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
  - ✓ 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.

Stony Brook Medicine

DEPARTMENT OF VOLUNTEER SERVICES
STONY BROOK UNIVERSITY HOSPITAL
STONY BROOK, NEW YORK 11794-7520
(631) 444-2610

SENIOR VOLUNTEER APPLICATION

Thank you for interest in becoming a Stony Brook University Hospital Volunteer. Applicants for the Senior Volunteer Program must be 18 years of age or older. Volunteering begins with a commitment. At Stony Brook University Hospital we encourage all volunteers to serve at least three hours a week for at least eight months or complete one hundred hours of volunteer service.

NAME: LAST	FIRST	MIDDLE	DATE

HOME ADDRESS	HOME TEL. NO.
	CELL NO.
DATE OF BIRTH Male or Female (please circle)	SOC. SEC. NO.

SUNYSB STUDENTS LIVING ON CAMPUS: LIST ADDRESS, TELEPHONE NUMBER AND SOLAR NUMBER

CAMPUS ADDRESS	EMAIL
	SOLAR NO.

ARE YOU CURRENTLY ENROLLED IN COLLEGE? ☐ YES ☐ NO | IF YES, WHERE?

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO ☐ FULL TIME ☐ PART TIME | JOB TITLE

IF EMPLOYED, WHERE? AND TEL. NO.

VOLUNTEER EXPERIENCE ☐ PREVIOUS ☐ PRESENT | WHAT CAPACITY

SERVICE DATES AND LOCATIONS

Have you ever been convicted of a felony or misdemeanor? ☐ YES ☐ NO If yes, provide date, charge, and disposition.

Authorization to Conduct Background Verification and General Release

In connection with my application to become a volunteer at the Stony Brook University Hospital, hereafter "employer", I hereby authorize the employer to conduct a background investigation pursuant to the Fair Credit Reporting Act which may include, but not limited to, a Social Security Number verification and Criminal Conviction verification. I also authorize the "employer" to conduct an Office of Inspector General (OIG) search to ascertain my current status with the OIG List of Sanctioned Individuals, and to conduct a General Services Administration (GSA) search of their List of Parties Excluded to ascertain my current status in the GSA.

I am aware that I have the right under Fair Credit Reporting Act to request from the vendor performing the background check, the nature and scope of any report they have prepared in conjunction with the verifications conducted related to my application to volunteer. I authorize and request all courts and law enforcement agencies to release such information without restriction or qualification.

I hereby release Stony Brook University, Stony Brook University Hospital, their respective officers, employees and agents, from any liability and responsibility arising from preparation of the above described background check, investigation or report, and any resulting outcome or consequences, as well as any liability and responsibility arising from obtaining, reviewing, discussing any information gathered in connection with a review of my application, and any resulting consequences.

Applicant's Signature	Date

PLEASE PROVIDE THREE REFERENCES WHOM WE MAY CONTACT (INCLUDE NAME, PHONE NUMBER, AND RELATIONSHIP.)

1._____

2._____

3._____

TO BE NOTIFIED IN CASE OF EMERGENCY

NAME RELATIONSHIP

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

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

Do you belong to any club or organization that you think may benefit from a visit from our staff to share with them information about volunteering? If yes, please list the name of the organization and if possible telephone number and a contact person.

Attention Applicant: Please be advised that Stony Brook University Hospital Volunteer Services does background checks on all new hires. Prior criminal conviction may not prevent you from getting the volunteer position. However, falsifying your volunteer application is grounds for withdrawal of a volunteer job offer or termination.

Acknowledgment & Authorization

I hereby affirm that this application and all documents submitted to me in connection with my application for volunteering contain no willful misrepresentations and that the information given by me is true and complete. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a candidate for volunteering or for my immediate termination and/or referral for criminal prosecution. I authorize persons, schools, my current employer (if applicable), and previous employers and organizations named in this application (and accompanying documents if any) to provide any relevant information that may be needed to arrive at a decision of acceptance into the volunteer program.

I agree if accepted as a volunteer to abide by all rules, policies and regulations of Stony Brook University.
I certify that the information that I have provided is complete and accurate.

Applicant's Signature	Date

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 applicant **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.

License # _____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.

License # _____

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.

License # _____

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.

License # _____

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.**