

Becoming part of the NUMC volunteer team is a process and has many steps. Please review all the information carefully as there are several requirements and procedures that should be considered.

The following steps are required:

1. The volunteer application
2. The credit report/background check form
3. Review and sign the commitment and expectation form
4. Mail back the above information- address info below.
5. You will be contacted once your application has been received to set up an interview.
6. Volunteers are required to make a *100 hour commitment* for the year.
7. Once your application has been received and reviewed you will be contacted to set up an interview (usually via email so please print your email address clearly).
8. After the interview you will be contacted as to whether you have been accepted into the Volunteer Program.
9. Please note that if you are accepted into the Volunteer Program you will need to have a health assessment with NUMC medical forms signed and stamped by your own physician. ***You may wish to start this process***, forms have been included:
 - a. This includes copies of immunizations or titers
 - b. Proof of a recent PPD (tuberculin skin test)
 - c. These two items must be brought to the NUMC Employee Health Center (open from 6:30am-3:30pm, M-F, Building E, Room 132) You will receive a clearance form from Employee Health. Please submit this form to Volunteer Services.

Please do not bring these items to the Employee Health Center until you have been accepted into the program. However, this step must be completed prior to Orientation.

10. Orientations are scheduled monthly.
11. Please note we can not guarantee any positions in particular departments.

Completed Applications should be returned to: Suzanne Staub, Coordinator of Volunteer Services
By Mail: Nassau University Medical Center
Department of Volunteer Services- Box 6
2201 Hempstead Turnpike, East Meadow, NY 11554
c/o Suzanne Staub
By Fax: 516.572.4831
By Email: sstaub@numc.edu

We look forward to meeting you! If you have any questions please do not hesitate to contact Volunteer Services at 516.572.6588 or by email at sstaub@numc.edu.

DEPARTMENT OF VOLUNTEER SERVICES
 THE NASSAU UNIVERSITY MEDICAL CENTER
 2201 HEMPSTEAD TURNPIKE BOX 6
 EAST MEADOW, NY 11554
 (516) 572-6588



Volunteer Application

Volunteering begins with a commitment. At The Nassau University Medical Center we encourage all volunteers to serve at least 4 hours a week for at least 8 months. Before an assignment can be made, each volunteer must obtain medical clearance from his/her physician, be seen by the Employee Health Center, be interviewed and attend an orientation program

NAME LAST	FIRST	DATE
MIDDLE		
ADDRESS		HOME TELEPHONE # CELL #
CITY	STATE	SOCIAL SECURITY NO
ZIP CODE		SS# IS REQUIRED

PLEASE LIST ANY RELATIVES OR FRIENDS WHO ARE EMPLOYEES OR VOLUNTEERS AT THE NASSAU UNIVERSITY MEDICAL CENTER (INCLUDE NAME, DEPARTMENT AND RELATIONSHIP.)

DATE OF BIRTH	EMAIL- PLEASE PRINT CLEARLY!	
ARE YOU CURRENTLY EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF HOURS PER WEEK	JOB TITLE
IF EMPLOYED WHERE? AND TEL #		

VOLUNTEER EXPERIENCE
 SERVICE DATES, LOCATION, VOLUNTEER DUTIES

TO BE NOTIFIED IN CASE OF EMERGENCY NAME	RELATIONSHIP
PHONE # (HOME)	PHONE # (CELL)
PERSONAL PHYSICIAN	
ADDRESS AND TEL. #	

WILL YOU BE DRIVING TO THE NASSAU UNIVERSITY MEDICAL CENTER: IF YES, PLEASE COMPLETE THE FOLLOWING
 YES NO

MAKE OF CAR	MODEL:	COLOR:	LICENSE PLATE NO.:	YEAR:
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ARE YOU UNDER MEDICAL TREATMENT OF ANY KIND:
 YES NO

IS 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:

PLEASE IDENTIFY SPECIFIC TIMES WHEN YOU WOULD BE ABLE TO VOLUNTEER. YOU MUST BE AVAILABLE FOR AT LEAST 4 HOURS PER WEEK.

<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>

IS THERE A PARTICULAR VOLUNTEER OPPORTUNITY THAT INTERESTS YOU?

WHY DO YOU WANT TO VOLUNTEER AT THE NASSAU UNIVERSITY MEDICAL CENTER?

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM AT THE NASSAU UNIVERSITY MEDICAL CENTER?

PLEASE INCLUDE 3 NON-RELATED REFERENCES

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE NO.</u>

I AGREE THAT AS A VOLUNTEER I WILL:

- FOLLOW THE COMMITMENT AND EXPECTATIONS OF THE NUMC VOLUNTEER PROGRAM
- ATTEND A MANDATORY TRAINING SESSION BEFORE I BEGIN TO VOLUNTEER

APPLICANT SIGNATURE:

DATE:

Welcome to the Nassau University Medical Center (NUMC) Thank you for volunteering. We feel that before you formally agree to volunteer at NUMC you understand what is expected of you. Please consider this information a basic guide, the commitment and expectations of all volunteers. More information is outlined in the Volunteer Orientation Manual.

1. As an NUMC Volunteer I agree to abide by the following and to accept and perform my volunteer services within the following confidentiality guidelines as well as to follow all mandatory HIPPA rules and regulations.
2. Student Volunteers together with their parent/guardian must attend a training session before volunteering is to begin. Trainings are offered periodically and include but are not limited to information on infection control, HIPPA regulations, etc...
3. Information regarding diagnosis and/or treatment of any patient receiving services from NUMC whether inpatient or outpatient should not be discussed or repeated. Searching for or disclosing any information found on patients' charts will be considered a breach of confidentiality.
4. Volunteers may not disclose the fact that a patient is or is not receiving services as a patient or an out patient. If a person wishes for their neighbors, religious community, employers, or fellow employees to know they have been hospitalized or undergoing treatment, they must inform such persons themselves. Any disclosure of patient's status will be considered a breach in confidentiality.
5. Volunteers may not disclose information regarding financial status of any person who is a patient at or receiving treatment from NUMC. Searching for, or disclosing financial information about any patient, will be considered a breach in confidentiality.
6. If necessary, more intensive training will be provided by the department in which the volunteers will be working in.
7. Volunteers must swipe in at the beginning of their shift and swipe out at the end.
8. Volunteers are expected to be dressed appropriately with their assigned uniforms and ID badges. Neatness, hygiene and professionalism are of the utmost importance.
9. NUMC reserves the right to discontinue volunteering in any particular department at any time if it is felt that your skills and ability would be better suited for a different volunteer opportunity. NUMC also reserves the right to discontinue participation in the volunteer program at any time. I understand that as a volunteer I can be terminated for breach of confidentiality, failure to obey Hospital rules and regulations; and for actions that are deemed not in the best interests of the Hospital.
10. After the completion of orientation all student volunteers will be expected to make a *60-hour* a year commitment.
11. It is our understanding in the NUMC Volunteer Department that volunteers often have busy schedules, but we do ask that if you commit to any of our opportunities that you contact the Coordinator of Volunteer Services as soon as possible if you will be unable to attend or meet that commitment. Your dependability, reliability and follow through are of the utmost importance.
12. All volunteers are asked to conduct themselves in a punctual, conscientious way, with dignity and respect for all patients, staff, visitors and people within the hospital and its grounds.
13. Volunteers are asked to abide by policies, procedures, supervision and directions of the Volunteer Services Department which includes all placements, schedules, assignments and responsibilities, etc...
14. Volunteers may not at anytime participate in observation of clinical services including but not limited to direct patient care.

15. Volunteers at all times must uphold the standard, ethics and mission statement of the Nassau University Medical Center.
16. Volunteers are expected to attend any scheduled NUMC volunteer service meetings.
17. Volunteers must attend annual in-service trainings on “mandatory” topics as outlined in the Volunteer Orientation Program Manual.
18. Annually, all volunteers must receive a mandatory tuberculin skin test, at no cost through the Employee Health Center or from their own physician.
19. All volunteers are expected and asked to maintain open communication with the Volunteer Services Department.
20. I will return my ID badge upon completion of my volunteer services.
21. I understand that there will be a \$20 charge for my uniform.
22. I understand that I as a volunteer I am expected to uphold the NHCC values at all times.
 - a. **CREATE A POSITIVE IMPRESSION**
First impressions are lasting impressions.
 - b. **ANTICIPATE AND RESPOND**
Take the initiative to meet needs and exceed expectations.
 - c. **RESPECT**
Value the opinion of others and appreciate each other’s contributions and diversity.
 - d. **INTEGRITY AND COMPASSION**
we perform our jobs in an ethical manner, with honesty, sincerity, and compassion for others.
 - e. **NEAT-CLEAN-SAFE**
We pride ourselves on providing a safe and healing environment.
 - f. **GOING ABOVE AND BEYOND**
Set high standards and strive to be the best.

If you have any questions or concerns please feel free to discuss them with the Coordinator of Volunteer Services.
Volunteers make a difference everyday.

Volunteer Signature _____ Date _____



NUHEALTH
FAIR CREDIT REPORTING ACT
DISCLOSURE AND AUTHORIZATION FOR
CRIMINAL BACKGROUND CHECK

Thank you for your interest in participating in the Volunteer Program at the Nassau Health Care Corporation (“NHCC”). Please read the following disclosure carefully and sign the authorization below:

In order to make a determination as to your suitability for the Volunteer Department with NHCC, NHCC will obtain from a “consumer reporting agency” a “consumer report” on you which details your criminal background. These terms are defined in the Fair Credit Reporting Act (“FCRA”), a Federal law which applies to you. As an applicant with NHCC, you are a “consumer” with rights under the FCRA.

BACKGROUND SCREENING Authorization

By signing below, I, _____, hereby voluntarily authorize NHCC to obtain from a “Consumer reporting agency” a “consumer report” about me detailing my criminal background. I understand that information obtained in the consumer report may be used by NHCC in making a program participation decision. I further understand that failure to consent to the release of a consumer report detailing my criminal background will render me ineligible for consideration at NHCC.

Signature

Date

I, _____, of my own free will, without any promises of immunity or coercion, agree to allow Nassau Health Care Corporation to conduct a criminal background investigation on myself in connection with my application at Nassau Health Care Corporation.

I hereby release, waive, and forever discharge each of the above named corporations, firms, their respective agents, employees and any of my former employers and all actions or cause of action, claim, demand or liability which I have now or may have resulting directly from conducting this background investigation.

First Name

Middle Initial

Last Name

Street

Address _____ City _____ State _____ Zip _____

Drivers License # _____ State _____ Date of Birth _____

Social Security _____

Signature: _____ Date: _____ Telephone _____

PLEASE KEEP THESE FORMS- DO NOT RETURN THEM WITH YOUR APPLICATION

NUHEALTH

NASSAU UNIVERSITY MEDICAL CENTER

Employee Health Services: *Physician Attestation Instructions for N employees*

New York State Department of Health Regulations 405.3(b) requires all healthcare personnel to have a physical examination and recorded medical history to ensure there is no health impairment that would pose a potential risk to patients.

Please have the attached Physician Attestation completed, signed and stamped by your healthcare provider. YES, YOU NEED ALL OF THE BELOW INFORMATION!

Immunity is required for measles/rubella/mumps. A person is considered immune if they have a documented vaccine history (detailed below)

1) 2 doses of live MMR vaccine on or after the first birthday and separated by at least 28 days.

OR

1) 2 doses of live measles vaccine on or after the first birthday and separated by at

Least 28 days AND

2) 1 dose of live rubella vaccine administered on or after the first birthday AND

3) 2 doses of live mumps vaccine administered on or after the first birthday and separated by at least 28 days.

OR

Laboratory confirmation of immunity (most desirable and preferred).

Varicella: Evidence of immunity includes:

1) Documentation of 2 doses of varicella vaccine at least 28 days apart

OR

2) Laboratory confirmation of immunity (most desirable and preferred).

TWO documented Tuberculin Skin Tests. One recent and one within one year. Or TWO recent. Those persons with a positive TST are required to submit proof of a chest x-ray done within the last year.

PLEASE COMPLETE THE ENTIRE FORM AND REVIEW CAREFULLY- EMPTY SPACES OR MISSING INFORMATION WILL RESULT IN NON CLEARANCE.

The completed Physician Attestation AND medical form may be returned to the Employee Health Office Room E 132

Monday thru Friday 6:30 a.m. – 3:30 p.m.



DO NOT RETURN THE FOLLOWING FORM TO VOLUNTEER SERVICES- PLEASE BRING IT TO THE ABOVE OFFICE AND RETURN ONLY THE CLEARANCE FORM RECEIVED FROM EMPLOYEE HEALTH TO VOLUNTEER SERVICES. KEEP A COPY FOR YOUR OWN RECORDS!

IF YOU HAVE QUESTIONS REGARDING THESE MEDICAL FORMS PLEASE CONTACT EMPLOYEE HEALTH DIRECTLY AT 516.572.6308



DO NOT RETURN THIS FORM TO VOLUNTEER SERVICES- PLEASE BRING IT TO NUMC EMPLOYEE HEALTH- RM E-132, M-F, 6:30AM-3:30PM. AFTERNOONS PREFERRED

**NUHEALTH
NASSAU UNIVERSITY MEDICAL CENTER**

Employee Health Services: Physician Attestation for N employees

Name print last/first: _____ / _____

Address print: _____

Date of Birth: ____/____/____

Below to be **completed**, signed and **stamped** by a Licensed Practitioner:

Proof of immunity to Measles, Mumps, Rubella

#1 MMR vaccine _____ Measles vaccine #1 _____ #2 _____
#2 MMR vaccine _____ Mumps vaccine #1 _____ #2 _____
Rubella vaccine _____
Rubella virus IgGAb titer results (attached) _____
Rubeola virus IgGAb titer results (attached) _____
Mumps virus IgGAb titer results (attached) _____

Proof of immunity to Varicella

#1 Varicella vaccine _____ Varicella virus IgGAb titer results (attached) _____
#2 Varicella vaccine _____

Proof of immunity to Hepatitis B

#1 Hepatitis B vaccine _____ HepBsAb results (attached) _____
#2 Hepatitis B vaccine _____ Refused Hepatitis B vaccine series _____
#3 Hepatitis B vaccine _____

2 Step Tuberculin Skin Test

TST #1 Date _____ **TST #2** (within 1 yr. of application) Date _____
Date evaluated _____ Date evaluated _____
Result: _____ mm induration Result: _____ mm induration

Has a positive reaction to the TST. A chest X-Ray report is required (within the year) (attached).

Review of symptoms: persistent cough, fever, chills, unexplained weight loss, night sweats, coughing up blood, loss of appetite, prolonged fatigue. does the above named have any of these symptoms? (please circle) NO YES

* I have performed a physical examination of sufficient scope to ensure that the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior (per N.Y.S. Code 405.3(b)).

Practitioner's signature: _____

Practitioner's name(print): _____

Address: _____

License #: _____ State: _____ Phone #: (____) _____

Date this certificate was completed: ____/____/____

Practitioner's Stamp: