



*Customer Relations  
Volunteer Services*

Dear Applicant:

Thank you for your interest in the Stony Brook University Medical Center Volunteer Program. **To expedite the application process, please carefully review the information below.**

- Applications are accepted:

**Monday through Thursday  
9:30am-11:30am  
and  
2pm-4pm**

Walk-ins are accepted, however, we strongly recommend you call the office on the day you would like to submit your application to confirm that a staff member will be available to meet with you.

- **Only completed applications will be accepted.** Did you:
  - √ Complete both pages of the application
  - √ Sign the authorization to conduct a background check
  - √ Complete the Employee Health Screening Pre-Admission Questionnaire
  - √ Complete the Volunteer Health History Form
  - √ Have your physician complete the Medical Reference Form
- When arriving at University Hospital please park in the visitors parking garage and bring in your parking ticket for validation. Our office is located on the second floor of the hospital; please stop at the Information Desk for a visitor pass and directions.
- When you arrive at the Volunteer Office, your complete application will be reviewed by the Volunteer Services staff (**only complete applications will be accepted**). At that time, you will be scheduled for an orientation appointment. If your application does not contain documentation of a current Tuberculosis screening and/or documentation of two MMR vaccines or positive titers, you will also be scheduled for an Employee Health Assessment. Information about the health assessment is included in this application packet.

If you have any questions about the application packet, please call the Volunteer Office at 444-2610 or visit the volunteer section of [www.stonybrookmedicalcenter.org](http://www.stonybrookmedicalcenter.org).

**STONY BROOK, NEW YORK 11794-7027**

# SENIOR VOLUNTEER APPLICATION

***Thank you for interest in becoming a Stony Brook University Hospital Volunteer. Applicants for the Senior Volunteer Program must be 18 years of age or older. Volunteering begins with a commitment. At Stony Brook University Hospital we encourage all volunteers to serve at least three hours a week for at least eight months or complete one hundred hours of volunteer service.***

NAME: LAST	FIRST	MIDDLE	DATE
HOME ADDRESS			HOME TEL. NO.
			CELL NO.
DATE OF BIRTH			SOC. SEC. NO.
SUNYSB STUDENTS LIVING ON CAMPUS: LIST ADDRESS, TELEPHONE NUMBER AND SOLAR NUMBER			EMAIL
CAMPUS ADDRESS			SOLAR NO.

ARE YOU CURRENTLY ENROLLED IN COLLEGE?  YES  NO | IF YES, WHERE?

ARE YOU CURRENTLY EMPLOYED?  YES  NO  FULL TIME  PART TIME | JOB TITLE

IF EMPLOYED, WHERE? AND TEL. NO.

VOLUNTEER EXPERIENCE  PREVIOUS  PRESENT | WHAT CAPACITY

SERVICE DATES AND LOCATIONS

Have you ever been convicted of a felony or misdemeanor?  YES  NO If yes, provide date, charge, and disposition.

### Authorization to Conduct Background Verification and General Release

In connection with my application to become a volunteer at the Stony Brook University Hospital, hereafter "employer", I hereby authorize the employer to conduct a background investigation pursuant to the Fair Credit Reporting Act which may include, but not limited to, a Social Security Number verification and Criminal Conviction verification. I also authorize the "employer" to conduct an Office of Inspector General (OIG) search to ascertain my current status with the OIG List of Sanctioned Individuals, and to conduct a General Services Administration (GSA) search of their List of Parties Excluded to ascertain my current status in the GSA.

I am aware that I have the right under Fair Credit Reporting Act to request from the vendor performing the background check, the nature and scope of any report they have prepared in conjunction with the verifications conducted related to my application to volunteer. I authorize and request all courts and law enforcement agencies to release such information without restriction or qualification.

I hereby release Stony Brook University, Stony Brook University Hospital, their respective officers, employees and agents, from any liability and responsibility arising from preparation of the above described background check, investigation or report, and any resulting outcome or consequences, as well as any liability and responsibility arising from obtaining, reviewing, discussing any information gathered in connection with a review of my application, and any resulting consequences.

Applicant's Signature	Date
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PLEASE PROVIDE THREE REFERENCES WHOM WE MAY CONTACT (INCLUDE NAME, PHONE NUMBER, AND RELATIONSHIP)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

TO BE NOTIFIED IN CASE OF EMERGENCY

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE NO. (HOME) \_\_\_\_\_ PHONE NO. (BUSINESS) \_\_\_\_\_

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM AT UNIVERSITY HOSPITAL?  
\_\_\_\_\_

Do you belong to any club or organization that you think may benefit from a visit from our staff to share with them information about volunteering? If yes, please list the name of the organization and if possible telephone number and a contact person.

**Attention Applicant:** Please be advised that Stony Brook University Hospital Volunteer Services does background checks on all new hires. Prior criminal conviction may not prevent you from getting the volunteer position. However, falsifying your volunteer application is grounds for withdrawal of a volunteer job offer or termination.

### Acknowledgment & Authorization

I hereby affirm that this application and all documents submitted to me in connection with my application for volunteering contain no willful misrepresentations and that the information given by me is true and complete. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a candidate for volunteering or for my immediate termination and/or referral for criminal prosecution. I authorize persons, schools, my current employer (if applicable), and previous employers and organizations named in this application (and accompanying documents if any) to provide any relevant information that may be needed to arrive at a decision of acceptance into the volunteer program.

I agree if accepted as a volunteer to abide by all rules, policies and regulations of Stony Brook University. I certify that the information that I have provided is complete and accurate.

Applicant's Signature	Date
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## **Health Assessment Information for Volunteer Applicants**

All applicants must be screened for Measles, Mumps and Rubella as well as Tuberculosis. All applicants have the option of having the screening completed by their private physician or the hospital's employee health office.

### **Please note:**

**The Medical Reference Form must be completed by your physician. Employee Health cannot satisfy this requirement.**

Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

### **Private Physician Documentation:**

You can provide documentation from your private physician to satisfy the screening requirement. Listed below is the required documentation, please be sure to carefully read each item.

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

\*Varicella (Chicken Pox) – IGG \*If you have had Chicken Pox in the past, the Varicella titer is not required, please be sure to note the approximate date of occurrence on the volunteer health history form.

2. Negative PPD (dated within 3 months) documented as follows:

Date planted  
Result  
Date read  
Signature, Stamp and License Number by an M.D., P.A. or N.P

**OR**

If you have had a past positive PPD, a negative chest x-ray report is required.

Continued on next page.....

## Health Assessment Information For Volunteer Applicants Continued....

### **Employee Health Appointment:**

Your appointment for a health assessment will be scheduled by the Department of Volunteer Services upon submission of your application. If you need to cancel or reschedule your Employee Health appointment, please contact the Volunteer Office at (631) 444-2610 as soon as possible.

On the day of your Employee Health appointment, please arrive approximately five minutes before the time of your appointment and go to the Volunteer Office on level 2 of the hospital. The Volunteer Office staff will validate your parking and direct you to the Employee Health Service on level 3.

If your applications does not include documentation of two MMR vaccines or positive titers for Mumps, Rubella and Rubeola, the Employee Health office will draw a tube of blood from your arm to test your immunities. Please have something to eat and drink before your appointment.

If your application does not include documentation of a current PPD, dated within three months, the Employee Health office will give you one of the two required PPD (Mantoux) tests for Tuberculosis. The PPD test is to see if your body has ever been exposed to Tuberculosis. Applicants who have had a past history of a positive PPD must provide a copy of a negative chest x-ray report. Employee Health cannot satisfy this requirement.

The PPD test is a two-step process. First you will receive an injection just under the skin of your forearm. Forty-eight to seventy-two hours later, you must return to Employee Health Office to have the test read. While having the first PPD test read you will be given the opportunity to schedule an appointment for the second PPD test or you can make the appointment at a later date by calling 444-7767. The second PPD test must be completed within 2 months of the initial test.

Please note, the Medical Reference Form must be completed by your physician, it is not part of the Employee Health screening process.

**Volunteer Health History:**

*Applicants are responsible for completing the non-shaded portion of the form. Please have a healthcare professional complete the shaded areas below, if they have information regarding your current PPD and/or two MMR vaccines. Signatures from an M.D., P.A., or N.P. will only be accepted. The healthcare provider's office stamp is also required.*

Name \_\_\_\_\_ Today's Date. \_\_\_\_\_

Address \_\_\_\_\_ Tel No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Place of Birth \_\_\_\_\_

Marital Status \_\_\_\_ Emergency Contact \_\_\_\_\_ Tel No. \_\_\_\_\_

Family Doctor \_\_\_\_\_ Tel. No. \_\_\_\_\_

Address \_\_\_\_\_

*Have you ever had PPD test? Yes or No What was the result? Positive or Negative*

*If your PPD result was positive, please provide a copy of the negative chest x-ray report.*

If your PPD was administered within the last three months, please have your healthcare professional document the PPD below:

Date Tuberculin Test Planted: \_\_\_\_\_ Date Read: \_\_\_\_\_

Result: Pos \_\_\_\_\_ Neg. \_\_\_\_\_

**Please circle applicable title:**

**Office Stamp:**

Signature: \_\_\_\_\_ M.D. P.A. or N.P.

*Have you had two MMR vaccines? Yes or No*

If yes, please have your healthcare professional document the MMR vaccines below:

Date of Previous MMR Vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_

**Please circle applicable title:**

**Office Stamp:**

Signature: \_\_\_\_\_ M.D. P.A. or N.P.

*Childhood Diseases: (Include approximate date)*

*Chicken Pox \_\_\_\_\_ Vaccine: \_\_\_\_\_*

*Allergies: Drugs \_\_\_\_\_ Food \_\_\_\_\_*

*Have you ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_*

1. *Operations (include dates)*

2. *Injuries* \_\_\_\_\_

3. *Illnesses* \_\_\_\_\_

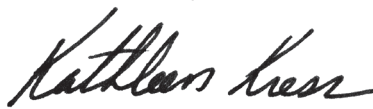
*Please list the medications you are currently taking:* \_\_\_\_\_

*Do you have any current or chronic illness such as: diabetes, high blood pressure, heart trouble, seizure disorder, tuberculosis, or other disease? Please list:* \_\_\_\_\_

**DEPARTMENT OF VOLUNTEER SERVICES  
MEDICAL REFERENCE**

\_\_\_\_\_ has applied to become a volunteer at University Hospital and has given us your name as a medical reference. Will you please give us the following information. It will be treated as confidential.  
Thank you for your assistance.

Sincerely,



Kathy Kress, CAVS  
Asst. Director Volunteer Services

**1. Does the applicant have any condition or disability that may be of potential risk to patients or personnel at University Hospital?**

**REMARKS:** \_\_\_\_\_

YES

\_\_\_\_\_

NO

\_\_\_\_\_

2. Does the applicant have any condition or disability that might interfere with the performance of his/her duties as a volunteer?

**REMARKS:** \_\_\_\_\_

YES

\_\_\_\_\_

NO

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**\*PHYSICIAN OFFICE STAMP/LICENSE NUMBER ARE ALSO REQUIRED.**