Dear Applicant:

Thank you for your interest in the Stony Brook University Hospital Volunteer Program. **To expedite the application process, please carefully review the information below.**

All applicants are required to make a commitment of at least **100 hours of service**. If you are only interested in volunteering during the summer months, please be sure to allow yourself enough time to complete the application process so that you can meet the hour requirement. Summer applicants should submit their applications **no later than April** and must complete the orientation process prior to the end of June.

- Applications are accepted:

  **Monday through Thursday**
  9:30am-11:30am
  And
  2pm-4pm

  Walk-ins are accepted; however we strongly recommend that 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. Please note: Volunteer Services is not open on holidays.

- **Only completed applications will be accepted.** Did you:
  - Complete both pages of the application
  - Have your parent or guardian sign the consent forms
  - Sign the authorization to conduct a background check
  - Complete the Employee Health Screening Pre-Admission Questionnaire
  - Have your physician complete the Volunteer Health History Form AND Medical Reference Form

- When arriving at University Hospital please park in the visitors parking garage and bring in your parking ticket 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.

- When you arrive at the Volunteer Office, your complete application will be reviewed by the Volunteer Services staff (**only complete applications will be accepted**). At that time, you will be scheduled for an orientation appointment. If you do not have documentation of two MMR vaccines, and/or two Varicella vaccines, you will be given the opportunity to schedule an Employee Health Assessment. Information outlining the health requirements to volunteer is included in this application packet.

If you have any questions about the application packet, please call the Volunteer Office at 444-2610 or visit the volunteer section of www.stonybrookmedicine.edu.
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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>LAST</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>DATE</th>
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<tbody>
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<td>ADDRESS</td>
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<td>HOME TEL. NO.</td>
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<td>CITY</td>
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<td>ZIP</td>
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<td>SCHOOL NAME</td>
<td>SOLAR NO.</td>
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<tr>
<td>SCHOOL ADDRESS</td>
<td>PRESENT GRADE</td>
<td>EMAIL</td>
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PLEASE LIST ANY RELATIVES OR FRIENDS WHO ARE EMPLOYEES OR VOLUNTEERS AT UNIVERSITY HOSPITAL (INCLUDE NAME, DEPARTMENT AND RELATIONSHIP)

<table>
<thead>
<tr>
<th>AGE</th>
<th>DATE OF BIRTH</th>
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ARE YOU CURRENTLY EMPLOYED

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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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:

<table>
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<tr>
<th>YES</th>
<th>NO</th>
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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 its 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)
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 (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 ____________________________________________________________

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. **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. Volunteers will be given the option to complete the booster PPD with their private physician or Employee Health free of charge.

   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).
3. Two Varicella Vaccines

   OR
   Positive Titers: Documented on a Lab report including Lab values

   OR
   If you do not wish to obtain the varicella vaccine you MUST
   sign the varicella vaccine declination below.

I understand that varicella is a potentially serious, vaccine-preventable

disease and that I may be at risk of acquiring and transmitting the disease. I

have been offered the varicella vaccine series, but choose to decline at this

time. If at any time I choose to receive the varicella vaccine series as an

active hospital volunteer, I may do so at no charge to me.

______________________________    ____________
Signature of applicant/ or parent or guardian    Date
if the applicant is a minor (under 18 yrs of age)

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.

   --------------------------------------------------------------------------------------------
   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
   practitioner. Documentation is only accepted from an MD, NP, PA or
   DO. Documentation by an RN or LPN will not be accepted unless the
   RN or LPN 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.
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
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: ____________________

(Circle One)
Print Name: _________________________ Title: MD  NP  PA

Signature: _________________________ License #: __________________

Address: ____________________________

Phone: ____________________________

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