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 are required to satisfy the health requirements for volunteering. Please 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 Lab report including 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 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**.

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.

5. **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

Name: _____

Part A -- Health History

To be completed by the patient.

Social and Work-Related Health History

Social History	Yes	No
Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more		
Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years):		
Do you use any other substances or recreational/street drugs?		
Have you ever received treatment for substance use or abuse?		
Work-Related Health History	**Yes**	**No**
Have you ever used a respirator? Please specify type:		
Have you ever experienced any problems when wearing a respirator?		
Have you ever been refused employment for health reasons or had to leave a job for health issues?		
Do you have visual, hearing, or other physical limitations? Please specify:		
Do you have any conditions or disabilities that may prevent you from performing the essential functions of your job or which require accommodation? Please specify:		
Have you ever had a work-related injury or illness? Please specify:		

Tuberculosis (Tb) Screening:

Travel outside of the United States within the past 12 months? ____ yes ____ no

If yes, specify where? _____

Experiencing fever, sweats, cough, weight loss, or hemoptysis (spitting up Blood)? ____yes____ no (If Yes CXR)

History of positive PPD? ____ yes ____ no

If History of Positive Screening Test: If you have ever had a positive PPD or Quantiferon/T-Spot test, one chest x-ray is REQUIRED (No additional PPD or blood test needed). Please complete the information below:

Date of positive PPD or blood test:____/____/__ Chest x-ray date:_/____/____(Must attach x-ray report)

Treated with INH: □ Yes, □ No History of BCG Vaccine: □ Yes □ No

If NO History of Positive Screening Test: A two-step PPD test is required. The two PPD tests must be at least one week apart but not greater than 12 months apart. The most recent test must be within the last 3 months. Lab report of a negative Quantiferon Gold or T-Spot test within the last 3 months may be submitted in place of the two step PPD.

I certify that the information on this form is correct and complete to the best of my knowledge. I further understand that the results of this examination will be used to identify any medical condition(s), which might interfere with my ability to perform work duties. My employer will be made aware only of my fitness status. I also certify that I am free from habituation or addiction to alcohol, drugs or other substances that may alter behavior or affect my ability to perform work-related duties.

_____ _____

Employee Signature Date

PPDs must be read by an Attending Physician, NP or PA. Self-reading is not acceptable.

OR □ I am submitting a Quantiferon Gold/T-spot lab report in place of two-step PPD

Stony Brook Southampton

Part A -- Health History

Name and date of birth: _____

To be completed by the patient.

Medical History and Review of Symptoms

Have you ever had, or do you have any of the following?

Infectious Diseases	Yes	No
Chicken Pox or Shingles		
Measles		
Mumps		
Tuberculosis or positive IGRA or PPD test		
Other Disease:		
Respiratory/Lungs		
Chronic Bronchitis/Emphysema/COPD		
Asthma/Wheezing		
Asbestosis, Silicosis, Pneumoconiosis		
Pneumonia		
Pneumothorax (collapsed lung)		
Broken ribs or chest injury/surgery		
Coughing up phlegm or blood		
Shortness of breath or chest tightness		
Cardiovascular/Heart		
Heart Attack		
Chest pain/Angina		
Heart failure		
Irregular heart rhythm or palpitations		
High blood pressure		
Edema (swelling of legs/feet)		
Stroke		
Neurologic		
Seizures or Epilepsy		
Numbness, weakness or paralysis of arms or legs		
Head injury or concussion		
Severe headaches or migraines		
Dizziness or fainting spells		
Other neurologic disorder		
Sleep apnea or other sleeping disorder		

Gastrointestinal and Kidney	Yes	No
Stomach or intestinal problem		
Hepatitis or other liver disease		
Kidney disease or kidney stones		
Hernia		
Blood in urine		
Skin, Endocrine, Severe Allergic Reaction		
Chronic rash or eczema		
Diabetes		
Thyroid or other endocrine problem		
Allergic reactions that affect breathing		
Vision and Hearing		
Wear glasses or contacts		
Eye disorder (e.g. glaucoma, macular degeneration, cataracts, etc.) or injury		
Color blindness		
Hearing loss or tinnitus (ringing in ears)		
Musculoskeletal		
Back/neck injury or pain		
Arthritis/gout		
Other bone/joint problem or injury- please specify:		
Miscellaneous		
Anemia		
Cancer		
Immune system disorder		
Bleeding or clotting disorder		
Trouble smelling odors		
Claustrophobia or anxiety		
Psychiatric illness (e.g. depression, bipolar)		
Surgeries or hospitalizations		
Reason:		

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed above._____

_____

_____

Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements):_____

_____

_____

Allergies: please specify	Yes	No
Medications:		
Latex		
Other (e.g. foods, animals, etc.):		

Stony Brook Southampton Hospital

Part B- Physical Exam

To be completed by a healthcare provider

Name: _____ **Date:** _____

Preplacement Physical

Pulse _____ Blood Pressure _____ Height _____ Weight _____

Ishihara Color Test: _____ ☐ Pass ☐ Fail

Review of Systems	Within Normal Limits	Abnormal
General Appearance		
Mental Status		
Skin		
Nodes		
Eyes		
Ears, Nose, Oral Cavity, Throat		
Neck, Thyroid		
Heart		
Chest, Lungs		
Abdominal		
Extremities		
Neurologic		
Spine/back		
Others		

Please explain any abnormal findings: _____

_____

_____

Note any recommended limitations or accommodations: _____

_____

After physical examination and review of past medical history, I find the above to be free from health impairment, which might interfere with the performance of his/her duties as required by NEW YORK health code (Title 10, Section 405.3).

_____ _____

Signature of Examining MD, DO, PA or NP Date

_____ _____

Print Name of Examining MD, DO, PA, or NP Date

A. Upon review of past medical history, vaccination records and/or titer results, I find the above named free from Tuberculosis and to show immunity to Rubella and Rubeola as required by New York State Health Code (Title 10, Section 405.3). As per SBUH policy HR008 the above-named shows immunity to Mumps and Varicella.

_____ _____

Signature of Employee Health Nurse Date

_____

Print name of Employee Health Nurse