

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 note that the Medical Reference form must be officially dated within three months of your intended volunteer start. 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**). Volunteers must begin service within three months of the test date.

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.

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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.

Please note that **multiple clinical factors** are considered when determining clearance for individuals with a history of positive TB screening tests. **Additional documentation or further testing may be required** based on individual circumstances.

4. Three dose series of Hepatitis B vaccine

OR

complete the **declination** that is found with our medical forms.

5. Influenza Vaccination (Seasonal Flu Vaccine)

OR

complete the declination that is found with our medical forms.

The COVID-19 vaccine is no longer required but is encouraged. Please note that COVID-19 vaccines are not provided by Employee Health Services.

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 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**

MRN: _____

Registrar to enter MRN

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 _____

OFFICE USE ONLY

Check One:

_____ Seeing Private Physician

_____ EHS Appointment: _____
Date of Appointment

Volunteer Health History

Today's Date: _____

Name _____
Address _____ Tel No. _____
Date of Birth _____ Age _____ Place of Birth _____
Marital Status _____ Nearest Relative _____ Tel No. _____
Family Doctor _____ Tel. No. _____
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

Print Name: _____ Circle applicable title **M.D. N.P. P.A. D.O.** | Office Stamp:

Signature: _____ License # _____

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

Print Name: _____ Circle applicable title **M.D. N.P. P.A. D.O.** | Office Stamp:

Signature: _____ License # _____

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.

Please circle applicable title:

Office Stamp:

Print Name: _____

M.D. N.P. P.A. D.O.

Signature: _____

License # _____

NAME: _____ Date of Birth: _____

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 _____
Please circle applicable title: _____ Office Stamp: _____
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 _____
Please circle applicable title: _____ Office Stamp: _____
Print Name: _____ **M.D. N.P. P.A. D.O.**
Signature: _____ License # _____

Date of Influenza Vaccine: _____
Please circle applicable title: _____ Office Stamp: _____
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.

Please circle applicable title: _____ Office Stamp: _____
Print Name: _____ **M.D. N.P. P.A. D.O.**
Signature: _____ License # _____

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: _____

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: _____

Print Name: _____

(Circle One)
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.

| | | | |
|-------|--|------------|--|
| Name: | | SB ID#: | |
| DOB: | | 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):

| | |
|--------------------------|---|
| <input type="checkbox"/> | I believe I will get the flu if I get the flu shot. |
| <input type="checkbox"/> | I do not like needles. |
| <input type="checkbox"/> | I have a medical contraindication to receiving the vaccine. |
| <input type="checkbox"/> | I do not wish to share my reason for declining. |
| <input type="checkbox"/> | Other: |

| | | | |
|------------|--|-------|--|
| Signature: | | Date: | |
|------------|--|-------|--|