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.

2nd Negative PPD (dated a minimum of one week after the first PPD) Documented as instructed above.

Individuals with a history of a positive PPD must provide a negative chest x-ray report. You may not substitute a negative chest x-ray report with a negative Quantiferon Gold.

4. **Documentation of COVID-19 Vaccination**. All volunteers are required to get vaccinated for COVID-19. Please provide a copy of the original card with dates, dose and location of COVID-19 vaccine.

   The New York State Department of Health (DOH) has issued an order that all hospitals and nursing homes "continuously require all covered personnel to be fully vaccinated against COVID-19, with the first dose for current personnel received by September 27, 2021." 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 patients, residents, or personnel working for such entity to the disease."

   The University is required to comply with this order and therefore all employees in the above categories are subject to the DOH order and must comply as a condition of continued employment. The order allows for ***limited*** medical and religious exemptions with reasonable accommodations, consistent with applicable law.

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.

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 practioner. 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.

Stony Brook Medicine

(Rev. 6/6/12)

VOLUNTEER EMPLOYEE HEALTH PRE-ADMISSION QUESTIONNAIRE

Orientation Date: _____

MRN: _____
Registrar to enter MRN and fax to 4-6632

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. _____

Social Security Number_____

Address _____

Allergies: Drugs _____ Food _____

Have you ever been hospitalized? Yes _____ No _____

1. Operations (include dates)
   _____
2. Injuries _____ Chronic illnesses: _____

To be completed by a Healthcare Provider

Tuberculosis Screening: PPD Documentation in millimeters or Quantiferon result **must be dated within three months for initial clearance**. If a PPD was completed within one year, it will be considered the first of the 2 step PPD process and a Booster PPD within 3 months will need to be submitted. Please document on the Booster PPD page of the application. If a Quantiferon test was completed, please attach the lab report. If the patient has a history of a positive PPD, a copy of the negative chest x-ray report must be provided. The date of the positive PPD must be clearly stated and the chest x-ray report must be after the date of the positive PPD.

Date Tuberculin Test Planted: _____ Date Read: _____

Result: Pos _____mm Neg._____mm

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

Print Name: _____ **M.D. N.P. P.A. D.O.**

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 _____

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 #** _____

COVID Vaccination:

A copy of your immunization card is required.

Booster PPD Documentation

Please have your practitioner complete the Two-Step PPD Screening by documenting the second PPD below.

Patient Name: _____

Date of Birth: _____

Date Tuberculin Test Planted: _____
Date Read: _____
Result: Positive _____mm Negative_____mm

Please circle applicable title:

Print Name: _____ 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.

Stony Brook Medicine

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

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)

Stony Brook Medicine

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

DECLINATION FOR INFLUENZA VACCINATION OR CONTRAINDICATION TO INFLUENZA VACCINE MASK WILL BE REQUIRED BY NYS DOH DURING DESIGNATED FLU SEASON

I_____(Name)
SB ID#_____understand that due to my possible contact with patients I am at risk for contracting and/or transmitting influenza to patients and other healthcare workers. I have been given the opportunity to receive the influenza vaccine recommended for healthcare workers by the CDC. I decline influenza vaccination. I understand that in declining this vaccine I am required by NYS DOH Section 2.59 of NY Codes Rules and Regulations Title 10 to wear a mask while working in areas where patient may be present. **If in the future before the end of the current influenza season I want to be vaccinated with the Influenza vaccines I can receive the vaccine at no charge if supplies are still available.**

Signature_____
Date_____