above.

Minor Applicant Signature

Date

Minor Applicant Name

PARENT OR LEGAL GUARDIAN ACKNOWLEDGMENT

The undersigned parent(s) and/or guardian(s) of the applicant/employee hereby acknowledges that I/we have read the above disclosure statement.

Parent Name or Guardian Signature

Date

Printed Parent or Guardian Name

**[NOTE TO DRAFTER: THE REMAINDER OF THIS FORM IS
INTENTIONALLY LEFT BLANK]**

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STATE DISCLOSURES

Please be advised that a consumer report and/or investigative consumer report may be obtained on you for employment purposes. The consumer reporting agency that may provide the company with your report is:

Certiphi Screening, Inc. (“Certiphi”)
P.O. Box 541
Southampton, PA 18966
Telephone: (800) 260-1680
www.certiphi.com

Certiphi’s privacy practices with respect to the preparation and processing of consumer reports and/or investigative consumer reports may be found at <http://www.certiphi.com/privacy-policy/>.

For Maine Applicants & Residents

Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For Massachusetts Applicants & Residents

You have the right, upon request, to know whether the company ordered an investigative consumer report about you. You also have the right to ask the consumer reporting agency for a copy of any such report.

For Minnesota Applicants & Residents

You have the right in most circumstances to submit a written request to the consumer reporting agency for a complete and accurate disclosure of the nature and scope of any consumer report the company ordered about you. The consumer reporting agency must provide you with this disclosure within five (5) business days after its receipt of your request or the report was requested by the company, whichever date is later. If an investigative consumer report is obtained, such a report may include information obtained through personal interviews regarding your character, general reputation, personal characteristics, or mode of living.

For New Jersey Applicants & Residents

You have the right to submit a request to the consumer reporting agency for a copy of any investigative consumer report the company ordered about you.

For New York Applicants & Residents

You have the right, upon written request, to be informed of whether or not a consumer report and/or investigative consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

For Washington Applicants & Residents

If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You are entitled to this disclosure within five business days after the date your request is received or we ordered the report, whichever is later. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

California, Minnesota, and Oklahoma Applicants & Residents:

You have the right to receive a free copy of your background report. Please check this box if you would like a free copy of your report:

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CALIFORNIA DISCLOSURE DOCUMENT

The company may order an investigative consumer report on you in connection with your employment application, and if you are hired, or if you already work for the company, may order additional such reports on you for employment purposes.

Such reports may contain information about your character, general reputation, personal characteristics, and mode of living. With respect to any investigative consumer report, the Company may investigate the information contained in your employment application and other background information about you, which may include information concerning your employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, and professional credentials and licenses.

The consumer reporting agency (“CRA”), **CERTIPHI SCREENING, INC.**, will prepare the investigative consumer report for the company. The CRA’s address is **P.O. Box 541, Southampton, PA 18966** and can be reached at **(800) 260-1680**. The privacy policies for the CRA can be found at its Web site: <http://www.certiphi.com/privacy-policy/>.

SUMMARY OF RIGHTS UNDER CIVIL CODE SECTION 1786.22

(a) An investigative consumer reporting agency shall supply files and information required under Section 1786.10 during normal business hours and on reasonable notice.

(b) Files maintained on a consumer shall be made available for the consumer’s visual inspection, as follows:

(1) In person, if he or she appears in person and furnishes proper identification. A copy of his or her file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided.

(2) By certified mail, if he or she makes a written request, with proper identification, for copies to be sent to a specified addressee. Investigative consumer reporting agencies complying with requests for certified mailings under this section shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the investigative consumer reporting agencies.

(3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.

(c) The term “proper identification” as used in subdivision (b) shall mean that information generally deemed sufficient to identify a person. Such information includes documents such as a valid driver’s license, social security account number, military identification card, and credit cards. Only if the consumer is unable to reasonably identify himself or herself with the information described above, may an investigative consumer reporting agency require additional information concerning the consumer’s employment and personal or family history in order to verify his or her identity.

(d) The investigative consumer reporting agency shall provide trained personnel to explain to the consumer any information furnished him or her pursuant to Section 1786.10.

(e) The investigative consumer reporting agency shall provide a written explanation of any coded information contained in files maintained on a consumer. This written explanation shall be distributed whenever a file is provided to a consumer for visual inspection as required under Section 1786.22.

(f) The consumer shall be permitted to be accompanied by one other person of his or her choosing, who shall furnish reasonable identification. An investigative consumer reporting agency may require the consumer to furnish a written statement granting permission to the consumer reporting agency to discuss the consumer’s file in such person’s presence.

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CALIFORNIA APPLICANTS & RESIDENTS WHO WILL REQUIRE CREDIT REPORT REVIEW:

Please be advised that your credit may be reviewed as part of this application process. A consumer credit report may be obtained through Certiphi Screening, Inc., P.O. Box 541, Southampton, PA 18966, Telephone (800) 260-1680, www.certiphi.com.

Specifically, the basis for review pursuant to California law (Section 1024.5(a) of the Labor Code) is:

[SEE BELOW NOTICE FOR CATEGORIES AND CONTACT YOUR EMPLOYER FOR THE CATEGORY THAT APPLIES TO YOU].

You have the right to receive a free copy of your consumer credit report. Please check this box if you would like a free copy of your report:

**Special Notice for Consumer Credit Report Review
CALIFORNIA LABOR CODE SECTION 1024.5**

California's new labor code provision severely restricts an employer's ability to conduct credit checks on employees. Labor Code 1024.5 only allows employers to conduct credit checks for employees who meet one of the following categories:

- A managerial position.
- A position in the State Department of Justice.
- That of a sworn peace officer or other law enforcement position.
- A position for which the information contained in the report is required by law to be disclosed or obtained.
- A position that involves regular access, for any purpose other than the routine solicitation and processing of credit card applications in a retail establishment, to all of the following types of information of any one person:
 - (A) Bank or credit card account information.
 - (B) Social security number.
 - (C) Date of birth.
- A position in which the person is, or would be, any of the following:
 - (A) A named signatory on the bank or credit card account of the employer.
 - (B) Authorized to transfer money on behalf of the employer.
 - (C) Authorized to enter into financial contracts on behalf of the employer.
- A position that involves access to confidential or proprietary information, including a formula, pattern, compilation, program, device, method, technique, process or trade secret that (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who may obtain economic value from the disclosure or use of the information, and (ii) is the subject of an effort that is reasonable under the circumstances to maintain secrecy of the information.
- A position that involves regular access to cash totaling ten thousand dollars (\$10,000) or more of the employer, a customer, or client, during the workday.

EXEMPT INDUSTRIES: This section does not apply to a person or business subject to Sections 6801 to 6809, inclusive, of Title 15 of the United States Code and state and federal statutes or regulations implementing those sections if the person or business is subject to compliance oversight by a state or federal regulatory agency with respect to those laws. Sections 6801 to 6809 include the following industries (which are excluded from this law):

- National banks, Federal branches and Federal agencies of foreign banks, and any subsidiaries of such entities (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Office of the Comptroller of the Currency;
- Member banks of the Federal Reserve System (other than national banks), branches and agencies of foreign banks (other than Federal branches, Federal agencies, and insured State branches of foreign banks), commercial lending companies owned or controlled by foreign banks, organizations operating under

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section 25 or 25A of the Federal Reserve Act [12 U.S.C. 601 et seq., 611 et seq.], and bank holding companies and their nonbank subsidiaries or affiliates (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Board of Governors of the Federal Reserve System;

- Banks insured by the Federal Deposit Insurance Corporation (other than members of the Federal Reserve System), insured State branches of foreign banks, and any subsidiaries of such entities (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Board of Directors of the Federal Deposit Insurance Corporation; and
- Savings associations the deposits of which are insured by the Federal Deposit Insurance Corporation, and any subsidiaries of such savings associations (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Director of the Office of Thrift Supervision.
- Under the Federal Credit Union Act [12 U.S.C. 1751 et seq.], by the Board of the National Credit Union Administration with respect to any federally insured credit union, and any subsidiaries of such an entity.
- Under the Securities Exchange Act of 1934 [15 U.S.C. 78a et seq.], by the Securities and Exchange Commission with respect to any broker or dealer.
- Under the Investment Company Act of 1940 [15 U.S.C. 80a-1 et seq.], by the Securities and Exchange Commission with respect to investment companies.
- Under the Investment Advisers Act of 1940 [15 U.S.C. 80b-1 et seq.], by the Securities and Exchange Commission with respect to investment advisers registered with the Commission under such Act.
- Under State insurance law, in the case of any person engaged in providing insurance, by the applicable State insurance authority of the State in which the person is domiciled, subject to section 6701 of this title.
- Under the Federal Trade Commission Act [15 U.S.C. 41 et seq.], by the Federal Trade Commission for any other financial institution or other person that is not subject to the jurisdiction of any agency or authority under paragraphs (1) through (6) of this subsection.

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BACKGROUND SCREENING AUTHORIZATION FORM [FOR EMPLOYMENT PURPOSES - MINORS]

Please be advised that we may also obtain an *investigative consumer report* including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting and/or conducting personal interviews with your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., is available at the Federal Trade Commission's web site (<http://www.ftc.gov>). For more information, including information about additional rights, go to www.consumerfinance.gov/ or write to: Consumer Financial Protection Bureau, PO Box 4503, Iowa City, IA 52244.

By signing below, I hereby authorize the company to obtain a consumer report and/or an investigative consumer report on me, and further authorize all entities having information necessary to complete a consumer report and/or investigative consumer report on me to release such information to the company or any of its affiliates or carriers, including: present and former employers; personal references; criminal justice agencies; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; departments of motor vehicles and motor vehicle records agencies; schools and learning institutions; licensing agencies; and credit bureaus and credit reporting agencies.

By signing below, I acknowledge the information that can be disclosed to the consumer reporting agency, if and only as allowed by law, includes information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, and professional credentials and licenses.

By signing below, I acknowledge and agree that this Background Screening Authorization Form shall remain valid and in effect during the term of my contract and/or employment, subject to applicable laws, and authorize the company to obtain a consumer report and/or an investigative consumer report on me during the hiring process as well as at any time during the term of my employment and/or contract, where permitted by law.

Minor Applicant Signature

Date

Minor Applicant Name

PARENT OR LEGAL GUARDIAN ACKNOWLEDGMENT AND AUTHORIZATION

The undersigned parent(s) and/or guardian(s) of the applicant/employee hereby agree with the applicable statements in this BACKGROUND SCREENING AUTHORIZATION FORM. By signing below, I/we fully provide consent on behalf of my/our minor child to authorize a background check for purposes of this Authorization.

Parent Name or Guardian Signature

Date

Printed Parent or Guardian Name

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Para información en español, visite www.consumerfinance.gov/learnmore o escribe al Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

Please be advised that this sample form that we have provided is intended as general guidance and not legal advice. Please consult competent counsel for specific legal advice. We assume no legal liability for any use or reliance upon any of the information or documentation provided.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or in some cases a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

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TYPE OF BUSINESS:	CONTACT:
<p>1. a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street N.W. Washington, DC 20552</p> <p>b. Federal Trade Commission: Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Administration area supervisor</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549</p>
<p>8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357</p>

Certiphi Screening, Inc.
A Vertical Screen® Company
Attn: Consumer Disclosure
P.O. Box 541, Southampton, PA 18966
Toll-free phone – 800-260-1680

**BRYN MAWR HOSPITAL BRYN MAWR REHAB LANKENAU MEDICAL CENTER PAOLI HOSPITAL
RIDDLE HOSPITAL**

Working Together to Serve the Community

All community volunteers are asked to sign a Volunteer Agreement. This implies commitment to volunteer service.

As a community volunteer, I understand that I am expected to:

1. Hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients and staff and not seek to obtain confidential information from a patient.
2. Become familiar with the hospital's policies and procedures and uphold its mission and values.
3. Donate my services to the hospital without contemplation of compensation or future employment.
4. Be punctual and conscientious, conduct myself with dignity, courtesy, and consideration of others and endeavor to make my work professional in quality.
5. Adhere to professional dress code including wearing the hospital issue ID and jacket.
6. Complete orientation and send health screening information as needed.
7. Carry out assignments and seek the assistance of the volunteer supervisor when necessary.
8. Take any problems, criticism, or suggestions to my volunteer supervisor.
9. Work the shift and department as indicated by the needs.
10. Adhere to the department's sign-in procedures.
11. **I understand that COVID-19 testing/treatment will not be covered by MLH either directly or under any MLH insurance policy or program.**
12. **Notify the Volunteer Office if I am unable to volunteer.**
13. I understand that any observed or reported inappropriate behavior will be addressed as soon as possible after occurrence before it should become habitual through silence and tacit approval.
14. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of (a) failure to comply with hospital policies, rules, and regulations; (b) absences without prior notification; unsatisfactory work, or appearance, or (d) any circumstance which, in the judgment of the hospital, would make continued presence as a volunteer contrary to the best interests of the hospital.

I have read each of the above statements, and I have been given the opportunity to ask questions so that I understand each statement.

Volunteer Signature: _____ Date: _____

Department Representative: _____ Date: _____

Revised 7/6/2021.

High School Volunteer Reference

(family references not permitted)

School Guidance Counselor or Teacher Recommendation

Name of Student: _____

The above student has expressed an interest in the High School Volunteer Program at Main Line Health.

Because of the concern we have for our patients' welfare as well as the students' well-being, we are interested in the following information regarding each applicant.

I WOULD RATE THE ABOVE STUDENT AS FOLLOWS:	GOOD	FAIR	POOR
Ability to Follow Instructions			
Ability to Follow Through on Assignments			
Attendance			
Cooperation with Adults			
Cooperation with Peers			
Degree of Responsibility			
General Appearance (Neat & Clean)			
Reliability			
Comments			

Thank you for your cooperation in making this information available to us. It will be kept in strict confidence.

I Do ____ I Do Not ____ recommend this student.

Name: _____ Title: _____

School: _____

Signature: _____ Date: _____

Parental Permission for School to Release Information

I give my permission to (Name of School) _____ to release information on my son/daughter requested by the Volunteer Department of Main Line Health.

Signature (Parent or Guardian)

Date

High School Volunteer Reference

(family references not permitted)

Letter Recommendation for High School Volunteer Program

NAME _____ DATE _____
Last First Middle

ADDRESS _____

CITY, STATE, ZIP CODE _____

SCHOOL _____

The above applicant is a candidate for admission to the High School Volunteer Program at Main Line Health. Please use your judgment to comment on the following, which assesses potential, maturity, and personal competencies of the applicant. Your cooperation in completing and returning this recommendation is greatly appreciated. Thank you for your time and consideration.

1. How long have you known this applicant? _____
In what capacity do you know the applicant? _____
2. Is the applicant self-motivated and does he/she follow through?

3. Dependability _____
4. Appearance _____
5. Additional comments _____

6. To the best of your knowledge would you recommend this applicant for the
Main Line Health Volunteer Program? _____

Name: _____

Address: _____

Telephone: _____

Relationship to applicant _____

Signature

Date

FAQ

Frequently Asked Questions

QuantIFERON - TB Gold in-Tube test (QFT)

Q: What is QuantIFERON TB Gold in-Tube test?

A: QuantIFERON - TB Gold in-Tube is an accurate, blood test that provides results showing if someone is either infected or not with the TB bacterium. QFT is unaffected by previous BCG vaccinations and most other environmental mycobacteria.

Q: Why is the QuantIFERON test better than the TB skin test?

A: The results through QFT are shown to be more accurate at detecting a tuberculosis infection than a TB skin test. A traditional TB skin test requires multiple visits to complete. A TB skin test may also result in false positives due to cross-reactivity with the BCG vaccination or responses to environmental mycobacteria. These and other limitations have shown QFT to be the most effective and best alternative to TB skin testing.

Q: What are the benefits of the QuantIFERON® - TB Gold in-Tube test?

A: Some of the benefits include:

- Requires only one visit
- Does not compromise previous test results
- Is a controlled laboratory test
- Is objective and not affected by interpretation
- Results can be available in as little as 72 hours

Q: Is the QuantIFERON test approved by the CDC and FDA for TB testing?

A: Yes, both the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) have approved the use of the QuantIFERON - TB Gold in-Tube test (QFT).

Q: Who at Main Line Health will be required to receive the QuantIFERON test?

A: Currently, all new-hires of Main Line Health are receiving the QFT test, and Main Line Health will be transitioning all annual tuberculosis required employees and volunteers to the QFT test beginning July 1, 2012.

Q: I am a MLH employee who is currently required to complete an annual PPD Skin Test, will I need to complete the QuantIFERON test?

A: Infection Control is currently working to redefine which employees at MLH will be required to complete an annual tuberculosis test. If it is determined that your position *will* require an annual tuberculosis test to be completed, you will be required to complete the QuantIFERON test instead of the PPD Skin Test.

Q: I have a history of a past-positive PPD and normally complete an annual Positive PPD Questionnaire, will I be required to complete the QuantIFERON test for medical surveillance?

A: Yes, you will be required to receive the QuantIFERON test initially which will determine if you are a confirmed positive. If you are confirmed as a positive, you will be required to continue annual monitoring, regardless if your position is taken off the annual requirement list by Infection Control. If you are confirmed negative by the QFT test, the Infection Control guidelines will determine if you are required to complete an annual tuberculosis test.

Q: Where will the QuantIFERON test be offered?

A: Currently, the QFT test is being offered at the Paoli and Lankenau Occupational Health offices. Other testing locations are as listed on the QFT instructions sheet.

Additional Questions?

Please contact Occupational Health at 484-565-1293 and someone will assist you.



Main Line Health
Well ahead.SM