



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 confidentiality may be grounds for dismissal.

Volunteer Signature

Date

FOR OFFICE USE ONLY:

Interview Date _____ Orientation Date _____

Starting Date _____ Assignment _____

Days _____ Times _____

Comments _____

Date _____ Interviewer _____

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

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.

- 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
- 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.
- 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.
- 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

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			

Recommendations:

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 _____

Meeting House Lane Medical-(631) 283-2100

Fax to Employee Health- (631)726-8344