Stony Brook Medicine

Dear Applicant:

Thank you for your interest in the Stony Brook University Hospital Volunteer Program**.** We care about the health and safety of you and your family. As you may know, Stony Brook Medicine is proactively addressing the ongoing situation regarding the Coronavirus (COVID-19). We want to assure you that your health and safety will remain our top priority. During this time, out of an abundance of caution, we are temporarily suspending our hospital volunteer program.

In addition to the suspension of our regular volunteer program, we are **canceling our summer only volunteer program**. If you have any questions please reach out directly to our Volunteer Department via email at volunteerservices@stonybrookmedicine.edu. We appreciate your understanding during this time. Thank you.

Regards,

Kathleen Kress

Kathleen Kress, CAVS
Director Volunteer Services

E.H. _____ ORT _____

Stony Brook Medicine

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	EMAIL

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

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 _____

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)

_____

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

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)

_____

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

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

Two step PPD testing

One Negative PPD (dated within 3 months) documented as follows for initial clearance:

Date planted
Result in millimeters
Date read
Signature, Stamp and License Number by an M.D., P.A. D.O. or N.P.

Booster PPD (second PPD test) is required for final clearance no later than 2 months after initial clearance.

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.

OR

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

4. Influenza Vaccination (Seasonal Flu Vaccine)

All volunteers must receive a seasonal influenza vaccine **OR** unvaccinated volunteers **MUST** wear a surgical mask at all times while in areas where patients may be present during the period the NYS Commissioner of Health determines the influenza season is underway. In addition to wearing a mask,volunteers who choose not to be vaccinated must complete a declination statement each flu season. Declination statements will be available during flu season in Volunteer Services.

If you do not have a positive titer or documentation of two doses of the MMR vaccine and/or the Varicella Vaccine, 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.

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.

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 _____

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 #** _____

If the patient does not wish to obtain the varicella vaccine, they MUST sign the Varicella vaccine declination statement in the application packet.

Date of Influenza Vaccine: _____

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

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

Signature: _____ **License #** _____

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:

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

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
Asst. 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: _____ Title: (Circle One) MD NP PA

Signature: _____ License #: _____

Address: _____

Phone: _____

(**All** identifying information is required –please be sure to complete)