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 follow the instructions below:**

1. Please be sure all forms in the packet are completed.

2. The medical reference form must be signed and stamped by your physician. *(SUNY Stony Brook students can have this form completed by the Student Health Service a.k.a. Infirmary)*

3. **After the application is complete and the medical reference form is signed and stamped by your physician**, please call the Volunteer Office at (631) 444-2610. **Applications will be accepted Monday through Thursday between the hours of 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.

   The Volunteer Office is open Monday through Friday during the hours of 8:30am to 4:30pm. If you are unable to submit an application during the times indicated, please call the office to see if a mutually convenient alternative arrangement can be made.

4. 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.

5. When you arrive at the Volunteer Office, your complete application will be reviewed by the Volunteer Services staff **(only complete applications will be accepted)** and you will have an opportunity to view our book of volunteer positions. At that time, you will also be selecting dates for two additional appointments. The first will be a health assessment appointment and the second will be a volunteer orientation session. Some perspective volunteers prefer to have the health assessment completed by their private physician to expedite the process. Information about the health assessment is included in the application packet.

6. **Please plan on spending approximately twenty – thirty minutes** at the Volunteer Office for the application review, appointment scheduling, and viewing of the volunteer positions book. We look forward to meeting you.

STONY BROOK, NEW YORK 11794-7027

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	SOC. SEC. NO.

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

CAMPUS ADDRESS	CAMPUS PHONE
	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

EMPLOYEE HEALTH SCREENING
PRE-ADMISSION QUESTIONNAIRE

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 ____

Maiden Name ____

Birthplace ____

Next of Kin's Name ____

Next of Kin's Address ____

Next of Kin's Telephone Number ____

- -

OFFICE USE ONLY

Date of EHS Appointment

Health Assessment Information For New Volunteers

Your appointment for a health assessment will be scheduled by the Department of Volunteer Services when you submit your completed application to the Volunteer Office. 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 5.

The Employee Health office will draw a tube of blood from your arm to test your immunities to Mumps, Rubella and Rubeola. Please have something to eat and drink before you come in for the blood test.

Also, 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. If you have had a PPD test within the year, you can satisfy the second PPD requirement by providing proper documentation. Ask your physician to document the PPD on the volunteer health history form or on his/her letterhead indicating the date the PPD test was planted, the date it was read, the result, and the physician's signature and office stamp.

Each 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.

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

1. <u>Two MMR (Measles, Mumps, Rubella) Vaccines</u> documented as follows:

   Dates Administered
   Signed and Stamped by Doctor

   OR

   <u>Positive Titers:</u> 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 dated within one year is required.

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

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.

If your PPD result was positive, please provide a copy of the negative chest x-ray report. If not, a chest x-ray will be administered during your Employee Health assessment.

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.

Childhood Diseases: (Include approximate date)
Chicken Pox ______________________ Vaccine:_________________________________

Allergies: Drugs ___________________ Food _________________

Smoking History: Cigarettes ______ Cigars ______ Pipe ______
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

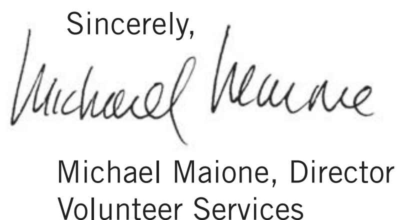
DEPARTMENT OF VOLUNTEER SERVICES

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,



Michael Maione, 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.**