Stony Brook
Southampton Hospital

APPLICATION FOR NODA
COMPASSIONATE COMPANION VOLUNTEERS

Date_____

Name_____

Mailing Address _____ City_____ Zip_____

Telephone_____ Cell Phone_____

E-mail Address _____

EMERGENCY CONTACT_____

REFERENCES: Present Employer _____

Address _____ Phone Number_____

SPIRITUAL AFFILIATION _____

VOLUNTEERISM:

PREVIOUS VOLUNTEER EXPERIENCE_____

REASON FOR VOLUNTEERING_____

ON CALL AVAILABILITY: Days most available_____
(4 HOUR SHIFTS)

Times most available _____

Seasonal Volunteer? _____ What Months? _____

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	___	___	_____

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

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 _____

8/17

****** For individuals not currently employed or volunteering at Stony Brook Southampton Hospital**

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME_____

PHONE_____

ADDRESS_____

RELATIONSHIP_____

NAME_____

PHONE_____

ADDRESS_____

RELATIONSHIP_____