Health Assessment Information for Volunteer Applicants

The following information from your private physician documented on the attached Volunteer
Health History form and Medical Reference form 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*
   OR
   Positive Titers: Documented on a Lab report including Lab values for:
   
   Mumps – IGG
   Rubella (German Measles) – IGG
   Rubeola (Measles) – IGG

   * A copy of your immunization records generated from the New York State
   Immunization Information System (NYSIIS) will be accepted documentation if
   printed and submitted by your physician’s office.

2. Two Varicella (Chicken Pox) Vaccines*
   OR
   Positive Titers: Documented on a Lab report including Lab values

   *A copy of your immunization records generated from the New York State
   Immunization Information System (NYSIIS) will be accepted documentation if
   printed and submitted by your physician’s office.

3. Tuberculosis Screening

   Quantiferon Gold (a type of blood test that is used to diagnose tuberculosis). Negative
   result documented on a lab report (dated within three months).

   OR

   PPD – 2 Step Screening

   One Negative PPD (dated within 3 months) documented as follows for clearance:
   
   ▪ Date planted
   ▪ Result in millimeters
   ▪ Date read
   ▪ Signature, Stamp and License Number by an M.D., P.A. D.O. or N.P.
Health Assessment Information for Volunteer Applicants

2nd Negative PPD (dated a minimum of one week (7 days) after the first PPD was planted) documented as instructed above.

Individuals with a history of a positive PPD and history of positive QuantiFERON Gold must provide a negative chest x-ray report dated after the positive tests.

Individuals with a history of a positive PPD but no positive QuantiFERON Gold must submit a negative QuantiFERON gold within the previous 3 months.

4. **Documentation of COVID-19 Vaccination.** All volunteers are required to get vaccinated for COVID-19. Hospital Volunteers are required to be **fully vaccinated against COVID-19 prior to their first volunteer shift.** To be considered fully vaccinated you must have received either:

   1. dose of J&J /Jansen vaccine.
   2. doses of the Moderna vaccine.
   3. doses of the Pfizer vaccine.

   A booster dose of the COVID-19 vaccine is not currently required. However, should a booster dose be required communication will be emailed to your email on file.

   COVID-19 vaccines are not provided by Employee Health Services. Volunteers are required to secure a vaccine through either a primary provider, or a local pharmacy.

   Please provide a copy of the original card with dates, doses and locations of COVID-19 vaccines.

   The NYS Department of Health (DOH) has modified the Public Health Law on the Prevention of COVID-19 Transmission by Covered Entities to require that “Covered entities shall continuously require personnel to be fully vaccinated against COVID-19, and to have received any booster or supplemental dose as recommended by the CDC.” The order broadly defines “covered personnel” as “all persons employed or affiliated with a covered entity, whether paid or unpaid, including but not limited to employees, members of the medical and nursing staff, contract staff, students, and volunteers, who engage in activities such that if they were infected with COVID-19, they could potentially expose other covered personnel, patients or residents to the disease.”

5. Three dose series of Hepatitis B vaccine
   OR
   complete the declination that is found with our medical forms.

6. **Influenza Vaccination (Seasonal Flu Vaccine)**
   OR
   complete the declination that is found with our medical forms.
Health Assessment Information for Volunteer Applicants

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

Please note all medical documentation not documented on the Volunteer Health History form, from NYSIIS, or on an official lab report must contain the printed name, signature and license number of the practitioner. Documentation is only accepted from an MD, NP, PA or DO. Documentation by an RN will not be accepted unless the RN or is an Employee Health or Student Health Nurse and proof of such is required.

If you do not have a positive titer or documentation of two doses of the MMR vaccine, Varicella vaccine, Hepatitis B vaccine, or you cannot obtain a PPD test, Volunteer Services will schedule an appointment for you when you submit your application at no cost at Stony Brook Employee Health Services. All other requested medical information must be completed by your physician.
VOLUNTEER EMPLOYEE HEALTH PRE-ADMISSION QUESTIONNAIRE

PLEASE PRINT CLEARLY – THANK YOU

Volunteer’s Name:  LAST ____________________________________________
                  FIRST ____________________________________________

Sex (check 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 _____________________________________

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OFFICE USE ONLY

Check One:

_____ Seeing Private Physician

_____ EHS Appointment:  __________________________  Date of Appointment

MRN: ____________________
Registrar to enter MRN and fax to 4-6632
Volunteer Health History

Name: ______________________________
Address: ____________________________________________ Tel No. ______________________________
Date of Birth______ Age____ Place of Birth ____________________________
Marital Status____ Nearest Relative________________ tel No. ______________________________
Family Doctor________________ Tel. No. ______________________________
Social Security Number ______________________________
Address ________________________________________________

If you answer no to any of the questions below. Please indicate NO or N/A. Unanswered questions will result in a request to resubmit the form with the questions answered.

Allergies: Drugs__________________ Food ____________________

Have you ever been hospitalized? Yes____ No ______

1. Operations (include dates): ________________________________

2. Injuries: _____________________________________________

3. Chronic illnesses: ______________________________________

To be completed by a Healthcare Provider

Tuberculosis Screening: PPD Documentation in millimeters or QuantiFERON-TB Gold result must be dated within three months

PPD #1
Please provide the dates of the first PPD below.
Date Tuberculin Test Planted: ________ Date Read: __________
Result: Pos____ mm Neg. ______ mm

PPD #2
Please provide the dates of the second PPD below – The second PPD can be placed no earlier than one week (7 days) after the first PPD was planted.

Date Tuberculin Test Planted: ________ Date Read: __________
Result: Pos____ mm Neg. ______ mm

QuantiFERON-TB Gold (QFT)

If a QFT test was administered it must be dated within three months. Please provide the date the test was administered below & attach the lab report to this packet.

QuantiFERON-TB Gold Test Date: ______________

Individuals with a history of a positive PPD and history of positive QuantiFERON gold must provide a negative chest x-ray report dated after the positive tests. Individuals with a history of a positive PPD but no positive QuantiFERON gold must submit a negative QuantiFERON gold within the previous 3 months.

Print Name: ______________________________ Office Stamp: ________
Signature: ______________________________ License # ________________
**Immunizations:** A print out from NYSIIS is permissible. If a titer test was performed, a copy of the Lab report including Lab values must be attached.

Date of Previous MMR Vaccine #1 ________ #2 __________

**Print Name:** ____________________________  M.D.  N.P.  P.A.  D.O.
**Signature:** ________________________________  License # __________

**Did the patient ever have Chicken Pox?** Approximate date: __________

Date of Previous Varicella Vaccine (chicken pox) #1 ________ #2 ________

**Print Name:** ____________________________  M.D.  N.P.  P.A.  D.O.
**Signature:** ________________________________  License # __________

Date of Influenza Vaccine: __________

**Print Name:** ____________________________  M.D.  N.P.  P.A.  D.O.
**Signature:** ________________________________  License # __________

Dates of Hepatitis B Vaccine: #1 ________ #2 ________ #3 ________

*Please note that we will not accept titers for Hepatitis B. You must either have the vaccines or sign the Hepatitis B Vaccine Declination.*

**Print Name:** ____________________________  M.D.  N.P.  P.A.  D.O.
**Signature:** ________________________________  License # __________

**COVID Vaccinations:**

A copy of your immunization card is required.

Hospital Volunteers are required to be **fully vaccinated against COVID-19 prior to their first volunteer shift.** To be considered fully vaccinated you must have received either:

1. 1 dose of J&J /Jansen vaccine.
2. 2 doses of the Moderna vaccine.
3. 2 doses of the Pfizer vaccine.

A booster dose of the COVID-19 vaccine is not currently required. However, should a booster dose be required communication will be emailed to your email on file.

COVID-19 vaccines are not provided by Employee Health Services. Volunteers are required to secure a vaccine through either a primary provider, or a local pharmacy.
2nd Step

Booster PPD Documentation

Please have your practitioner complete the Two-Step PPD Screening by documenting the second PPD below (dated a minimum of one week after the first PPD planted)

Patient Name: ________________________________

Date of Birth: ________________________________

Date Tuberculin Test Planted: _________
Date Read: _________
Result: Positive______mm Negative_______mm

Print Name: ________________________________

Print Name: ________________________________

Please circle applicable title:
M.D.  D.O.  N.P.  P.A.

Signature: ________________________________
License # __________________

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

Office Stamp:

Individuals who provided a current Quantiferon Gold (dated within three months) are not required to complete a booster PPD.

Individuals who have had a positive PPD in the past and have submitted a chest x-ray report are not required to complete a booster PPD.

If you prefer to have the booster PPD completed by Employee Health, you may schedule an appointment directly with them. You will be provided with their contact information after you attend a new volunteer orientation session.
HEALTHCARE PROVIDER MEDICAL REFERENCE

Volunteer Applicant Name: ____________________________

Date of Birth: ____________________________

Thank you for providing a medical reference for the above referenced volunteer applicant. Please complete the two questions below. Please mark your response (yes or no). You may add remarks if you feel it is warranted. Thank you for your assistance.

Sincerely,

Kathleen Kress, CAVS
Director of Volunteer Services

1. Does the applicant have any condition or disability that may be a potential risk to patients or personnel at University Hospital? Please mark:

   [ ] YES   [ ] NO

Remarks:
________________________________________

________________________________________

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

   [ ] YES   [ ] NO

Remarks:
________________________________________

________________________________________

Today’s Date: ____________________________  (Circle One)

Print Name: ____________________________  Title:  MD NP PA

Signature: ____________________________  License #: __________________

Address: __________________________________________

Phone: __________________________________________  (All identifying information is required – please be sure to complete)
Hepatitis B Vaccine Declination

(If you do not have documentation of a completed three dose series of Hepatitis B vaccine and do not wish to be vaccinated, you MUST sign the declination statement below)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I know this continues to put me at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Please check one box below:

☐ I have started my Hepatitis B vaccine series and have received ______ number of vaccines. I have attached evidence of initiation of the vaccine series. I understand that I will not be considered to have developed lifelong immunity to Hepatitis B until I complete the 3-shot vaccine series and obtain a positive Hepatitis B surface antibody titer. I expect to complete the vaccine series by the following date ____________

☐ I have previously completed the 3-dose Hepatitis B vaccination series but do not have the vaccine documentation. I have the option of being revaccinated free of charge but decline at this time.

☐ The vaccine is contraindicated for medical reasons

☐ I have completed the Hepatitis B vaccination series twice and did not develop positive antibody titers following vaccination. I am thus considered a Hepatitis B vaccine non-responder and will submit supporting documentation (i.e. two complete Hepatitis B vaccine series AND lab reports of negative post-vaccination Hepatitis B surface antibody titers AND lab reports of negative Hepatitis B surface antigen and negative total Hepatitis B core antigen (anti-HBc). I have received counseling regarding precautions to prevent Hepatitis B and the need to obtain Hepatitis B immunoglobulin (HBIG) prophylaxis in the event of an exposure to Hepatitis B.

☐ None of the above apply. I am declining the Hepatitis B vaccine series at this time.

Volunteer Print Name ______________________________ Volunteer Signature ______________________________ Date ___________

If you are under 18, please have a parent/legal guardian print and sign their name:

Parent/Legal Guardian Print Name ______________________________ Parent/Legal Guardian Signature ______________________________ Date ___________
Influenza Vaccine Declination Form

In order to ensure your privacy and confidentiality, Please return this form directly to Employee Health & Wellness.

Please retain a copy of this form for your records.

2022-2023 Flu Season

Name:  
DOB:  
SB ID#:  
Job Title:  

I understand that due to my possible contact with patients, I am at risk for contracting and/or transmitting influenza to patients and/or other healthcare workers. I have been given the opportunity to receive the influenza vaccine recommended for healthcare workers by the CDC and I am declining this vaccine.

I understand that by declining this vaccine I will be required, by NYS DOH Section 2.59 of NY Codes Rules and Regulations Title 10, to wear a mask throughout the entire flu season while working in areas where patients may be present. I understand that failure to comply with this requirement will result in referral to Labor Relations for appropriate administrative action.

I also understand that if I am a “Hospital Access Employee”, I remain eligible to receive the vaccine at no charge until the end of the current flu season if supplies are still available.

Please read below and check all that apply:

I decline the vaccination for the following reason(s):

- I believe I will get the flu if I get the flu shot.
- I do not like needles.
- I have a medical contraindication to receiving the vaccine.
- I do not wish to share my reason for declining.
- Other:

Signature:  
Date:  

Rev: 06/15/2022