



*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
  - √ Have your parent or guardian sign the consent forms
  - √ 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).



# UNIVERSITY HOSPITAL

DEPARTMENT OF VOLUNTEER SERVICES  
HEALTH SCIENCES CENTER  
STATE UNIVERSITY OF NEW YORK AT STONY BROOK  
STONY BROOK, NEW YORK 11794  
(631) 444-2610

# JUNIOR VOLUNTEER APPLICATION

*Applicants for the Junior Volunteer Program must be 14 to 17 years of age and in good academic standing at school.*

*Volunteering begins with a commitment. At University Hospital we encourage all volunteers to serve at least three hours a week for at least eight months. Before an assignment can be made, each volunteer must obtain a medical clearance from his / her physician, purchase a volunteer uniform, and attend an orientation program.*

NAME	LAST	FIRST	MIDDLE	DATE
ADDRESS				HOME TEL. NO.
CITY	STATE		ZIP	SOC. SEC. NO.
SCHOOL NAME			SOLAR NO.	
SCHOOL ADDRESS			<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
SCHOOL TEL. NO.		PRESENT GRADE		EMAIL

PLEASE LIST ANY RELATIVES OR FRIENDS WHO ARE EMPLOYEES OR VOLUNTEERS AT UNIVERSITY HOSPITAL (INCLUDE NAME, DEPARTMENT AND RELATIONSHIP)

AGE	DATE OF BIRTH		
ARE YOU CURRENTLY EMPLOYED	NO. OF HOURS PER WEEK	JOB TITLE	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
IF EMPLOYED WHERE? AND TEL. NO.			
VOLUNTEER EXPERIENCE			
SERVICE DATES, LOCATION, VOLUNTEER DUTIES			
TO BE NOTIFIED IN CASE OF EMERGENCY			
NAME		RELATIONSHIP	
PHONE NO. (HOME)		PHONE NO. (BUSINESS)	
PERSONAL PHYSICIAN			
ADDRESS AND TEL. NO.			

WILL YOU BE DRIVING TO UNIVERSITY HOSPITAL? IF YES, PLEASE COMPLETE THE FOLLOWING:

<input type="checkbox"/> YES <input type="checkbox"/> NO				
MAKE OF CAR:	MODEL:	COLOR:	LICENSE PLATE NO.:	YEAR:

ARE YOU UNDER MEDICAL TREATMENT OF ANY KIND?

YES  NO

IF YES, PLEASE EXPLAIN

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT MIGHT AFFECT YOUR VOLUNTEERING?

YES  NO

IF YES, PLEASE EXPLAIN

PLEASE LIST  
FOREIGN LANGUAGES THAT YOU SPEAK FLUENTLY:

SPECIAL SKILLS THAT MIGHT BE USEFUL IN YOUR VOLUNTEER WORK:

CLUBS OR ORGANIZATIONS TO WHICH YOU BELONG:

ARE YOU PLANNING A CAREER IN HEALTH SERVICES?

YES  NO

IF YES, PLEASE EXPLAIN

WHAT ARE YOUR PLANS AFTER GRADUATION?

NUMBER OF HOURS YOU ARE WILLING TO VOLUNTEER EACH WEEK

ARE THERE ANY TYPES OF ASSIGNMENTS IN WHICH YOU ARE ESPECIALLY INTERESTED?

WHY DO YOU WANT TO VOLUNTEER AT UNIVERSITY HOSPITAL?

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

I AGREE THAT AS A JUNIOR VOLUNTEER I WILL:

- SERVE REGULARLY AS ASSIGNED.
- ACCEPT SUPERVISION GRACEFULLY.
- ABIDE BY ALL RULES AND POLICIES OF THE DEPARTMENT OF VOLUNTEER SERVICES.
- KEEP CONFIDENTIAL ALL INFORMATION THAT COMES TO ME IN THE PERFORMANCE OF MY DUTIES.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**CONSENT TO INTERVIEW, PHOTOGRAPH, FILM, VIDEOTAPE  
OR RECORD**

I, \_\_\_\_\_, hereby give my consent and permission to  
(Parent/Guardian Print Name)  
University Hospital at Stony Brook and to its employees and authorized agents to  
interview, take photographs, motion pictures, videotape and/or sound recordings of me or  
of \_\_\_\_\_ for whom I am legally responsible.  
(Jr. Vol. Print Name)

The purpose of this activity has been clearly explained to me and I release University Hospital, State University of New York at Stony Brook, and the State of New York from any claim that I may have against each by reason of this interview, recording photography or videotaping. I also waive any claims to payment or royalties derived therefrom.

University Hospital reserves the right to grant or deny permission to patients or their authorized agents to interview, photograph, film, videotape or record patients while in the hospital. The patient or authorized guardian agrees to indemnify University Hospital, State University of New York, and/or the State of New York against any and all damages or losses they may sustain as a result of taking such recordings.

Interviews, photographs, films, videotapes or recordings obtained by University Hospital may be used for any or all of the following purposes, with or without names or other identification:

- a. Clinical documentation of current patient condition
- b. Educational purposes
- c. Health care research
- d. Publicity for Hospital programs
- e. Staff recruitment and training
- f. Fund raising and development
- g. Other (specify) \_\_\_\_\_

\_\_\_\_\_ X \_\_\_\_\_  
Date Parent/Guardian Signature



# Parent/Guardian Consent Form Junior Volunteer Program

Date \_\_\_\_\_

I give my consent for my son/daughter \_\_\_\_\_ to  
participate in the Junior Volunteer Program at Stony Brook University  
Hospital.

I will assume responsibility for my son/daughter's transportation to  
and from Stony Brook University Hospital.

\_\_\_\_\_  
(Parent/Guardian Name Printed)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Parent/Guardian Address)

\_\_\_\_\_

# Medical Authorization Junior Volunteer Program

Date \_\_\_\_\_

I, \_\_\_\_\_, the  
parent/guardian of \_\_\_\_\_, give my consent  
to Stony Brook University Hospital and to its medical and nursing staff to  
examine or treat my son/daughter in the event of accident or illness that may  
occur in the course of performing duties as a volunteer at Stony Brook  
University Hospital.

I also give my consent to Stony Brook University Hospital to perform  
health assessments/screenings as required by hospital policy.

\_\_\_\_\_  
(Parent/Guardian Name Printed)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Parent/Guardian Address)

\_\_\_\_\_



## **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* \_\_\_\_\_

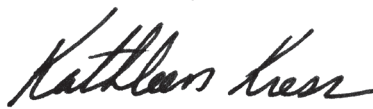
*Please list the medications you are currently taking:* \_\_\_\_\_

*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.**