



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. Ideally summer applicants should begin the process 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
  - ✓ 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](http://www.stonybrookmedicine.edu).



**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 or Female (please circle)		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 | WHAT CAPACITY  
 PREVIOUS  PRESENT

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
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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
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**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 \_\_\_\_\_

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*OFFICE USE ONLY*

Check One:

\_\_\_\_\_ Seeing Private Physician

\_\_\_\_\_ EHS Appointment: \_\_\_\_\_

Date of Appointment

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Health Assessment Information For Volunteer Applicants

The following documentation from your private physician 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 documented as follows:

Dates Administered  
Signed and Stamped by Doctor

**OR**

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

Mumps – IGG  
Rubella (German Measles) –IGG  
Rubeola (Measles) – IGG

2. Negative PPD (dated within 3 months) documented as follows:

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

**OR**

QuantiFERON Gold (a type of blood test that is used to diagnose tuberculosis). Negative result documented on a lab report.

**OR**

If you have had a past positive PPD, a negative chest x-ray report is required.

3. 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.

4. Two Varicella Vaccines documented as follows:

Dates Administered  
Signature, Stamp and License Number by an M.D., P.A. or N.P

**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 statement below**

### Varicella Declination

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

\_\_\_\_\_  
Date

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**If you do not have a positive titer or documentation of two doses of the MMR vaccine and/or the Varicella Vaccine, the vaccinations are available at no cost at Stony Brook Employee Health Services. Volunteer Services will schedule an appointment for you when you submit your application.**

**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 \_\_\_\_\_

*Have you ever had PPD test? Yes or No What was the result? Positive or Negative*

PPD Documentation in mm: Must be dated within three months for initial clearance. If dated within one year it will be considered a booster PPD and you will be required to obtain a more current PPD (dated within three months).

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.**

**Signature:** \_\_\_\_\_ **License #** \_\_\_\_\_

If your PPD result was positive, a copy of the negative chest x-ray report must be provided.

*Have you had two MMR vaccines? Yes or No*

If yes, please have your healthcare professional document the MMR vaccines below:

Date of Previous MMR Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_

**Please circle applicable title:**

**Office Stamp:**

**Print Name:** \_\_\_\_\_

**M.D. N.P. P.A.**

**Signature:** \_\_\_\_\_ **License #** \_\_\_\_\_

*Did you 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.**

**Signature:** \_\_\_\_\_ **License #** \_\_\_\_\_

If you do not wish to obtain the varicella vaccine, you **MUST** sign the Varicella vaccine declination statement.

*Have you had the Influenza vaccine? Yes or No*

Date of Influenza Vaccine: \_\_\_\_\_

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

**Print Name:** \_\_\_\_\_

**M.D. N.P. P.A.**

**Signature:** \_\_\_\_\_ **License #** \_\_\_\_\_

*Allergies: Drugs* \_\_\_\_\_ *Food* \_\_\_\_\_

*Have you ever been hospitalized? Yes* \_\_\_\_\_ *No* \_\_\_\_\_

1. *Operations (include dates)*

2. *Injuries* \_\_\_\_\_ *Chronic Illnesses:* \_\_\_\_\_



**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: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: MD NP PA (Circle One)

Signature: \_\_\_\_\_ License #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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