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 _____

EMERGENCY CONTACT_____

Are you currently employed? If yes,

Present Employer _____

Address _____ Phone Number _____

PREVIOUS VOLUNTEER EXPERIENCE _____

_____

_____

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			

<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_____

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.

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____