



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 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 \_\_\_\_\_

**\*\*\*\* 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\_\_\_\_\_



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.

- 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
- 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.**
- 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.
- 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.**



# 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