Stony Brook
Southampton Hospital

VOLUNTEER SERVICES

NODA/Spiritual Compassionate Companions
(21yrs and older)

Date________________________

Name____

Mailing Address ______________________ City ________________ Zip ________

Home Telephone ______________________ Cell Phone ______________________

E-mail Address ____

Social Security Number ____

EMERGENCY CONTACT ____

Are you currently employed? If yes,

Present Employer ____

Address _________________________ Phone Number __________

PREVIOUS VOLUNTEER EXPERIENCE ___________________________________

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____

REASON FOR VOLUNTEERING ____

AVAILABILITY: Days most available _____________________________________

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 ____________________________

Day ____________________________ Time ____________________________________

Comments ____

____

____

Date ______________________ Interviewer ______________________

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** __________

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.

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME ______________________________

PHONE ______________________________

ADDRESS ______________________________

RELATIONSHIP ______________________________

NAME ______________________________

PHONE ______________________________

ADDRESS ______________________________

RELATIONSHIP ______________________________