PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

CONSENT TO PRE-EMPLOYMENT PHYSICAL EXAMINATION AND TESTING

I am an applicant to be a volunteer at St. Luke's University Health Network and/or its subsidiaries, affiliates, or other related business entity (collectively, the "Network"). I hereby affirm the information provided on the volunteer tuberculosis questionnaire and immunization history are true and complete to the best of my knowledge. I also agree that any falsified information or material omission (including but not limited to any undisclosed impairment, condition and/or prescribed medication), may disqualify me from further consideration for volunteer services by the Network and may result in disciplinary action, up to and including discharge, if subsequently discovered during my role as a volunteer.

I understand that my volunteer health evaluation is solely for the determination of volunteer status or ability to perform duties at a Network entity or campus; it is not to diagnose any new condition or provide medical care or treatment of any kind. I understand that it does not take the place of a personal/primary care provider's ("PCP") health care examination or treatment plan and I understand that I must return to my PCP for any such care or treatment.

I understand I will be tested for tuberculosis. If the result indicates infection, further testing will need to be completed to determine if I can perform the essential functions of my volunteer role with or without reasonable accommodation.

I understand I will be screened for immunity to several communicable diseases through laboratory testing. If the laboratory test determines I am not immune, I understand I must be immunized PRIOR to my start date. I understand that ALL Network volunteers are required to be immune to rubella, rubeola(measles), mumps, and varicella. I also understand that all Network volunteers are required to have a Tdap vaccine within the past 10 years. Volunteers are referred to their provider for required immunizations and responsible for determining if personal health insurance will cover the associated costs. If out of pocket charges are expected, I can contact Volunteer Services to be provided with low cost options. Influenza vaccinations are required for all Network volunteers, and will be offered at predetermined Network influenza vaccine clinics. I understand that I am responsible for any costs associated with obtaining the required immunizations. I will not be permitted to start my volunteer role without the required immunizations or an approved exemption because of a valid and documented medical reason. Hepatitis B vaccine is strongly recommended for those volunteers who are at risk for blood or body fluid exposure.

By signing below, I acknowledge that I understand and agree with the information above.

Signature	Date	Time

FOR MINOR APPLICANTS:

As the parent/guardian of the volunteer applicant I understand that testing may be done for immune status of Measles, Mumps, Rubella, Varicella and/or Hepatitis B. Should any of these tests indicate that the volunteer applicant is not protected against these diseases, I give permission for the necessary vaccine to be administered to the volunteer applicant by the volunteer's provider or the Network.

Print Name	Signature	
Relationship to Applicant	Date	Time

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HIPAA AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Last Name:	First Name:
Phone Number:	DOB:
Address:	

I agree that protected health information about me ("Health Information") can be shared by my medical providers with **St. Luke's University Network and/or its subsidiaries, affiliates, and related entities ("St. Luke's")**. I agree that this includes medical providers doing volunteer health evaluation or caring for me. I agree that the **purpose** for which this Health Information can be shared is for purposes of considering my volunteer application and serving in my role as a volunteer. My Health Information will be shared with personnel of St. Luke's who are involved with the purpose including human resources personnel and supervisors at St. Luke's.

Health Information shared under this Form is limited to:

- Results of my volunteer health evaluation, including notes, fitness for duty evaluations, exam dates, and information I give to the medical provider.
- Immunizations and vaccines, like measles, mumps, rubella, varicella, pneumococcal, hepatitis B, COVID-19, and flu shots.
- Test results, like tuberculin/mantoux tests or drug tests.
- COVID-19, HIV/AIDS, STD and other infectious or communicable disease information.
- Other Health Information which St. Luke's is required by law to get for workplace medical surveillance, illness or injury, or to meet CDC and other health requirements.

I do not have to sign this Form. However, I may not be eligible for volunteer services or my role as a volunteer could be affected if I do not sign this Form. I can change my mind by writing to St. Luke's University Health Network, 801 Ostrum Street, Bethlehem, PA 18015, Attn: Network Director of Volunteer Services, unless St. Luke's has already relied on the permission I gave in this Form. My Health Information is protected by a law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If my Health Information is shared with St. Luke's for the purposes described in this Form, it could be re-disclosed and no longer be protected by HIPAA.

I agree that I can ask questions about this Form. This Form can be used by St. Luke's until St. Luke's no longer needs information for the purposes described in this Form.

Print Name _____ Signature _____

Parent/Guardian Signature (if under age 18) _____ Date _____ Time _____

Relationship to Volunteer Applicant: _____