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 complete the packet with help from a parent or guardian. The medical reference form must be signed and stamped by your physician.

2. **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.

3. When arriving at the Hospital please park in the visitors parking garage and bring your parking ticket with you 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.

4. 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.

5. **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

E.H. ______________________ ORT ______________________

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 | GUIDANCE COUNSELOR

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 ☐ YES ☐ NO | NO. OF HOURS PER WEEK | JOB TITLE

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 ______________

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

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)

____

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)

____

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

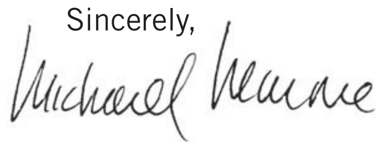
DEPARTMENT OF VOLUNTEER SERVICES

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.**