Stony Brook
Southampton Hospital

# APPLICATION FOR VOLUNTEER AMBASSADOR
## (18 yrs and older)

Date_____

Name_____

Mailing Address _____City_____Zip_____

Telephone_____ Cell Phone_____

E-mail Address _____

EMERGENCY CONTACT_____

EDUCATION: High School _____ College _____

Other Schools/Training _____

REFERENCES: Present Employer _____

Address_____Phone Number_____

VOLUNTEERISM:

PREVIOUS VOLUNTEER EXPERIENCE_____

REASON FOR VOLUNTEERING_____

AVAILABILITY: Days most available _____

Times most available _____

Seasonal Volunteer? _____ What Months?_____

SKILLS:

Please circle all that apply: Computer Clerical Public Relations Fundraising

Other_____

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 _____

Days_____Times_____

Comments_____

_____

_____

Date_____Interviewer_____

STONY BROOK SOUTHAMPTON HOSPITAL
PERSONNEL HEALTH PROGRAM
VOLUNTEER PHYSICAL EXAMINATION

Name_____ Date of Birth_____

CHECK NORMAL (N) OR ABNORMAL (ABN):

| | (N) | (ABN) | COMMENTS |
|---|---|---|---|
| Head and Neck | ___ | ___ | _____ |
| Eyes | ___ | ___ | _____ |
| Ears | ___ | ___ | _____ |
| Nose | ___ | ___ | _____ |
| Mouth and Throat | ___ | ___ | _____ |
| Glands | ___ | ___ | _____ |
| Breasts, Chest Wall | ___ | ___ | _____ |
| Heart | ___ | ___ | _____ |
| Lungs | ___ | ___ | _____ |
| Abdomen | ___ | ___ | _____ |
| Extremities: | | | |
| Edema | ___ | ___ | _____ |
| Varicose Veins | ___ | ___ | _____ |
| Deformities | ___ | ___ | _____ |
| Skin | ___ | ___ | _____ |

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Hernia_____ Inguinal_____ Femoral_____
Back: Deformities_____ Tenderness or Palpation_____
Limitation of Motion_____ Other Abnormalities_____

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Remarks:
Describe any physical
limitations_____
_____

Any evidence of addiction to depressants, stimulants, narcotics? _____
_____

Observations_____
_____

Volunteer is/is not fit for hospital volunteer service.
If unfit, please explain_____
_____
_____

Physician's Signature _____ Date _____

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME_____

PHONE_____

ADDRESS_____

RELATIONSHIP_____

NAME_____

PHONE_____

ADDRESS_____

RELATIONSHIP_____

Stony Brook Southampton Hospital

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 – 2 step PPD is required) 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 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 Employee Health Services.**
**Volunteer Services will schedule an appointment for you when you submit your application.**

Stony Brook Southampton Hospital

**240 Meeting House Lane**
**Southampton, NY 11968**
Phone (631) 726-8376 Fax (631)726-8344

**EMPLOYEE HEALTH PHYSICAL EXAMINATION FORM**
***To be completed by health care practitioner***

**Name_____ Date of Birth _____Position Title_____**

**Age_____ Ht_____ Wt_____ Temp_____ Pulse_____Resp_____ BP____/_____**

**Vision: Rt 20/_____ Lt 20/_____**
**[ ] Glasses [ ] Without [ ] With [ ] Reading [ ] Distance**

**Ishihara's Color Test [ ] Normal [ ] Abnormal Administered by: _____Date_____**

**Medications: _____**

**Allergies: _____**

## Physical Examination

| | WNL | Abnormal | Comments |
|---|---|---|---|
| **General Appearance** | | | |
| **Abdomen** | | | |
| **Back/Spine** | | | |
| **Extremities** | | | |
| **Lungs** | | | |
| **Heart** | | | |
| **HEENT** | | | |
| **Neurological** | | | |
| **Skin** | | | |

**<u>Recommendations:</u>**

**Can employee perform essential functions of position? _____**

**Describe any limitations and/or accommodations that may required: _____**

**Refer to PMD for medical clearance related to:_____**

**Comments/Questions:_____**

**Print Practitioner's Name: _____**

**Practitioner's Signature_____Date_____**