STONY BROOK
UNIVERSITY
MEDICAL CENTER

Customer Relations
Volunteer Services

Dear Applicant:

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

- Applications are accepted:

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

Walk-ins are accepted, however, we strongly recommend 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.

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

  - √ Complete both pages of the application
  - √ Have your parent or guardian sign the consent forms
  - √ Complete the Employee Health Screening Pre-Admission Questionnaire
  - √ Complete the Volunteer Health History Form
  - √ Have your physician complete the 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 your application does not contain documentation of a current Tuberculosis screening and/or documentation of two MMR vaccines or positive titers, you will also be scheduled for an Employee Health Assessment. Information about the health assessment 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.stonybrookmedicalcenter.org .

E.H. _____ ORT _____

STONY BROOK UNIVERSITY MEDICAL CENTER

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 _____

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

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)

_____

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)

_____

EMPLOYEE HEALTH SCREENING
PRE-ADMISSION QUESTIONNAIRE

Orientation Date: _____

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

Date of EHS Appointment

(Rev. 9/16/10)

Health Assessment Information for Volunteer Applicants

All applicants must be screened for Measles, Mumps and Rubella as well as Tuberculosis. All applicants have the option of having the screening completed by their private physician or the hospital's employee health office.

Please note:

The Medical Reference Form must be completed by your physician. Employee Health cannot satisfy this requirement.

Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

Private Physician Documentation:

You can provide documentation from your private physician to satisfy the screening requirement. Listed below is the required documentation, please be sure to carefully read each item.

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
   *Varicella (Chicken Pox) – IGG *If you have had Chicken Pox in the past, the Varicella titer is not required, please be sure to note the approximate date of occurrence on the volunteer health history form.

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
   If you have had a past positive PPD, a negative chest x-ray report is required.

Continued on next page…..

Health Assessment Information For Volunteer Applicants Continued….

Employee Health Appointment:

Your appointment for a health assessment will be scheduled by the Department of Volunteer Services upon submission of your application. If you need to cancel or reschedule your Employee Health appointment, please contact the Volunteer Office at (631) 444-2610 as soon as possible.

On the day of your Employee Health appointment, please arrive approximately five minutes before the time of your appointment and go to the Volunteer Office on level 2 of the hospital. The Volunteer Office staff will validate your parking and direct you to the Employee Health Service on level 3.

If your applications does not include documentation of two MMR vaccines or positive titers for Mumps, Rubella and Rubeola, the Employee Health office will draw a tube of blood from your arm to test your immunities. Please have something to eat and drink before your appointment.

If your application does not include documentation of a current PPD, dated within three months, the Employee Health office will give you one of the two required PPD (Mantoux) tests for Tuberculosis. The PPD test is to see if your body has ever been exposed to Tuberculosis. Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

The PPD test is a two-step process. First you will receive an injection just under the skin of your forearm. Forty-eight to seventy-two hours later, you must return to Employee Health Office to have the test read. While having the first PPD test read you will be given the opportunity to schedule an appointment for the second PPD test or you can make the appointment at a later date by calling 444-7767. The second PPD test must be completed within 2 months of the initial test.

Please note, the Medical Reference Form must be completed by your physician, it is not part of the Employee Health screening process.

Volunteer Health History:

Applicants are responsible for completing the non-shaded portion of the form. Please have a healthcare professional complete the shaded areas below, if they have information regarding your current PPD and/or two MMR vaccines. Signatures from an M.D.,P.A., or N.P. will only be accepted. The healthcare provider's office stamp is also required.

Name _____ Today's Date. _____

Address _____ Tel No. _____

Date of Birth _____ Age ____ Place of Birth _____

Marital Status _____ Emergency Contact _____ Tel No. _____

Family Doctor _____ Tel. No. _____

Address _____

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

If your PPD result was positive, please provide a copy of the negative chest x-ray report.

If your PPD was administered within the last three months, please have your healthcare professional document the PPD below:

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

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

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

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 circle applicable title: **Office Stamp:**

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

Childhood Diseases: (Include approximate date)
Chicken Pox _____ *Vaccine:*_____

Allergies: Drugs _____ *Food* _____

Have you ever been hospitalized? Yes _____ *No* _____

1. *Operations (include dates)*
   _____
2. *Injuries* _____
3. *Illnesses* _____

Please list the medications you are currently taking: _____
_____

*Do you have any current or chronic illness such as: diabetes, high blood pressure, heart trouble, seizure disorder, tuberculosis, or other disease? Please list:*_____
_____

STONY BROOK
UNIVERSITY
MEDICAL CENTER

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.**