Volunteer application

Welcome

We are extremely pleased you have expressed interest in volunteering at Catholic Health. Your commitment, hard work and unique skills will allow for an amazing healthcare experience for our patients and residents. Volunteering at a hospital, nursing home or assisted living facility is a wonderful way to give back to an organization that may have helped you or a loved one and to apply your special talents while making a positive impact on the community.

Enclosed you will find the application that requests personal information and references for you to complete and return. A medical reference form that must be completed by your physician will be provided separately after acceptance of your application (medical consent is required for the health and safety of all our patients and those working at and visiting a Catholic Health Entity). Please allow us approximately two weeks to review your application. You will only be contacted if we have an opening that fits the time, days, location and interests that you have indicated on your application. We ask your cooperation in being open to volunteering in an area that needs assistance.

When all requirements have been met, prospective volunteers are interviewed. At the interview, selected applicants will be requested to consent to a background check performed by an outside vendor (via a link sent in an email), with the understanding that acceptance is contingent upon Catholic Health's review of the results. Applicants who need assistance completing the volunteer background check are invited to contact the volunteer office to schedule an appointment. All volunteers will be required to attend a Catholic Health orientation and department specific training prior to beginning their assignment. Acceptance to the volunteer program is contingent upon Catholic Health's review of the results.

We appreciate your interest in Catholic Health and look forward to having you join our Volunteer Program in the near future.

Thank you,
Catholic Health Volunteer Services

St. Francis Hospital & Heart Center®
Phoebe.Duran@chsli.org
T (516) 562-6112

Good Samaritan Hospital
Brittany.Colasanto@chsli.org
T (631) 376-3659

St. Charles Hospital
Tasha.Felix-Jerome@chsli.org
T (631) 474-6251

St. Catherine of Siena Hospital
St. Catherine of Siena Nursing & Rehabilitation
Daniel.Baier@chsli.org
T (631) 862-3057

Mercy Hospital
Joseph.Lanzetta@chsli.org
T (516) 705-2608

St. Joseph Hospital
Elizabeth.Schwind@chsli.org
T (516) 520-2801

Good Shepherd Hospice
Nadine.Moyse@chsli.org
T (631) 828-7611

Good Samaritan Nursing & Rehabilitation
Jeannean.Thomasch@chsli.org
T (631) 244-2400

Our Lady of Consolation Nursing & Rehabilitation
Christine.Centrone@chsli.org
(631) 587-1600 ext. 6624

Volunteer application

Catholic Health

Personal Information

The information you provide in this application is strictly confidential.

Name _____ Date _____

Name to Appear on ID Badge _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Volunteer Uniform shirt size _____

How do you prefer to be contacted? ☐ Home phone ☐ Cell phone ☐ Email

Person to notify in the event of an emergency:

Name _____ Relationship _____ Phone _____

Address _____

Select Primary Catholic Health Entity Interested in Volunteering at (select one; application will be sent to this location only):

☐ Good Samaritan Hospital ☐ Good Samaritan Nursing & Rehabilitation ☐ Good Shepherd Hospice

☐ Mercy Hospital ☐ Our Lady of Consolation Nursing & Rehabilitation ☐ St. Catherine of Siena Hospital

☐ St. Catherine of Siena Nursing & Rehabilitation ☐ St. Charles Hospital ☐ St. Francis Hospital & Heart Center

☐ St. Joseph Hospital

Please list any additional Catholic Health entities interested in volunteering at: _____

_____

_____

Education

Are you currently attending school? ☐ Yes ☐ No

If yes, school attending and graduation year: _____

Education Level: ☐ High School ☐ College ☐ Other _____

Volunteer application

Catholic Health

Experience

Work Experience _____

_____

_____

Volunteer Experience _____

_____

_____

Skills

What qualities (hobbies, talents, knowledge, foreign languages, office machines, etc.) do you feel you can incorporate into your volunteer work? _____

_____

_____

Which service areas interest you (not applicable for Good Shepherd Hospice)?

☐ **Clerical** ☐ **Information Desk** ☐ **Spiritual Care** ☐ **Patient Service** ☐ **Gift Shop**

☐ **Specific Medical Department of Interest** _____

☐ **Other (please list)** _____

Are you certified in CPR? ☐ **Yes** ☐ **No** **Date:** _____

Volunteer questions

What is your purpose in becoming a volunteer? _____

_____

What is appealing to you about volunteering in a healthcare/hospice setting? _____

_____

Are you interested in a medical career? _____

How did you hear about our program? _____

Volunteer application

Catholic Health

Do you have a family member employed/volunteering at a Catholic Health Entity? ☐ Yes ☐ No If yes, please provide name of relative, Catholic Health Entity and title. _____

_____

Volunteer Availability: Please indicate which days and times you are available to volunteer:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

GOOD SHEPHERD HOSPICE VOLUNTEERS ONLY MUST COMPLETE THIS SECTION:

Have you experienced the death of a loved one in the last year? ☐ Yes ☐ No If yes, please explain briefly.

_____

_____

Have you ever been with someone at the time of their death? ☐ Yes ☐ No If yes, please describe briefly.

_____

_____

Good Shepherd Hospice Volunteers are required to complete training prior to their start date. Please indicate your availability to attend training:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

Which service areas interest you?

☐ Community Hospice Volunteer

☐ Compassionate Shepherd

☐ Administrative Volunteer

☐ Bereavement Volunteer

☐ Other (please list) _____

Volunteer application

Catholic Health

References

Please provide two references (excluding family members) who can attest to your character and ability to perform as a volunteer.

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email Address** _____

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email Address** _____

Consents

By signing below, the applicant acknowledges reading, understanding and consenting to all of the following attached disclosure:

☐ **Background Check Disclosure and Authorization Form** _____

By signing below, a parent or guardian of an applicant under the age of 18 acknowledges reading, understanding and consenting to the following attached disclosures:

☐ **Parental Consent Form** _____

☐ **Background Check Disclosure and Authorization Form - Minors** _____

Please provide any additional information here that will assist us with the application process.

_____

_____

Applicant Signature _____ **Date** _____

Volunteer Background Report Disclosure and Authorization

Disclosure Regarding Volunteer Background Report

_____ ("COMPANY") may obtain from Sterling Volunteers, 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860. www.sterlingvolunteers.com, a consumer report and/or an investigative consumer report ("REPORT") that contains background information about you in connection with volunteerism. Sterling Volunteers may obtain further reports throughout your volunteerism so as to update your report without providing further disclosure or obtaining additional consent.

The REPORT may contain information about your character, general reputation, personal characteristics and mode of living. The REPORT may include, but is not limited to, credit reports and credit history information; criminal and other public records and history; public court records; motor vehicle and driving records; and Social Security verification and address history, subject to any limitations imposed by applicable federal and state law. This information may be obtained from public record and private sources, including credit bureaus, government agencies and judicial records, and other sources.

If an investigative consumer REPORT is obtained, in addition to the description above, the nature and scope of any such REPORT will be for personal references.

Volunteer Signature_____ Date _____

California Disclosure Regarding Volunteer Background Report

_____("COMPANY") may obtain from Sterling Volunteers, 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860, www.sterlingvolunteers.com, a consumer report and/or an investigative consumer report ("REPORT") that contains background information about you in connection with your volunteerism. Sterling Volunteers may obtain further reports throughout your volunteerism so as to update your report without providing further disclosure or obtaining additional consent.

The REPORT may contain information about your character, general reputation, personal characteristics and mode of living. The REPORT may include, but is not limited to, credit reports and credit history information; criminal and other public records and history; public court records; motor vehicle and driving records; and Social Security verification and address history, subject to any limitations imposed by applicable federal and state law. This information may be obtained from public record and private sources, including credit bureaus, government agencies and judicial records, and other sources.

If an investigative consumer REPORT is obtained, in addition to the description above, the nature and scope of any such REPORT will be personal references.

You may inspect Sterling Volunteers' files concerning you during normal business hours and upon reasonable notice. You can inspect the files at Sterling Volunteers' offices if you furnish proper identification, and you can obtain a copy by paying duplication costs. One other person can accompany you if he or she furnishes reasonable identification. You can also obtain a copy of your files by sending Sterling Volunteers at the address listed above a written request, including proper identification, by certified mail. Sterling Volunteers will give you a summary of the information in the files by telephone if you submit a written request including proper identification. Sterling Volunteers has trained personnel

who can explain the information furnished to you, and can provide a written explanation of any coded information contained in your files. "Proper identification" includes documents such as a valid driver's license, Social Security card, military identification card or credit card. If necessary, Sterling Volunteers may request additional information about your volunteerism and personal or family history to verify your identity.

Volunteer Signature_____ Date _____

Authorization to Obtain Volunteer Background Report

I have read the Disclosure Regarding Volunteer Background Report provided by _____("COMPANY") and this Authorization to Obtain Volunteer Background Report. By my signature below, I hereby consent to the preparation by Sterling Volunteers, a consumer reporting agency located at 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860, www.sterlingvolunteers.com, of background reports regarding me and the release of such reports to the COMPANY and its designated representatives, to assist the COMPANY in making a volunteer decision involving me at any time after receipt of this authorization and throughout my volunteerism, to the extent permitted by law. To this end, I hereby authorize, without reservation, any state or federal law enforcement agency or court, educational institution, motor vehicle record agency, credit bureau or other information service bureau or data repository, to furnish any and all information regarding me to Sterling Volunteers and/or the COMPANY itself, and authorize Sterling Volunteers to provide such information to the COMPANY. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

I acknowledge receipt of a copy of the Consumer Financial Protection Bureau's "A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT."

Volunteer Name (Printed): _____

Volunteer Signature: _____

Date: _____

State Law Notices Relating to Your Background Report

Washington State Volunteers only: You have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act. By signing, you acknowledge that you are aware of this right.

Volunteer Signature_____ Date _____

☐ **California, Massachusetts, Minnesota, New Jersey and Oklahoma Volunteers Only:** Please check the box to the left if you would like a free copy of any REPORT obtained by COMPANY from Sterling Volunteers.

New York Volunteers Only: By signing, you acknowledge that you have received a copy of New York Correction Law Article 23-A. You have the right, upon written request, to be informed whether an investigative consumer REPORT was requested. If such a REPORT was requested, you will be provided with the name and address of the consumer reporting agency that prepared the REPORT and you can contact that agency to inspect or receive a copy of the REPORT.

Volunteer Signature_____ Date _____

Volunteer Information:

First Name: _____ Middle: _____ Last:_____

Social Security Number: _____ Email: _____

Date of Birth: _____ Phone Number: _____

Driver's License #: _____ Driver's License State: _____

Other Names Used (alias, maiden name, etc.): _____

Address History (Within the last seven years):

Address 1:_____ From _____To_____

Address 2:_____ From _____To _____

Address 3:_____ From _____To_____

Address 4:_____ From _____To_____

Address 5:_____ From _____To_____

A Summary of Your Rights under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552.**

You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.

You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies.
See www.consumerfinance.gov/learnmore for additional information.

You have the right to ask for a credit score. Credit scores are numerical summaries of your creditworthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1 888 5OPTOUT (1 888 567 8688).

You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

Identity theft victims and active duty military personnel have additional rights. For more Information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For more information about your federal rights, contact:

For questions or concerns regarding:	Please contact:
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	**a.** Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list in addition to the Bureau:	**b.** Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	**a.** Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.	**b.** Federal Reserve Consumer Help Center PO Box 1200 Minneapolis, MN 55480
c. Nonmember Insured banks, Insured State Branches of Foreign Banks, and insured state savings associations	**c.** FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106

For questions or concerns regarding:	Please contact:
d. Federal Credit Unions	**d.** National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, SW Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates **or** Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357

Consumers have the right to obtain a security freeze

You have a right to place a ''security freeze'' on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit. As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years. A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

Catholic Health

Parental consent form (Junior Volunteers under age 18)

I give permission for my child, _____, to join the Junior Volunteer Program at Catholic Health. I understand that all junior volunteers are provided with orientation regarding the safe and responsible performance of their activities and that they are expected to meet all the requirements of the program, including regular attendance and adherence to hospital policies and procedures. I have reviewed and understand the guidelines established for the program.

_____ _____ _____

Print Name Signature Date

_____

Relationship to Applicant

Emergency medical treatment authorization

In the event my child becomes sick or injured while volunteering at Catholic Health and I cannot be contacted or urgency dictates, I hereby authorize the qualified clinicians at Catholic Health entities, to administer necessary treatment to my son/daughter.

_____ _____ _____

Print Name Signature Date

_____

Relationship to Applicant

Sterling Volunteers

Catholic Health

Date _____

I, the undersigned parent or legal guardian of _____, do hereby consent, on behalf of myself and said child, to have a background report prepared by Sterling Volunteers and delivered to _____ for use for volunteer purposes consistent with the disclosure and authorization provided to said child.

_____

Signature of Legal Parent or Guardian

_____

Print Name

Catholic Health

COVID-19 Vaccine Declination/Waiver

I understand that due to the nature of my employment in a healthcare facility, I have increased risk of coming into contact with Covid-19.

Center for Disease Control (CDC) and Catholic Health continues to recommend that all healthcare employees be vaccinated against COVID-19, however it is no longer required.

I decline the Covid-19 Vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Covid-19, a serious disease. If in the future I want to be vaccinated against Covid-19, I can receive the vaccination at no charge to me through employee health services, where available.

I have read and fully understand the information on this declination form.

Name (printed): _____ Date of Birth: _____

Signature: _____ Date: _____

References:
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html

Catholic Health
Good Samaritan
University Hospital

Declination of Influenza Vaccination 2025-2026

The New York State Department of Health and my employer, Catholic Health Services of Long Island has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I understand that because I was not immunized, I must wear a mask at all times while at work in areas where patients or residents may be present when influenza is declared prevalent.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____ Date of Birth: _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011. www.immunize.org/catg.d/p4068.pdf • Item #P4068 (10/11)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

GUIDANCE COUNSELOR to fill out and forward as soon as possible

Catholic Health
Good Samaritan Hospital

1000 Montauk Highway , West Islip, NY 11795

REFERENCE FORM

Applicant's Name: _____

Address: _____

School Name: _____

School Address: _____ **Telephone No.** _____

Please grade on a scale of 1 to 5, with 5 as the best, (1 and 5 should be commented upon)

Responsibility ( ) _____

Work Habits ( ) _____

Cooperation ( ) _____

Integrity ( ) _____

School Activities & Special Interests:

_____

_____

Additional Comments:

_____

_____

_____

This Applicant is: Recommended _____ Not Recommended _____

Signature: _____ Date: _____

Title: _____

EMPLOYEE HEALTH SERVICE
VOLUNTEER PRE-PLACEMENT HISTORY & PHYSICAL

PLEASE PRINT

Name: _____ Date: _____

Dept / Position _____ Date of Birth: _____

Home Phone: _____ Cell phone: _____

Address: _____ Sex: Female_____ Male_____

City, State, Zip Code: _____ Emergency Contact: _____

_____ Contact's Telephone: _____

Social Security # (Required) _____ Volunteer Area: _____

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING

Medical / Surgical History:

_____

Current Medications, Include over the counter medications and herbal supplements:

_____

Allergies (Drug, Seasonal, Latex)

_____

Have you ever had a positive/reactive PPD (TB) skin test? Yes _____ No _____

This evaluation is for the purpose of determining my physical ability to perform my duties as a volunteer and is not considered a substitute for my total medical care by my private physician. I have read the above and declare that I have had no injury, illness or ailment other than specifically noted. I attest to the fact that I am free from a health impairment which is a potential risk to the patient or which might interfere with the performance of my duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances, which may alter my behavior (N.Y.S. Code 405.3-b10).

Signature of Volunteer _____ **Date** _____

To Be Completed by Healthcare Provider:

The above named individual would like to volunteer services not requiring medical training. NYS Department of Health Code, section 405.3, requires the following tests to be completed before the individual starts volunteering. An accurate and honest evaluation of your patient's medical status is most important. Please complete all sections. This evaluation will become part of their confidential file. If you have any questions, please feel free to contact EHS at 631-376-41335. Thank you.

A physical examination was performed on _____ and there is no evidence of communicable disease or any disability that would interfere with his/her anticipated responsibilities as a volunteer.

_____ At this time my patient **has no** restrictions to preform volunteer service.

_____ At this time my patient **has** restrictions to preform volunteer service.

State Restriction: _____

Contraindications to receiving: _____ PPD, _____ MMR, _____ Hepatitis B, _____ Varivax

Date _____ Examiner's Signature _____ Office Phone Number _____

Office Address _____

NAME _____

FOR EMPLOYEE HEALTH SERVICE USE ONLY

Immunization History: REQUIRED All senior volunteers can get titers done free of charge by Employee Health

MMR #1 date _____ **Mumps** titer date _____ result _____

MMR #2 date _____ **Rubeola** titer date _____ result _____

Varivax #1 date _____ **Rubella** titer date _____ result _____

Varivax #2 date _____ **Varicella** titer date _____ result _____

Hepatitis B Surface Antibody titer date _____ result _____

Hepatitis B Surface Antigen titer date _____ result _____

History of positive PPD: _____yes _____ no _____ unsure _____

Documentation received, TB symptoms Sheet provided _____ yes _____no

If yes, chest x-ray: _____ provided past report _____ ordered

1 PPD 5 TU 0.1 cc ID manufacturer _____ Lot # _____ Expiration date _____ LFA / RFA

Administered by _____ Date _____

Date Evaluated: _____ Result _____mm induration Follow up needed: _____ Signature _____

2 PPD 5 TU 0.1 cc ID manufacturer _____ Lot # _____ Expiration date _____ LFA / RFA

Administered by _____ Date _____

Date Evaluated: _____ Result _____mm induration Follow up needed: _____ Signature _____

Chest X-Ray (if new positive): Date ordered: _____ **TB Symptom Sheet** _____

Comments: _____

_____

_____

Final Chart Review:

_____ _____ _____

Employee Health Clinician Authorized Signature **Title** **Date**

Clearance Stamp