



**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 confidentiality may be grounds for dismissal.

_____ Volunteer
Signature Date

FOR OFFICE USE ONLY:

Interview Date _____ Orientation Date _____

Starting Date _____ Assignment _____

Day _____ Time _____

Comments _____



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



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 _____