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

Stony Brook Medicine

DEPARTMENT OF VOLUNTEER SERVICES
STONY BROOK UNIVERSITY HOSPITAL
STONY BROOK, NEW YORK 11794-7520
(631) 444-2610

SENIOR VOLUNTEER APPLICATION

Thank you for interest in becoming a Stony Brook University Hospital Volunteer. Applicants for the Senior Volunteer Program must be 18 years of age or older. Volunteering begins with a commitment. At Stony Brook University Hospital we encourage all volunteers to serve at least three hours a week for at least eight months or complete one hundred hours of volunteer service.

NAME: LAST | FIRST | MIDDLE | DATE

HOME ADDRESS | HOME TEL. NO.

CELL NO.

DATE OF BIRTH ☐ MALE ☐ FEMALE | SOC. SEC. NO.

SUNYSB STUDENTS LIVING ON CAMPUS: LIST ADDRESS, TELEPHONE NUMBER AND SOLAR NUMBER

CAMPUS ADDRESS | EMAIL

SOLAR NO.

ARE YOU CURRENTLY ENROLLED IN COLLEGE? ☐ YES ☐ NO | IF YES, WHERE?

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO ☐ FULL TIME ☐ PART TIME | JOB TITLE

IF EMPLOYED, WHERE? AND TEL. NO.

VOLUNTEER EXPERIENCE ☐ PREVIOUS ☐ PRESENT | WHAT CAPACITY

SERVICE DATES AND LOCATIONS

Have you ever been convicted of a felony or misdemeanor? ☐ YES ☐ NO If yes, provide date, charge, and disposition.

Authorization to Conduct Background Verification and General Release

In connection with my application to become a volunteer at the Stony Brook University Hospital, hereafter "employer", I hereby authorize the employer to conduct a background investigation pursuant to the Fair Credit Reporting Act which may include, but not limited to, a Social Security Number verification and Criminal Conviction verification. I also authorize the "employer" to conduct an Office of Inspector General (OIG) search to ascertain my current status with the OIG List of Sanctioned Individuals, and to conduct a General Services Administration (GSA) search of their List of Parties Excluded to ascertain my current status in the GSA.

I am aware that I have the right under Fair Credit Reporting Act to request from the vendor performing the background check, the nature and scope of any report they have prepared in conjunction with the verifications conducted related to my application to volunteer. I authorize and request all courts and law enforcement agencies to release such information without restriction or qualification.

I hereby release Stony Brook University, Stony Brook University Hospital, their respective officers, employees and agents, from any liability and responsibility arising from preparation of the above described background check, investigation or report, and any resulting outcome or consequences, as well as any liability and responsibility arising from obtaining, reviewing, discussing any information gathered in connection with a review of my application, and any resulting consequences.

Applicant's Signature	Date

PLEASE PROVIDE THREE REFERENCES WHOM WE MAY CONTACT (INCLUDE NAME, PHONE NUMBER, AND RELATIONSHIP.)

1._____

2._____

3._____

TO BE NOTIFIED IN CASE OF EMERGENCY

NAME RELATIONSHIP

PHONE NO. (HOME) PHONE NO. (BUSINESS)

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM AT UNIVERSITY HOSPITAL?

Do you belong to any club or organization that you think may benefit from a visit from our staff to share with them information about volunteering? If yes, please list the name of the organization and if possible telephone number and a contact person.

Attention Applicant: Please be advised that Stony Brook University Hospital Volunteer Services does background checks on all new hires. Prior criminal conviction may not prevent you from getting the volunteer position. However, falsifying your volunteer application is grounds for withdrawal of a volunteer job offer or termination.

Acknowledgment & Authorization

I hereby affirm that this application and all documents submitted to me in connection with my application for volunteering contain no willful misrepresentations and that the information given by me is true and complete. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a candidate for volunteering or for my immediate termination and/or referral for criminal prosecution. I authorize persons, schools, my current employer (if applicable), and previous employers and organizations named in this application (and accompanying documents if any) to provide any relevant information that may be needed to arrive at a decision of acceptance into the volunteer program.

I agree if accepted as a volunteer to abide by all rules, policies and regulations of Stony Brook University.
I certify that the information that I have provided is complete and accurate.

Applicant's Signature	Date

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
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)