STEVENS COMMUNITY
MEDICAL CENTER
Caring is our Reason for Being

400 E. First Street
Morris, MN 56267
phone 320.589.1313
scmcinc.org

Dear Prospective Volunteer,

Thank you for your interest in volunteering at Stevens Community Medical Center. Our vision here at SCMC is "Continued excellence through compassionate patient centered care". Volunteering is a wonderful way for you to help others, and your desire to be a volunteer shows your support of the work we do here. We have a variety of volunteer opportunities as well as many areas to shadow. Benefits of joining our team include complimentary lunch while volunteering, invitation to our recognition events and more.

Due to the serious nature of volunteering in healthcare, there are several steps to our screening process. We ask volunteers to do the following:

- ☐ Complete the Volunteer Application
- ☐ Criminal Background Check (fingerprinting if required)
- ☐ Provide copy of photo ID
- ☐ Confidentiality Agreement & HIPAA Video
- ☐ Up-to-date Immunization Records
- ☐ Provide proof of Covid Vaccination or request a Religious or Medical Disability Exemption to be reviewed by SCMC's exemption committee.
- ☐ Negative Mantoux or Quantiferon Test within the past 3 months (provided)

If you are ready to join the team at SCMC, please submit your completed application forms to our Community Outreach Coordinator via email at nolson@scmcinc.org or mail to SCMC Attn: Nancy Olson. After receiving your complete application, we will contact you about the next step in finding a place here for you.

Again, thank you for your sincere interest in contributing to the experience of patients and families at Stevens Community Medical Center. If you have any questions, please don't hesitate to contact my office.

Sincerely,

Nancy Olson
Community Outreach and Employee Recognition Coordinator | Human Resources
Direct phone 320-208-7803 | nolson@scmcinc.org

STEVENS COMMUNITY MEDICAL CENTER

400 E. First Street Morris, Minnesota 56267-0660 Phone (320) 589-1313

Volunteer and Student Application Form

Please return this form to:
Stevens Community Medical Center: Community Outreach Email: nolson@scmcinc.org, *Email is not generally considered to be secure*
Phone: 320-208-7803

Full Name (first, middle, last) _____

Mailing Address: _____

Phone Number: _____

Email: _____

Emergency Contact: _____Relationship:_____Phone: _____

Have you ever worked at Stevens Community Medical Center or Courage Cottage? YES / NO
Are you a UMM Student applying to volunteer to become eligible to shadow: YES / NO
If yes, please tell us the type of provider you hope to work with:
_____
Are you a student applying for a professional student internship/clinical/rotation/residency? YES / NO
Are you a general community member looking to contribute to SCMC and volunteer YES / NO

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning (before noon)							
Afternoon (after 1:00)							
Evening (after 5:00)							
Specific Time							
Specific Time							

Volunteer interests please check all that apply:

□ Gift Shop
□ Screening Desk
□ Fundraising Activities
□ Patient Escort - procedures
□ Courage Cottage Resident Activities
□ Cleaning Equipment
□ Administrative Support
□ Lab
□ Community Activities

STEVENS COMMUNITY MEDICAL CENTER
400 East First Street Morris, Minnesota 56267-0660 Phone (320) 589-1313 Fax (320) 589-7686

Stevens Community Medical Center
MN Department of Human Services Background Study Form

Minnesota law requires that all persons having patient contact must have a background study completed prior to having any patient contact. Fingerprinting is now part of this process. Please be sure you have also received the Background Study Privacy Notice. Additional information regarding the MN requirement for background study can be found at http://mn.gov/dhs/general-public/background-studies/.
In order to complete the background study, the following information is needed.

❒Attach a copy of your Minnesota Driver's license or other government issued ID.

Full Name (first, middle, last): _____

Previous Names (both first and last): _____

Permanent Address: _____

_____

Mailing Address: ❒ Check if same as Permanent

_____

_____

Have you lived in any U.S. state outside of Minnesota within last five years? ❒ No ❒ Yes
If yes, please provide:

City	State	Date Range

Birth date: _____ Place of Birth: _____ Gender: ❒ Female ❒ Male

Height: _____ Weight: _____ Eye color: _____ Hair color: _____

MN Driver's License or Authorized ID number: _____ Exp. Date: _____

Social Security Number: _____ E-mail: _____

Race: ❒ African American ❒ Asian or Pacific Islander ❒ White
❒ Hispanic/Latino ❒ Native American ❒ Unknown/Other

I have received/reviewed the Background Study Privacy Notice and consent to the background study. Fingerprinting is required. I understand I will have 7 days to be fingerprinted from the time this study is initiated. (If previous fingerprinting can be used by SCMC, no additional fingerprinting is required.)

_____ _____
Signature Date

Please return this form to:
Stevens Community Medical Center
Attn: Nancy, Community Outreach
400 East First Street
Morris, MN 56267

Nancy Olson direct phone: 320-208-7803
Fax to: 320.589.7686
Email: nolson@scmcinc.org
Email is not generally considered to be secure

DEPARTMENT OF HUMAN SERVICES

BACKGROUND STUDY NOTICE OF PRIVACY PRACTICES

Because the Department of Human Services (DHS) is asking you to provide private information, you have privacy rights under the Minnesota Government Data Practices Act. This law protects your privacy, but also allows DHS to give information about you to others when the law requires it. This notice describes how your private information may be used and disclosed, and how you may access your information.

Why is DHS asking me for my private information?

A background study from the Department of Human Services (DHS) is required for your job or position. Private information is needed to conduct the background study.

How will I be notified that a background study was submitted on me?

DHS will mail you a notice within three working days after a request for a background study is submitted on you. The notice will contain the background study result or let you know that more time is needed to complete the background study. The notice will also identify the entity that submitted the background study request.

What information must I provide to complete the background study?

You are required to provide enough information to ensure an accurate and complete background study. This includes your:

- first, middle, and last name and all names you have ever been known by or used;
- current home address, city, zip code, and state of residence;
- previous home addresses, city, county, and states of residence for the last five years;
- sex and date of birth;
- driver's license or other identification number, and;
- fingerprints and a photograph, as required by law.

How will the information that I give be used?

The information will be used to perform a background study that will include a check to determine whether you have any criminal records and/or have been found responsible for substantiated maltreatment of a vulnerable adult or child. Background study data is classified as "private data" and cannot be shared without your consent except as explained in this notice.

What may happen if I provide the information?

You could be disqualified from positions that require a DHS background study if you are found to have committed certain crimes, been determined responsible for maltreatment of a vulnerable adult or child, or have other records that require a disqualification. If you do not have a disqualifying record, you will be cleared for your job or position.

What if I refuse to provide the information?

You will be disqualified if you refuse to provide information to complete an accurate background study. You will not be able to work in a position that requires a DHS background study.

Who will DHS give my information to?

DHS will only share information about you as needed and as allowed or required by law. The identifying information you provide will be shared with the Minnesota Bureau of Criminal Apprehension and in some cases the Federal Bureau of Investigation (FBI). If there is reasonable cause to believe that other agencies may have information related to a disqualification, your identifying information may also be shared with:

- county attorneys, sheriffs, and agencies;
- courts and juvenile courts;
- local police;
- the Office of the Attorney General, and;
- agencies with criminal record information systems in other states.

What information will DHS share with the entity that requested my background study?

The entity that requested the background study will be notified of your background study determination.

If you are disqualified, the entity will not be told the reason unless you were disqualified for refusing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

What other entities might DHS share information with?

Information about your Background study may be shared with:

- the Minnesota Department of Health;
- the Minnesota Department of Corrections;
- the Office of the Attorney General, and;
- health-related licensing boards.

What if my disqualification is set aside?

If you request reconsideration of your disqualification and your disqualification is set aside, the entity that requested the background study will be informed of the reason(s) for your disqualification unless the law states otherwise. DHS will provide information about the decision to set aside your disqualification if the entity requests it.

Unless prohibited by law, your name and the reason(s) for your disqualification will become public data if your set aside is for:

- a child care center or a family child care provider licensed under chapter 245A, or;
- an offense identified in section 245C.15, subdivision 2.

For future background studies submitted by entities that provide the same type of services as the services you were set aside for, the set aside will apply unless:

- you were disqualified for an offense in section 245C.15, subdivision 1 or 2, or;
- DHS receives additional information indicating that you pose a risk of harm, or;
- your set aside was limited to a specific person receiving services.

In addition, those entities will be informed of the reason(s) for your disqualification unless prohibited by law.

Will my fingerprints be kept?

DHS and the Bureau of Criminal Apprehension will not keep your fingerprints. If an FBI check is required for your background study, the Federal Bureau of Investigation (FBI) may keep your fingerprints and may use them for other purposes in accordance with state and federal law.

What information can the fingerprint and photo site view and keep?

The fingerprint and photo site can view identifying information to verify your identify. The fingerprint and photo site will not keep your fingerprints, photo, or most other information. The fingerprint and photo site can keep your name and the date and time your fingerprints were recorded and sent, for auditing and billing purposes.

Who can see my photo?

Your photo will be kept by DHS. If you provide your social security number to allow your background study to be transferable to future entities, your photo will be available to those entities to verify your identity.

What are my rights about the information you have about me?

- You may ask if we have information about you and request in writing to get copies. You may have to pay for copies.
- You may give other people permission to see and have copies of private information about you.
- You may ask (in writing) for a report that lists the entities that submitted a background study request on you.
- You may ask in writing that the information used to complete your background study be destroyed. The information will be destroyed if you have:

  (1) not been affiliated with any entity for the previous two years, and;
  (2) no current disqualifying characteristic(s).

Please send all written requests to:

Minnesota Department of Human Services
Background Studies Division
NETStudy 2.0 Coordinator
PO Box 64242
St. Paul, MN 55164-0242

How long will DHS keep my background study information?

DHS will destroy:

- your photo when you have not been affiliated with an entity for two years.
- any background data collected on a you after two years following your death or 90 years after your date of birth, except when readily available data indicates that you are still living.

What is the legal authority for DHS to conduct background studies?

Background studies are completed by DHS according to the requirements in Minnesota Statutes, chapter 245C. Background studies are authorized under Minnesota Statutes, sections 256B.0943, subdivision 5a; 256B.0659, subdivision 11(a)(3); 241.021, subdivision 6(a);144.057, subdivision 1; 518.165, subdivision 4, and 524.5-118;

What if I think my privacy rights have been violated?

You may report a complaint if you believe your privacy rights have been violated. If you think that the Minnesota Department of Human Services violated your privacy rights, you may send a written complaint to the Minnesota Department of Human Services, Privacy Official at:

Minnesota Department of Human Services
Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

DEPARTMENT OF HUMAN SERVICES

Minnesota law requires some background studies conducted by the Department of Human Services (DHS) to include a fingerprint-based Federal Bureau of Investigation (FBI) record check. The FBI requires that you be provided the following Privacy Act Statement if a FBI record check is conducted as part of your DHS background study.

FBI Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBIs Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Your Rights

You have the right to directly obtain your FBI record and to work with the FBI to correct your record if it is wrong. You are not required to do this, but if you want to you must send your fingerprints and a fee to the FBI. Information about the process is on the FBI's web site at https://www.fbi.gov/services/cjis/identity-history-summary-checks

If your background study results in a disqualification, you will be provided with information about how to ask DHS for reconsideration of the determination. At that time, you may inform DHS that the information used was wrong (this is a correctness review) and/or that the disqualification should not apply (this is a risk of harm review).

STEVENS COMMUNITY MEDICAL CENTER
400 East First Street ● Morris MN 56267
Phone # 320.589.7642 ● Fax # 320.589.1065

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	**NAME:** _____ **DATE OF BIRTH:** _____ **Previous / Maiden Name:** _____ **Address:** _____ **Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.**	**NAME:** Minnesota Immunization Information Connection and/or Stevens Community Medical Center **Address:** 400 East First Street **Phone:** 320-589-7642 **City:** Morris **Fax:** 320-589-1065 **State:** MN **Zip:** 56267
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	**NAME:** Stevens Community Medical Center **Attention to:** Human Resources **Address:** 400 East First Street **Phone:** 320-589-7642 **City:** Morris **Fax Number:** 320-589-1065 **(HEALTHCARE FACILITY ONLY)** **State:** MN **Zip:** 56267
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	Routine Records **Service Dates: From:** _____ **To:** _____ □ Clinic (office visit, lab, radiology, medicines, immunizations) □ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) □ Billing Records □ Copies of Films / Images □ Alcohol and / or Drug Treatment records □ HIV/AIDS □ STD □ Mental Health (Psychotherapy Notes – require a separate release) **Only check record types to be released below:** □ Discharge Summary □ Progress Notes/ Clinic Notes □ Emergency Record(s) ■ Immunization Record □ History & Physical Exam □ Rehab Records (PT/OT/ST) □ X-ray / Radiology Reports □ Allergy / Immunology Record □ Operative Report □ Laboratory Reports □ EKG / Echo / Cardiology □ **Entire Medical Record** □ Consultations □ Pathology Reports □ Medication Records □ Other records specify record type(s) _____ OPTIONAL Limits – Disclose only records related to following injury or illness: _____
Release Instructions (***How*** and ***When*** do you want the information?)	**Date information is needed:** asap **(NOTE: PLEASE ALLOW 5 - 7 DAYS FOR PROCESSING)** **Release Method / Format requested: (check one)** **□ Mail □ View my Record □ Fax (patient care only) □ Pickup – picture ID may be required. If someone other than you are picking up your records, print their name here:** _____
Purpose of Release (***Why*** is it needed?)	□ **Continuing care** □ **Transfer of care** □ **Social security appeal** □ **Insurance application*** ■ **Personal use or review*** □ **Social security disability determination*** □ **Insurance payment/claim** □ **Litigation/legal*** ***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524**

This authorization lasts for **one year** after the date you sign it unless you enter a different date or expiration here: _____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Stevens Community Medical Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Stevens Community Medical Center will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Stevens Community Medical Center records may include records that it received from other organizations. If these records have been used by Stevens Community Medical Center and filed in the record Stevens Community Medical Center maintains about you, these records may be released with your Stevens Community Medical Center records.
- Stevens Community Medical Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, and that information, you release Stevens Community Medical Center from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____
Patient / Legal Guardian Signature Date

_____ _____
Authority to act on behalf of patient (attach document) Date

Routing: Scan into Chart Maxx
(Auth for Release of Info - S) → Shred

him9a (12-99) rev 1-19

DT0069

STEVENS COMMUNITY MEDICAL CENTER

INFECTIOUS DISEASE AND IMMUNIZATIONS

Name: _____ Dept. hired for: _____

Date of Birth: _____ Place of Birth: _____

Places you have lived outside USA: _____

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS. **CHECK ALL ANSWERS THAT APPLY TO YOU.**	**DO NOT WRITE IN THIS COLUMN**
Tuberculosis (TB) ____ I have never had a skin test for TB (Mantoux). ____ I have had a negative skin test for TB. ● MDH requires all new employees that provide direct patient care to have a 2-step Mantoux. If you have a **documented** (neg) Mantoux test result < 3 months old then only 1 additional Mantoux is required or a **documented Quantiferon test result** ● MDH requires non direct patient care givers to provide **1 documented Mantoux test result** < 3 months old or a **Quantiferon test result** ____ I have had a Quantiferon test. Results: +_____ -_____ Date: _____ ____ I have had a positive test for TB. ❒ not treated ❒ treated with isoniazid (INH) or other medication ❒ chest x-ray Date: _____ ____ I have received BCG vaccine. (uncommon in U.S) ____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe: _____	
Measles, Mumps, Rubella (MMR) ____ I was born before January 1, 1957 ____ I had Measles. ❒ Yes ❒ No Documented Date: _____ ____ I have had Mumps. ❒ Yes ❒ No Documented Date: _____ ____ I have had Rubella. ❒ Yes ❒ No Documented Date: _____ ____ I have had MMR vaccine. ❒ Yes ❒ No Documented Dates: _____; _____ (2 dates required) Ever had a lab test to determine immunity to measles, mumps, rubella? ❒ Yes ❒ No If yes, documentation required.	MMR Vaccine Given: Place: _____ Date: _____ Monovalent (measles) Vaccine Given: Place: _____ Date: _____ Titer Drawn: _____ Date: _____ Result: Immune Susceptible
Hepatitis B ____ I have had Hepatitis B. If yes, date _____ ____ I have had the Hepatitis B vaccine. **If yes, documentation required.** Dose 1 _____ Dose 2 _____ Dose 3 _____ Other (describe): _____ ____ I have been tested for Hepatitis B antibody. If yes, date: _____ Documented required. ____ I don't know if I have had Hepatitis or been vaccinated.	Hep B Series Started: ❒ Yes ❒ No Declination Signed: ❒ Yes ❒ No Other: _____
COVID-19 Vaccine ____ I have had the COVID-19 vaccine. **If yes, documentation required.** If yes, date(s): Dose 1: _____ Dose 2: _____ Booster: _____ Manufacturer: _____ ____ I have requested a Medical Exemption SCMC Approval Date: _____ ____ I have requested a Religious Exemption SCMC Approval Date: _____	

STEVENS COMMUNITY MEDICAL CENTER
INFECTIOUS DISEASE AND IMMUNIZATIONS

Tetanus/Diphtheria/Pertussis ____ I had a primary series of 3 or 4 doses of Td, or Tetanus vaccine. _____ Date of last tetanus vaccine "booster" _____ Date of last documented Tdap vaccine _____ Dates Unknown ____ I have had the following immunizations/vaccines: ❒ Oral polio Date: _____ ❒ influenza vaccine Date: _____ ❒ pneumococcal vaccine Date: _____	Td booster advised Q 10 yr: _____ _____ _____
Chickenpox ____ I have had chickenpox. If yes, at what age? _____ ____ My children have had chickenpox while living with me. ____ I have had chickenpox vaccine. ❒ Yes ❒ No Documented Dates: _____; _____ (2 dates required) ____ I have been tested for chickenpox antibodies. Date:_____ Was test: ❒ positive ❒ negative ❒ don't know Where tested: _____ ____ I don't know if I have had Chickenpox or been vaccinated. ____ I have had Shingles (also called Herpes Zoster) ____ I have had Shingles vaccine. ❒ Yes ❒ No Date: _____ ____ I have had Varicella lab test. ❒ Yes ❒ No If yes, documentation required.	Titer Drawn: _____ Date: _____ Result: Immune Susceptible Advised to call EOHS if exposed. ❒ Yes ❒ No
Hepatitis A ____ I have had Hepatitis A. ____ I have had the Hepatitis A Vaccine. ❒ Yes ❒ No If yes, approximate dates: Dose 1 _____ Dose 2 _____ ____ I am currently recovering from Hepatitis A. ____ I have recently been exposed to Hepatitis A.	
Hepatitis C ____ I have had Hepatitis C ____ I have been tested for Hepatitis C antibody. If yes, date: _____ Where tested: _____ Was test: ❒ positive ❒ negative ❒ don't know. If positive, documentation required.	
Herpes ____ I get cold sores or Herpetic Whitlow (finger infection with Herpes) ____ I have never had cold sores or Herpetic Whitlow (finger infection with Herpes)	Need for work restrictions assessed _____ _____
Other Do you have any skin disorders (i.e. eczema, latex allergies)? ❒ Yes ❒ No Have you had problems with back injury, hernias, vision, or hearing? ❒ Yes ❒ No If yes, please specify and explain _____ _____ Are there any past or present disease processes which could predispose you to infection or injury while working? _____	

_____ _____
Employee Signature Date

_____ _____
Infection Control Nurse Signature Date

Routing: Employee to fill out → retained in employee file (Employee Health / Med Staff Credentialing)

STEVENS COMMUNITY
MEDICAL CENTER

Attestation Form

I verify that the Covid-19 vaccination information I am submitting is complete and accurate to the best of my knowledge and I understand that any misrepresentation contained may result in disciplinary action.

Please mark one of the following options:

____ Attached is a copy of proof of my Covid-19 vaccination.

____ I received my Covid-19 vaccination in Minnesota and I hereby authorize release of my immunization information to SCMC's HR Department.

Signature: _____ Date: _____

Name (please print): _____

==========
==========

Date Form Received: _____

STEVENS COMMUNITY
MEDICAL CENTER

Attestation Form

I verify that the Covid-19 Booster dose information I am submitting is complete and accurate to the best of my knowledge and I understand that any misrepresentation contained may result in disciplinary action.

Please mark one of the following options:

____ Attached is a copy of proof of my Covid-19 booster dose(s).

____ I received my Covid-19 booster dose(s) in Minnesota and I hereby authorize release of my immunization information to SCMC's HR Department.

____ I have not received any Covid-19 booster dose(s) as of: _____

Signature: _____ Date: _____

Name (please print): _____

==========
==========

Date Form Received by SCMC HR: _____