Dear Applicant:

Thank you for your interest in the Stony Brook University Hospital Volunteer Program**. To expedite the application process, please carefully review the information below.**

All applicants are required to make a commitment of at least **100 hours of service**. If you are only interested in volunteering during the summer months, please be sure to allow yourself enough time to complete the application process so that you can meet the hour requirement. Ideally summer applicants should begin the process no later than April.

- Applications are accepted:

Monday through Thursday
9:30am-11:30am
And
2pm-4pm

Walk-ins are accepted; however we strongly recommend that you call the office on the day you would like to submit your application to confirm that a staff member will be available to meet with you. Please note: Volunteer Services is not open on holidays.

- **Only completed applications will be accepted.** Did you:

  - ✓ Complete both pages of the application
  - ✓ Have your parent or guardian sign the consent forms
  - ✓ Sign the authorization to conduct a background check
  - ✓ Complete the Employee Health Screening Pre-Admission Questionnaire
  - ✓ Have your physician complete the Volunteer Health History Form AND Medical Reference Form

- When arriving at University Hospital please park in the visitors parking garage and bring in your parking ticket for validation. Our office is located on the second floor of the hospital; please stop at the Information Desk for a visitor pass and directions.

- When you arrive at the Volunteer Office, your complete application will be reviewed by the Volunteer Services staff (**only complete applications will be accepted**). At that time, you will be scheduled for an orientation appointment. If you do not have documentation of two MMR vaccines, and/or two Varicella vaccines, you will be given the opportunity to schedule an Employee Health Assessment. Information outlining the health requirements to volunteer is included in this application packet.

If you have any questions about the application packet, please call the Volunteer Office at 444-2610 or visit the volunteer section of www.stonybrookmedicine.edu.

E.H. _____ ORT _____

Stony Brook Medicine

UNIVERSITY HOSPITAL

DEPARTMENT OF VOLUNTEER SERVICES
HEALTH SCIENCES CENTER
STATE UNIVERSITY OF NEW YORK AT STONY BROOK
STONY BROOK, NEW YORK 11794
(631) 444-2610

JUNIOR VOLUNTEER APPLICATION

Applicants for the Junior Volunteer Program must be 14 to 17 years of age and in good academic standing at school.

Volunteering begins with a commitment. At University Hospital we encourage all volunteers to serve at least three hours a week for at least eight months. Before an assignment can be made, each volunteer must obtain a medical clearance from his / her physician, purchase a volunteer uniform, and attend an orientation program.

NAME LAST	FIRST	MIDDLE	DATE

ADDRESS	HOME TEL NO.

CITY	STATE	ZIP	SOC. SEC. NO.

SCHOOL NAME	SOLAR NO.

SCHOOL ADDRESS	☐ FEMALE ☐ MALE

SCHOOL TEL. NO.	PRESENT GRADE	EMAIL

PLEASE LIST ANY RELATIVES OR FRIENDS WHO ARE EMPLOYEES OR VOLUNTEERS AT UNIVERSITY HOSPITAL (INCLUDE NAME, DEPARTMENT AND RELATIONSHIP)

AGE	DATE OF BIRTH	

ARE YOU CURRENTLY EMPLOYED	NO. OF HOURS PER WEEK	JOB TITLE
☐ YES ☐ NO		

IF EMPLOYED WHERE? AND TEL. NO.

VOLUNTEER EXPERIENCE

SERVICE DATES, LOCATION, VOLUNTEER DUTIES

TO BE NOTIFIED IN CASE OF EMERGENCY

NAME RELATIONSHIP

PHONE NO. (HOME) PHONE NO. (BUSINESS)

PERSONAL PHYSICIAN

ADDRESS AND TEL. NO.

WILL YOU BE DRIVING TO UNIVERSITY HOSPITAL? IF YES, PLEASE COMPLETE THE FOLLOWING:

☐ YES ☐ NO

MAKE OF CAR:	MODEL:	COLOR:	LICENSE PLATE NO.:	YEAR:

ARE YOU UNDER MEDICAL TREATMENT OF ANY KIND?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT MIGHT AFFECT YOUR VOLUNTEERING?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN

PLEASE LIST
FOREIGN LANGUAGES THAT YOU SPEAK FLUENTLY:

SPECIAL SKILLS THAT MIGHT BE USEFUL IN YOUR VOLUNTEER WORK:

CLUBS OR ORGANIZATIONS TO WHICH YOU BELONG:

ARE YOU PLANNING A CAREER IN HEALTH SERVICES?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN

WHAT ARE YOUR PLANS AFTER GRADUATION?

NUMBER OF HOURS YOU ARE WILLING TO VOLUNTEER EACH WEEK

ARE THERE ANY TYPES OF ASSIGNMENTS IN WHICH YOU ARE ESPECIALLY INTERESTED?

WHY DO YOU WANT TO VOLUNTEER AT UNIVERSITY HOSPITAL?

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM AT UNIVERSITY HOSPITAL?

I AGREE THAT AS A JUNIOR VOLUNTEER I WILL:
— SERVE REGULARLY AS ASSIGNED.
— ACCEPT SUPERVISION GRACEFULLY.
— ABIDE BY ALL RULES AND POLICIES OF THE DEPARTMENT OF VOLUNTEER SERVICES.
— KEEP CONFIDENTIAL ALL INFORMATION THAT COMES TO ME IN THE PERFORMANCE OF MY DUTIES.

SIGNATURE _____ DATE _____

Parent/Guardian Consent Form
Junior Volunteer Program

Date _____

I give my consent for my son/daughter _____to participate in the Junior Volunteer Program at Stony Brook University Hospital.

I will assume responsibility for my son/daughter's transportation to and from Stony Brook University Hospital.

_____
(Parent/Guardian Name Printed)

_____
(Parent/Guardian Signature)

_____
(Parent/Guardian Address)

_____

CONSENT TO INTERVIEW, PHOTOGRAPH, FILM, VIDEOTAPE OR RECORD

I, _____ , hereby give my consent and permission to
(Parent/Guardian Print Name)
University Hospital at Stony Brook and to its employees and authorized agents to interview, take photographs, motion pictures, videotape and/or sound recordings of me or of _____ for whom I am legally responsible.
(Jr. Vol. Print Name)

The purpose of this activity has been clearly explained to me and I release University Hospital, State University of New York at Stony Brook, and the State of New York from any claim that I may have against each by reason of this interview, recording photography or videotaping. I also waive any claims to payment or royalties derived therefrom.

University Hospital reserves the right to grant or deny permission to patients or their authorized agents to interview, photograph, film, videotape or record patients while in the hospital. The patient or authorized guardian agrees to indemnify University Hospital, State University of New York, and/or the State of New York against any and all damages or losses they may sustain as a result of taking such recordings.

Interviews, photographs, films, videotapes or recordings obtained by University Hospital may be used for any or all of the following purposes, with or without names or other identification:

a. Clinical documentation of current patient condition
b. Educational purposes
c. Health care research
d. Publicity for Hospital programs
e. Staff recruitment and training
f. Fund raising and development
g. Other (specify) _____

_____ X_____
Date Parent/Guardian Signature

KK/rbc

Medical Authorization
Junior Volunteer Program

Date _____

I, _____, the parent/guardian of _____, give my consent to Stony Brook University Hospital and to is medical and nursing staff to examine or treat my son/daughter in the event of accident or illness that may occur in the course of performing duties as a volunteer at Stony Brook University Hospital.

I also give my consent to Stony Brook University Hospital to perform health assessments/screenings as required by hospital policy.

_____
(Parent/Guardian Name Printed)

_____
(Parent/Guardian Signature)

_____
(Parent/Guardian Address)

_____

Stony Brook Medicine

(Rev. 6/6/12)

VOLUNTEER EMPLOYEE HEALTH PRE-ADMISSION QUESTIONNAIRE

Orientation Date: _____

MRN: _____
Registrar to enter MRN and fax to 4-6632

PLEASE PRINT CLEARLY – THANK YOU

Volunteer's Name: LAST _____

FIRST _____

Sex (circle one) MALE FEMALE

Date of Birth _____ Marital Status _____

Ethnic Group _____ Telephone Number _____

Street Address _____

City, State, Zip Code _____

Social Security Number _____

Religion _____

Veteran Status _____

Mother's Maiden Name _____

Birthplace _____

Emergency Contact Name _____

Emergency Contact Address _____

Emergency Contact Telephone Number _____

Relationship to Emergency Contact _____

OFFICE USE ONLY

Check One:

_____ Seeing Private Physician

_____ EHS Appointment: _____
Date of Appointment

Applicant Name: _____ Date of Birth: _____

Health Assessment Information For Volunteer Applicants

The following documentation from your private physician is needed to satisfy the health requirements for volunteering. Please be sure to carefully read each item listed below.

1. Two MMR (Measles, Mumps, Rubella) Vaccines documented as follows:
   Dates Administered
   Signed and Stamped by Doctor
   OR
   Positive Titers: Documented on a Lab report including Lab values for:
   Mumps – IGG
   Rubella (German Measles) –IGG
   Rubeola (Measles) – IGG

2. Negative PPD (dated within 3 months) documented as follows:

   Date planted
   Result
   Date read
   Signature, Stamp and License Number by an M.D., P.A. or N.P
   OR
   QuantiFERON Gold (a type of blood test that is used to diagnose tuberculosis). Negative result documented on a lab report.
   OR
   If you have had a past positive PPD, a negative chest x-ray report is required.

3. Influenza Vaccination (Seasonal Flu Vaccine)

   All volunteers must receive a seasonal influenza vaccine **OR** unvaccinated volunteers **MUST** wear a surgical mask at all times while in areas where patients may be present during the period the NYS Commissioner of Health determines the influenza season is underway.

4. Two Varicella Vaccines documented as follows:
   Dates Administered
   Signature, Stamp and License Number by an M.D., P.A. or N.P
   OR
   Positive Titers: Documented on a Lab report including Lab values
   OR
   If you do not wish to obtain the varicella vaccine you MUST sign the varicella vaccine declination statement below

Varicella Declination

I understand that varicella is a potentially serious, vaccine-preventable disease and that I may be at risk of acquiring and transmitting the disease. I have been offered the varicella vaccine series, but choose to decline at this time. If at any time I choose to receive the varicella vaccine series as an active hospital volunteer, I may do so at no charge to me.

_____ _____

Signature of Parent/ Guardian **Date**

If you do not have a positive titer or documentation of two doses of the MMR vaccine and/or the Varicella Vaccine, the vaccinations are available at no cost at Stony Brook Employee Health Services. Volunteer Services will schedule an appointment for you when you submit your application.

Volunteer Health History

Today's Date: _____

Name _____ Soc. Sec. No. _____

Address _____ Tel No. _____

Date of Birth _____ Age ____ Place of Birth _____

Marital Status _____ Nearest Relative _____ Tel No. _____

Address _____

Family Doctor _____ Tel. No. _____

Address _____

Have you ever had PPD test? Yes or No What was the result? Positive or Negative

PPD Documentation: MUST BE DATED WITHIN 3 MONTHS

Date Tuberculin Test Planted: _____ Date Read: _____
Result: Pos _____ Neg._____

Please circle applicable title: **Office Stamp:**

Signature:_____M.D. P.A. or N.P.

If your PPD result was positive, a copy of the negative chest x-ray report must be provided.

Have you had two MMR vaccines? Yes or No

If yes, please have your healthcare professional document the MMR vaccines below:

Date of Previous MMR Vaccine #1_____ #2 _____

Please include signature of the healthcare professional

Please circle applicable title: **Office Stamp:**

Signature:_____M.D. P.A. or N.P.

Did you ever have Chicken Pox? Approximate date: _____
Date of Previous Varicella Vaccine (chicken pox) #1_____ #2 _____

Please circle applicable title: **Office Stamp:**

Signature:_____M.D. P.A. or N.P.

Have you had the Influenza vaccine? Yes orNo

Date of Influenza Vaccine: _____

Please include signature of the healthcare professional

Please circle applicable title: **Office Stamp:**

Signature:_____M.D. P.A. or N.P.

If you do not wish to obtain the varicella vaccine, you MUST sign the Varicella vaccine declination statement.

Allergies: Drugs _____ Food _____
Smoking History: Cigarettes _____ Cigars _____ Pipe _____
Have you ever been hospitalized? Yes _____ No _____

1. *Operations (include dates)*
   _____
2. *Injuries _____ Chronic Ilnesses:_____*

Stony Brook Medicine

DEPARTMENT OF VOLUNTEER SERVICES

MEDICAL REFERENCE

_____has applied to become a volunteer at University Hospital and has given us your name as a medical reference. Will you please give us the following information. It will be treated as confidential.
Thank you for your assistance.

Sincerely,

Kathleen Kress

Kathy Kress, CAVS
Asst. Director Volunteer Services

1. **Does the applicant have any condition or disability that may be of potential risk to patients or personnel at University Hospital?**

REMARKS: _____

☐ **YES** _____

☐ **NO** _____

2. Does the applicant have any condition or disability that might interfere with the performance of his/her duties as a volunteer?

REMARKS: _____

☐ **YES** _____

☐ **NO** _____

Physician's Signature _____ Date _____

Name _____

Address _____

Telephone _____

***PHYSICIAN OFFICE STAMP/LICENSE NUMBER ARE ALSO REQUIRED.**