Dear Prospective Volunteer:

Thank you for your interest in participating in the Paws for Patients pet therapy program. An exciting experience and commitment may be about to begin. The Paws for Patients pet therapy program at Jefferson Health – Northeast is an integral part of the care provided to our patients and a special way of providing comfort to our patients during their stay.

In order to participate in the Paws for Patients program, you must register with the hospital as a volunteer. An application is enclosed for your review, completion, and signature. Please return the completed application and proof of immunizations for yourself and your therapy animal(s) to the Volunteer Services Department by faxing it to (215) 612-5027. Upon receiving your application, we will contact you regarding next steps, including scheduling orientation and receiving a hospital badge.

As a volunteer and pet therapy participant, you are a vital part of our commitment to provide exceptional patient care and customer service to the patients and communities we serve. If you have any questions, please do not hesitate to contact me at (215) 612-4170. Again, thank you for your interest in the Paws for Patients pet therapy program, and I look forward to hearing from you.

Sincerely,

Caroline Williams, BA, CHES, CTTS
Director, Volunteer Services
ADULT APPLICATION

YOUR INFORMATION

Name ____________________________________________ Home Phone: _____________________
Work Phone: _____________________
Cell Phone: _____________________
Email Address: _____________________

Address __________________________________________

City/State/Zip __________________________________________

Date of Birth: _____________________ SSN: _____________________

Can we call you at work? _________
Are you a … Student _________ Homemaker _________ Employed _________ Retired _________
Are you currently attending college? _______ If yes, where? _____________________
Are you doing this for credit? ___ Yes ___ No If yes, who is your advisor? _____________________
What do you plan to do after graduation? _____________________

THERAPY ANIMAL INFORMATION

Please complete this section for each therapy animal you plan on bringing on hospital premises.

Name ____________________________________________ Age _________ Color __________
Breed ____________________________________________ Gender ____ Male  ____ Female
Certified ____ Yes  ____ No  If yes, with what organization? _____________________
Has this therapy animal lived in your home for at least 6 months? ____ Yes ____ No

Name ____________________________________________ Age _________ Color __________
Breed ____________________________________________ Gender ____ Male  ____ Female
Certified ____ Yes  ____ No  If yes, with what organization? _____________________
Has this therapy animal lived in your home for at least 6 months? ____ Yes ____ No

Name ____________________________________________ Age _________ Color __________
Breed ____________________________________________ Gender ____ Male  ____ Female
Certified ____ Yes  ____ No  If yes, with what organization? _____________________
Has this therapy animal lived in your home for at least 6 months? ____ Yes ____ No
PET THERAPY EXPERIENCE

1. Organization _________________________________________________________________________
   Frequency of Visits ___________________________________________________________________
   From __________________________________ to __________________________________________
   Do you currently provide visits to this organization? _____ Yes   _____ No

2. Organization _________________________________________________________________________
   Frequency of Visits ___________________________________________________________________
   From __________________________________ to __________________________________________
   Do you currently provide visits to this organization? _____ Yes   _____ No

3. Organization _________________________________________________________________________
   Frequency of Visits ___________________________________________________________________
   From __________________________________ to __________________________________________
   Do you currently provide visits to this organization? _____ Yes   _____ No

EMPLOYMENT EXPERIENCE

1. Company _____________________________ Responsibilities _________________________________
   __________________________________________________________________________________
   From __________________________________ to _________________________________________

2. Company _________________________ Responsibilities __________________________________
   __________________________________________________________________________________
   From ____________________________________ to ________________________________________

Are you able to perform all functions of the volunteer position for which you are applying, with or without reasonable accommodation?   ______ Yes   ______ No
If no, please explain:  ________________________________________________________________________

What do you want to gain from your volunteer experience? __________________________________________
__________________________________________________________________________________________
What days and hours (including weekends) are you available? (Please circle)

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To the best of your knowledge, will you be available as a volunteer for at least six months from this date?
Yes _______  No _______

Have you ever been convicted of a crime? Yes _______ No _______. If yes, please describe the nature of the offense, the date of the offense, and your rehabilitation since conviction. (A conviction record will not necessarily bar you from a volunteer position with the hospital.) The hospital will conduct a criminal background check if you are accepted into the volunteer program.

__________________________________________________________________________________________
__________________________________________________________________________________________

Is there any other information you would like to offer that would help in the process of placing you as a volunteer? ____________________________________________________________
__________________________________________________________________________________________

The information I have provided above is accurate to the best of my knowledge.

Date: ___________________________  Signature ___________________________

Return the completed application to:  Volunteer Services Department
Jefferson Health – Northeast
10800 Knights Road
Philadelphia, PA  19114

Or fax/email your completed application to:
Fax:  215-612-5027

Rev 06/14
IMMUNIZATION POLICY FOR PROSPECTIVE VOLUNTEERS

Aria Health requires that all employees and volunteers born in or after 1957 show proof of immunity for measles, mumps and rubella. All volunteers are also required to show proof of chicken pox (varicella) immunity, tuberculosis (PPD) screening, and influenza immunization during flu season.

MEASLES Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of receipt of two doses of measles containing vaccine (measles, MR, or MMR) given on or after twelve months of age.
- Documentation of health care provider diagnosed measles.
- laboratory evidence of measles immunity (positive titer).
- born before 1957.

MUMPS Any one of the following are acceptable as proof of immunity:

- born in or after 1957 - documentation of one dose of mumps containing vaccine (mumps or MMR) given on or after twelve months of age.
- documentation of health care provider diagnosed mumps.
- laboratory evidence of mumps immunity (positive titer).

RUBELLA Any one of the following are acceptable as proof of immunity:

- documentation of one dose of rubella containing vaccine (rubella, MR, or MMR).
- laboratory evidence of rubella immunity (positive titer).

Anyone unable to show proof of immunity for measles/mumps/rubella will be required to receive the necessary immunization from their family physician as a condition of volunteering. Volunteers excluded from measles/mumps/rubella immunization include pregnant volunteers and volunteers with immuno-suppression.

CHICKEN POX (VARICELLA) Any one of the following is acceptable as proof of immunity:

- documentation of chicken pox vaccination.
- laboratory evidence of chicken pox immunity (positive titer).

TUBERCULOSIS (PPD) Any one of the following is acceptable proof of PPD:

- documentation of negative PPD test given within the last 12 months.
- documentation of normal chest x-ray given within the last 12 months if positive PPD.

A PPD will be provided by Aria Health free of charge if needed.

FLU Proof of annual flu vaccination is required during flu season only (October 1 through March 31).

If I can be of any further assistance, please call me at (215) 612-4170.

Caroline Williams, BA, CHES, CTTS
Director, Volunteer Services
IMMUNIZATION POLICY FOR THERAPY ANIMALS

Jefferson Health – Northeast requires that all therapy animals receive annual medical clearance from a veterinarian and are up-to-date on the following inoculations: rabies, distemper, canine hepatitis, and parvovirus. Proof of vaccination and annual medical clearance are required.

Anyone unable to show proof of inoculations and annual medical clearance for their therapy animal(s) will be required to receive the necessary vaccinations from their veterinarian prior to visiting with patients.

If I can be of any further assistance, please call me at (215) 612-4170.

Caroline Williams, BA, CHES, CTTS
Director, Volunteer Services