Stony Brook
Southampton Hospital

VOLUNTEER SERVICES

Junior Volunteer Application

Applicants must be at least 15 years old before acceptance as a Junior Volunteer at the Hospital and be in good academic standing in their school. Applicants under 18 years will not be able to volunteer in clinical areas (ED, OR, Patient Floors).

Date _____

Name _____

Mailing Address _____ City _____ Zip _____

Home Telephone _____Cell Phone _____

E-mail Address _____

In the event of an Emergency: Name _____ Telephone No. _____

Date of Birth _____ Social Security Number _____

Mother's Name _____ Father's Name _____

School Name _____Telephone No. _____

Personal Physician _____ Telephone No. _____

If employed, where? _____ Employer's Telephone No. _____

Previous Volunteer Experience _____

_____

Second Language _____ Hobbies & Interests _____

Computer Skills _____

Availability: Days most available _____

Times most available _____

VOLUNTEER SERVICES

Junior Volunteer

TO CONSIDER YOUR APPLICATION, WE NEED THE FOLLOWING:

1. LETTER OF RECOMMENDATION FROM A TEACHER.

Fill out the first page yourself, have your parent or guardian sign the second page and have the third page filled out by your guidance counselor. A teacher's letter of recommendation is also required; **please note that the guidance counselor should not write your letter of recommendation.** Please return the application, a copy of your working papers and the consent form to the Volunteer office. Upon completion the guidance counselor should forward the third page, together with the teacher's letter of recommendation, to the Volunteer office.

PARENTAL/GUARDIAN CONSENT TO VOLUNTEER

I, _____, hereby give my consent for my child to participate as a Junior Volunteer at Stony Brook Southampton Hospital.

Signature of Parent or Guardian _____ Date _____

PARENTAL PERMISSION FOR TESTS and MEDICAL AUTHORIZATION

I, _____, the parent/guardian of _____, give my permission to Stony Brook Southampton Hospital and its medical and nursing staff to examine or treat my son/daughter in the event of accident or illness that may occur while volunteering at Stony Brook Southampton Hospital. I also give my permission to the Employee Health Nurse at Stony Brook Southampton Hospital to administer any tests required and necessary to be accepted as a Junior Volunteer. I further understand that I can have a copy of these test results forwarded to my physician upon written request.

Signature of Parent/Guardian _____ Date _____

VOLUNTEER SERVICES

Confidential School Reference for Junior Volunteer
(To be completed by Guidance Counselor—NOT by applicant)

Name _____

School _____

Date of Birth _____

The applicant has applied to be a Junior Volunteer at Stony Brook Southampton Hospital. The student must be at least 15 years old and be in good academic standing.

ASSESSMENT OF STUDENT

Please circle all that apply:

1. Responsibility: Conscientious Assumes responsibility Unreliable

2. Integrity: Trustworthy Honest Dependable Not dependable

Academic Standing: _____

Significant School Activities & Special Interests: _____

Overall Assessment: Recommended Not Recommended

Signature _____ Title _____

Telephone Number _____ Date _____

Please return all pages to: Volunteer Services Department
Stony Brook Southampton Hospital
240 Meeting House Lane
Southampton, NY 11968

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.

Signature of Volunteer _____ Date _____

For Office Use Only:

Interview Date _____ Starting Date _____

Assignment _____ Days _____ Times _____

Comments _____

Date _____ Interviewer _____

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**

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_____