Stony Brook
Southampton Hospital

**VOLUNTEER SERVICES**
**ADULT APPLICATION (18yrs and older)**

Date_____

Name_____

Mailing Address _____ City _____ Zip _____

Home Telephone _____ Cell Phone _____

E-mail Address _____

Social Security Number _____

EMERGENCY CONTACT_____

Are you currently employed? If yes,

Present Employer _____

Address _____ Phone Number _____

PREVIOUS VOLUNTEER EXPERIENCE _____

_____

_____

REASON FOR VOLUNTEERING _____

AVAILABILITY: Days most available _____

Times most available _____

Seasonal Volunteer? _____ What Months? _____

SECOND LANGUAGE _____

SECOND LANGUAGE _____

AS A VOLUNTEER, I WILL:

1. Take any problems, criticisms or suggestions to the Director of Volunteer Services 2.

Endeavor to make my work professional in its quality.

3. Uphold the traditions and high standards of this Hospital and will interpret them to the community at large.
4. Be punctual and conscientious in the fulfillment of my duties and accept supervision.
5. Uphold the volunteer dress code as established by the Volunteer department.
6. Conduct oneself with dignity, courtesy and consideration.
7. I understand that the Volunteer department reserves the right to terminate my volunteer status as a result of (a) failure to comply with Hospital policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the department director, would make my continued service as a volunteer contrary to the best interests of the Hospital.

STONY BROOK SOUTHAMPTON HOSPITAL VOLUNTEER SERVICE CONFIDENTIALITY STATEMENT

Volunteers have access to a wide variety of confidential information regarding a patient, the Hospital, its Medical Staff and employees. Under no condition can this information be disclosed. All patient care information is to be regarded as confidential. Access to medical records is limited to our medical staff and any other person the patient may allow. Information obtained by any volunteer in the course of his/her service is strictly confidential, and the volunteer shall not divulge such information to any person either orally or in writing. Failure to comply with the Hospital policy on confidentially may be grounds for dismissal.

_____ _____ Volunteer

Signature Date

FOR OFFICE USE ONLY:

Interview Date _____ Orientation Date _____

Starting Date _____ Assignment _____

Day _____ Time _____

Comments _____

_____

_____

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## Part A -- Health History

Name and date of birth: _____

To be completed by the patient.

# Medical History and Review of Symptoms

Have you ever had, or do you have any of the following?

| Infectious Diseases | Yes | No |
|---|---|---|
| Chicken Pox or Shingles | | |
| Measles | | |
| Mumps | | |
| Tuberculosis or positive IGRA or PPD test | | |
| Other Disease: | | |
| **Respiratory/Lungs** | | |
| Chronic Bronchitis/Emphysema/COPD | | |
| Asthma/Wheezing | | |
| Asbestosis, Silicosis, Pneumoconiosis | | |
| Pneumonia | | |
| Pneumothorax (collapsed lung) | | |
| Broken ribs or chest injury/surgery | | |
| Coughing up phlegm or blood | | |
| Shortness of breath or chest tightness | | |
| **Cardiovascular/Heart** | | |
| Heart Attack | | |
| Chest pain/Angina | | |
| Heart failure | | |
| Irregular heart rhythm or palpitations | | |
| High blood pressure | | |
| Edema (swelling of legs/feet) | | |
| Stroke | | |
| **Neurologic** | | |
| Seizures or Epilepsy | | |
| Numbness, weakness or paralysis of arms or legs | | |
| Head injury or concussion | | |
| Severe headaches or migraines | | |
| Dizziness or fainting spells | | |
| Other neurologic disorder | | |
| Sleep apnea or other sleeping disorder | | |

| Gastrointestinal and Kidney | Yes | No |
|---|---|---|
| Stomach or intestinal problem | | |
| Hepatitis or other liver disease | | |
| Kidney disease or kidney stones | | |
| Hernia | | |
| Blood in urine | | |
| **Skin, Endocrine, Severe Allergic Reaction** | | |
| Chronic rash or eczema | | |
| Diabetes | | |
| Thyroid or other endocrine problem | | |
| Allergic reactions that affect breathing | | |
| **Vision and Hearing** | | |
| Wear glasses or contacts | | |
| Eye disorder (e.g. glaucoma, macular degeneration, cataracts, etc.) or injury | | |
| Color blindness | | |
| Hearing loss or tinnitus (ringing in ears) | | |
| **Musculoskeletal** | | |
| Back/neck injury or pain | | |
| Arthritis/gout | | |
| Other bone/joint problem or injury- please specify: | | |
| **Miscellaneous** | | |
| Anemia | | |
| Cancer | | |
| Immune system disorder | | |
| Bleeding or clotting disorder | | |
| Trouble smelling odors | | |
| Claustrophobia or anxiety | | |
| Psychiatric illness (e.g. depression, bipolar) | | |
| **Surgeries or hospitalizations** | | |
| Reason: | | |

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed above._____

_____

_____

Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements):_____

_____

_____

| **Allergies: please specify** | Yes | No |
|---|---|---|
| Medications: | | |
| Latex | | |
| Other (e.g. foods, animals, etc.): | | |

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Name: _____

**Part A -- Health History**

To be completed by the patient.

# Social and Work-Related Health History

| Social History | Yes | No |
|---|---|---|
| Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more | | |
| Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years): | | |
| Do you use any other substances or recreational/street drugs? | | |
| Have you ever received treatment for substance use or abuse? | | |
| **Work-Related Health History** | **Yes** | **No** |
| Have you ever used a respirator? Please specify type: | | |
| Have you ever experienced any problems when wearing a respirator? | | |
| Have you ever been refused employment for health reasons or had to leave a job for health issues? | | |
| Do you have visual, hearing, or other physical limitations? Please specify: | | |
| Do you have any conditions or disabilities that may prevent you from performing the essential functions of your job or which require accommodation? Please specify: | | |
| Have you ever had a work-related injury or illness? Please specify: | | |

**Tuberculosis (Tb) Screening:**

Travel outside of the United States within the past 12 months? ____ yes ____ no

If yes, specify where? _____

Experiencing fever, sweats, cough, weight loss, or hemoptysis (spitting up Blood)? ____yes____ no (If Yes CXR )

History of positive PPD? ____ yes ____ no

**If History of Positive Screening Test:** If you have ever had a positive PPD or Quantiferon/T-Spot test, one chest x-ray is REQUIRED (No additional PPD or blood test needed). Please complete the information below:

Date of positive PPD or blood test:____/____/__ Chest x-ray date:_/____/____(Must attach x-ray report)

Treated with INH: □ Yes, □ No History of BCG Vaccine: □ Yes □ No

**If NO History of Positive Screening Test:** A two-step PPD test is required. The two PPD tests must be at least one week apart but not greater than 12 months apart. The most recent test must be within the last 3 months. Lab report of a negative Quantiferon Gold or T-Spot test within the last 3 months may be submitted in place of the two step PPD.

I certify that the information on this form is correct and complete to the best of my knowledge. I further understand that the results of this examination will be used to identify any medical condition(s), which might interfere with my ability to perform work duties. My employer will be made aware only of my fitness status. I also certify that I am free from habituation or addiction to alcohol, drugs or other substances that may alter behavior or affect my ability to perform work-related duties.

_____ _____

Employee Signature Date

***PPDs must be read by an Attending Physician, NP or PA. Self-reading is not acceptable.***

OR □ I am submitting a Quantiferon Gold/T-spot lab report in place of two-step PPD

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## Part B- Physical Exam

To be completed by a healthcare provider

**Name:** _____ **Date:** _____

## Preplacement Physical

Pulse _____ Blood Pressure _____ Height _____ Weight _____

Ishihara Color Test: _____ ☐ Pass ☐ Fail

| Review of Systems | Within Normal Limits | Abnormal |
|---|---|---|
| **General Appearance** | | |
| **Mental Status** | | |
| **Skin** | | |
| **Nodes** | | |
| **Eyes** | | |
| **Ears, Nose, Oral Cavity, Throat** | | |
| **Neck, Thyroid** | | |
| **Heart** | | |
| **Chest, Lungs** | | |
| **Abdominal** | | |
| **Extremities** | | |
| **Neurologic** | | |
| **Spine/back** | | |
| **Others** | | |
| | | |

Please explain any abnormal findings: _____

_____

_____

Note any recommended limitations or accommodations: _____

_____

After physical examination and review of past medical history, I find the above to be free from health impairment, which might interfere with the performance of his/her duties as required by NEW YORK health code (Title 10, Section 405.3).

_____ _____

Signature of Examining MD, DO, PA or NP Date

_____ _____

Print Name of Examining MD, DO, PA, or NP Date

**A.** Upon review of past medical history, vaccination records and/or titer results, I find the above named free from Tuberculosis and to show immunity to Rubella and Rubeola as required by New York State Health Code (Title 10, Section 405.3). As per SBUH policy HR008 the above-named shows immunity to Mumps and Varicella.

_____ _____

Signature of Employee Health Nurse Date

_____

Print name of Employee Health Nurse

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Applicant Name: _____ Date of Birth: _____

# Health Assessment Information for Volunteer Applicants

The following documentation from your private physician are required to satisfy the health requirements for volunteering. Please 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 Lab report including values for:
   Mumps-IGG
   Rubella (German measles)-IGG
   Rubeola (Measles)-IGG

2. **Negative PPD (dated within 3 months - 2 step PPD is required)** documented as follows: Date planted
   Result
   Date read
   Signature, Stamp and License by an M.D., P.A., or N.P.
   **OR**
   QuantiFERON Gold (a type of blood test that 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.

5. **Documentation of COVID-19 Vaccination:**
   Provide copy of the original card with dates, dose and location of Covid-19 vaccine.

**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 Employee Health Services.**
**Volunteer Services will schedule an appointment for you when you submit your application.**

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

**Employee COVID-19 Self-Screening Attestation**

We continue our commitment to do all we can to ensure the health and safety of our employees and to comply with all NYS Department of Health and other regulations regarding employee self-screening for signs and symptoms of COVID-19 and for any other communicable diseases.

Therefore, all employees are required to conduct a self-screening by carefully evaluating themselves for the following symptoms before reporting to work on each shift:

- Temperature of 100.0 F/38C or higher within the last 24 hours
- New or worsening shortness of breath
- New or worsening cough
- New or worsening body aches/muscle aches/chills
- New or worsening sore throat
- New or worsening loss of taste or sense of smell
- New or worsening fatigue/generally feeling sick or unwell (malaise)
- New or worsening headache
- New or worsening nausea, vomiting or diarrhea
- New or worsening skin lesions

**If you experience any of the above symptoms**, you must not come to work and must follow your departmental call-out procedures. If you begin experiencing any of these symptoms while at work, notify your supervisor immediately and leave work immediately thereafter.

Once home, employees must contact Employee Health and Wellness at (631) 726-8376 for guidance regarding return to work and testing. Those who tested positive for COVID-19 in the past 5 days or recently tested positive and not yet met the criteria for return to work as provided by Employee Health and Wellness must remain home until cleared by Employee Health.

**If you have had recent exposure to COVID-19 and have NO symptoms**, you may continue to work if you are fully vaccinated and current with any boosters for which you are eligible.

**If you have not received your booste**r and are eligible or if you are not yet fully vaccinated, you may work but must call Employee Health (631-726-8376) and **must be tested on days 1, 2, 3 and 5 to 7 after exposure**.

*If you are returning from international travel*, you may continue to work if you are fully vaccinated and current with any boosters for which you are eligible but must be tested 3 to 5 days after return and follow CDC guidance. If you have not received your booster and are eligible or if you are not yet fully vaccinated, you must stay home and quarantine for 5 full days after return and follow CDC guidance.

**While at work all employees must**:

- Wear a well-fitting mask fully covering their mouth and nose.
- Practice good hand hygiene, using soap and water or hand sanitizer frequently.
- Maintain social distancing.

Additional information is available at Employee Health and Coronavirus - What You Need to Know **THE PULSE.**

- *I attest that I have carefully read and fully understand the requirements above, and I agree to fully comply with all of these requirements.*

Print Name _____ Department _____

Signature _____ Date _____

**Thank you for reviewing and agreeing to comply with these requirements.**
**Please return your signed attestation to Employee Health.**