

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. 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.

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, 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.



(Rev. 6/6/12)

Stony Brook **Medicine**

**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: _____

Please complete all questions in this section

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 # _____

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

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:

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,

A handwritten signature in black ink that reads "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: _____

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

Signature: _____ License #: _____

Address: _____

Phone: _____

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