STONY BROOK
UNIVERSITY
MEDICAL CENTER

Customer Relations
Volunteer Services

Dear Applicant:

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

- Applications are accepted:

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

Walk-ins are accepted, however, we strongly recommend 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.

- **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
  - √ Complete the Volunteer Health History Form
  - √ Have your physician complete the 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 your application does not contain documentation of a current Tuberculosis screening and/or documentation of two MMR vaccines or positive titers, you will also be scheduled for an Employee Health Assessment. Information about the health assessment 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.stonybrookmedicalcenter.org .

STONY BROOK UNIVERSITY MEDICAL CENTER

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	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

EMPLOYEE HEALTH SCREENING
PRE-ADMISSION QUESTIONNAIRE

Orientation Date: _____

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

Date of EHS Appointment

(Rev. 9/16/10)

Health Assessment Information for Volunteer Applicants

All applicants must be screened for Measles, Mumps and Rubella as well as Tuberculosis. All applicants have the option of having the screening completed by their private physician or the hospital's employee health office.

Please note:

The Medical Reference Form must be completed by your physician. Employee Health cannot satisfy this requirement.

Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

Private Physician Documentation:

You can provide documentation from your private physician to satisfy the screening requirement. Listed below is the required documentation, please be sure to carefully read each item.

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
   *Varicella (Chicken Pox) – IGG *If you have had Chicken Pox in the past, the Varicella titer is not required, please be sure to note the approximate date of occurrence on the volunteer health history form.

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

Continued on next page…..

Health Assessment Information For Volunteer Applicants Continued….

Employee Health Appointment:

Your appointment for a health assessment will be scheduled by the Department of Volunteer Services upon submission of your application. If you need to cancel or reschedule your Employee Health appointment, please contact the Volunteer Office at (631) 444-2610 as soon as possible.

On the day of your Employee Health appointment, please arrive approximately five minutes before the time of your appointment and go to the Volunteer Office on level 2 of the hospital. The Volunteer Office staff will validate your parking and direct you to the Employee Health Service on level 3.

If your applications does not include documentation of two MMR vaccines or positive titers for Mumps, Rubella and Rubeola, the Employee Health office will draw a tube of blood from your arm to test your immunities. Please have something to eat and drink before your appointment.

If your application does not include documentation of a current PPD, dated within three months, the Employee Health office will give you one of the two required PPD (Mantoux) tests for Tuberculosis. The PPD test is to see if your body has ever been exposed to Tuberculosis. Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

The PPD test is a two-step process. First you will receive an injection just under the skin of your forearm. Forty-eight to seventy-two hours later, you must return to Employee Health Office to have the test read. While having the first PPD test read you will be given the opportunity to schedule an appointment for the second PPD test or you can make the appointment at a later date by calling 444-7767. The second PPD test must be completed within 2 months of the initial test.

Please note, the Medical Reference Form must be completed by your physician, it is not part of the Employee Health screening process.

Volunteer Health History:

Applicants are responsible for completing the non-shaded portion of the form. Please have a healthcare professional complete the shaded areas below, if they have information regarding your current PPD and/or two MMR vaccines. Signatures from an M.D.,P.A., or N.P. will only be accepted. The healthcare provider's office stamp is also required.

Name _____ Today's Date. _____

Address _____ Tel No. _____

Date of Birth _____ Age ____ Place of Birth _____

Marital Status _____ Emergency Contact _____ Tel No. _____

Family Doctor _____ Tel. No. _____

Address _____

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

If your PPD result was positive, please provide a copy of the negative chest x-ray report.

If your PPD was administered within the last three months, please have your healthcare professional document the PPD below:

Date Tuberculin Test Planted: _____ Date Read: _____
Result: Pos _____ Neg._____

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

Signature:_____M.D. P.A. or N.P.

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:**

Signature:_____M.D. P.A. or N.P.

Childhood Diseases: (Include approximate date)
Chicken Pox _____ *Vaccine:*_____

Allergies: Drugs _____ *Food* _____

Have you ever been hospitalized? Yes _____ *No* _____

1. *Operations (include dates)*
   _____
2. *Injuries* _____
3. *Illnesses* _____

Please list the medications you are currently taking: _____
_____

*Do you have any current or chronic illness such as: diabetes, high blood pressure, heart trouble, seizure disorder, tuberculosis, or other disease? Please list:*_____
_____

STONY BROOK
UNIVERSITY
MEDICAL CENTER

DEPARTMENT OF VOLUNTEER SERVICES

MEDICAL REFERENCE

_____has applied to become a volunteer at University Hospital and has given us your name as a medical reference. Will you please give us the following information. It will be treated as confidential.
Thank you for your assistance.

Sincerely,

Kathleen Kress

Kathy Kress, CAVS
Asst. Director Volunteer Services

1. **Does the applicant have any condition or disability that may be of potential risk to patients or personnel at University Hospital?**

REMARKS: _____

☐ **YES** _____

☐ **NO** _____

2. Does the applicant have any condition or disability that might interfere with the performance of his/her duties as a volunteer?

REMARKS: _____

☐ **YES** _____

☐ **NO** _____

Physician's Signature _____ Date _____

Name _____

Address _____

Telephone _____

***PHYSICIAN OFFICE STAMP/LICENSE NUMBER ARE ALSO REQUIRED.**