



HIGH-SCHOOL STUDENT VOLUNTEER PROGRAM

2016-2017 School Year Volunteer Application

Becoming part of the NUMC volunteer team is a process and has many steps. Please review all the information carefully with your parent/guardian as there are several requirements and procedures that should be considered. The following steps are required:

1. Students must be between the ages of 14 and 18 years old and be enrolled in High School
2. Complete the volunteer application
3. Review and sign the Commitment and Expectation form
4. Enclose a copy of your working papers
5. Your teacher evaluation should be submitted with your application in a sealed, signed envelope
6. Mail back the above information to the address listed below or drop off the application in person (please note that emailed applications will not be accepted). The Volunteer Office is located in B Building, Room 229.
7. You will be contacted once your application has been processed and notified of interview dates through email (phone calls will be made if email is unavailable)
8. Volunteers are required to make a minimum commitment of **100 hours** no later than 6/15/17
9. At the interview you will be informed about how to complete the rest of the process for medical clearance and orientation schedule(s) if accepted
10. 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. ***If you wish to initiate this process after you have been interviewed***, the forms have been included for your convenience:
 - a. This includes copies of immunizations or titers
 - b. Proof of 2 recent PPD (tuberculin skin test)
 - c. This form must be submitted to the Employee Health Center (516)572-6308
11. Accepted students must attend a mandatory orientation training prior to beginning service
12. Please note we cannot guarantee any positions in specific departments and have the right to change assignment at any time. Some assignments are considered priority.
13. Please understand that a shadowing program is not available through this office
14. Applications received after November 1, 2016 will not be accepted for consideration into this year's program

Completed Applications should be returned to in person or by mail to:
Michele Silvestri, ATR-BC, LCAT
Nassau University Medical Center
B Building Room 229
Department of Volunteer Services- SMB #72
2201 Hempstead Turnpike, East Meadow, NY 11554

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



Student Volunteer Application

2016-2017 High-School Student Volunteer Application (must be received no later than 11/1/16 for review): *Volunteering begins with a commitment. At Nassau University Medical Center we encourage all volunteers to serve at least 100 hours. Before an assignment can be made, each volunteer must be interviewed, obtain medical clearance through NUMC Employee Health Center, attend an orientation program and complete a background check. Please print clearly and complete the entire application. Please be sure to provide an accurate and clear email address!* **THIS APPLICATION SHOULD BE COMPLETED BY THE APPLICANT!**

NAME: LAST MIDDLE	FIRST	DATE	
ADDRESS	HOME TELEPHONE #: CELL #:		
CITY	STATE	ZIP CODE	SOCIAL SECURITY #
YOU MUST PROVIDE A SS#			

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 ADDRESS:	
DO YOU HAVE A PAYING JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF HOURS PER WEEK	JOB NAME:
JOB TELEPHONE #:	SUPERVISOR:	

VOLUNTEER EXPERIENCE:
SERVICE DATES, LOCATIONS, VOLUNTEER DUTIES

PARENT/GUARDIAN NAME NAME RELATIONSHIP
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GUARDIAN PHONE # (HOME)	GUARDIAN PHONE # (CELL)
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MODE OF TRANSPORTATION TO HOSPITAL:

IS VOLUNTEERING A SCHOOL REQUIREMENT. IF SO, EXPLAIN REQUIREMENTS:

ARE YOU ABLE TO STAND FOR A PERIOD OF TIME, LIFT, CARRY, BEND, STRECH, PUSH A CART OR WHEEL CHAIR WITHOUT COMPLICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO, PLEASE EXPLAIN:

DO YOU HAVE ANY ALLERGIES OR MEDICAL ISSUES NUMC SHOULD BE AWARE OF: <input type="checkbox"/> YES <input type="checkbox"/> 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:

- 1) List all possible hours
- 2) List four hour shift preference: 8am-12pm, 12pm-4pm, 4pm-8pm)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

ARE THERE ANY PARTICULAR DEPARTMENTS THAT INTEREST YOU?

- Clerical
- Clinics
- Emergency Room
- Information Desk
- Medical Units
- Pharmacy
- Other: _____

WHEN WILL YOU BE ABLE TO START?

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

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

I AGREE THAT AS A VOLUNTEER I WILL:

- **FOLLOW THE COMMITMENT AND EXPECTATIONS OF THE NUMC VOLUNTEER PROGRAM**
- **ATTEND A MANDATORY TRAINING SESSIONS BEFORE I BEGIN TO VOLUNTEER**
- **RETURN MY ID BADGE AT THE COMPLETION OF MY VOLUNTEER SERVICE**

STUDENT APPLICANT SIGNATURE:

X

DATE:

I CERTIFY THAT THE INFORMATION PROVIDED HERE IS CORRECT AS WRITTEN.

PARENT/GUARDIAN SIGNATURE

X

DATE:

2016-2017 High School Student Volunteer Application

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

1. As an NUMC Volunteer, one agrees to abide by the following and to accept and perform their volunteer duties following confidentiality guidelines as well as all mandatory HIPAA rules and regulations.
2. Volunteers must attend a training session before they begin volunteering. Trainings are offered periodically and include, but are not limited to, information on infection control, HIPAA regulations, etc... These sessions must be completed yearly should you decide to stay on after your yearly service has completed.
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 outpatient. If a person wishes for their neighbors, religious community, employers, or fellow employers 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 are assigned.
7. Volunteers must punch in at the beginning of their shift and punch out at the end at the designated time clock. If a volunteer shift is scheduled for 5.5 hours or more, a break of one hour is deducted from the shift.
8. Volunteers are expected to be dressed appropriately with their assigned uniforms and ID badges. Neatness, hygiene and professionalism are of the utmost importance. Jeans, shorts, leggings, open-toed shoes and other inappropriate attire are not permitted. Volunteers may be sent home if attire is deemed inappropriate, or if they are not wearing their ID badge.
9. NUMC reserves the right to discontinue any volunteer to 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. As a volunteer, one 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 volunteers will be expected to make at least a 100 hour commitment over the 2016-2017 school year. Hours must be completed no later than 6/15/17.**
11. It is our understanding in the NUMC Volunteer Department that volunteers often have busy schedules, but we do ask that if one should commit to any of our opportunities that they contact the Director of Therapeutic Recreation & Volunteer Services as soon as possible if they will be unable to attend or meet that commitment. Our volunteer's 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 any time participate in observation of clinical services; including but not limited to, direct patient care. A shadowing program is not offered through this office.
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 meeting(s).

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. Volunteers must return their ID badge upon completion of their volunteer services. A letter of completion will be issued and mailed to the address on file upon its receipt.
21. There is a \$10 charge for the mandatory volunteer uniform and it must be worn when inside the hospital during scheduled volunteer hours.
22. As a volunteer one is expected to uphold the NHCC values at all times.
23. It is the policy of NuHealth to maintain an environment that insures equality of opportunity for all, where everyone is treated with respect and dignity and that is free from all forms of discrimination or harassment by anyone, including supervisors, patients, co-workers, students, volunteers, vendors or contractors. NuHealth will not tolerate unlawful discrimination, including harassment, based on a person’s race, color, religion, gender, sexual orientation, gender identity, marital or military status, age, national origin, genetic predisposition, and disability, status as victim of domestic violence or any other protected status.

- **CREATE A POSITIVE IMPRESSION**
First impressions are lasting impressions.
- **ANTICIPATE AND RESPOND**
Take the initiative to meet needs and exceed expectations.
- **RESPECT**
Value the opinion of others and appreciate each other’s contributions and diversity.
- **INTEGRITY AND COMPASSION**
We perform our jobs in an ethical manner, with honesty, sincerity, and compassion for others.
- **NEAT-CLEAN-SAFE**
We pride ourselves on providing a safe and healing environment.
- **GOING ABOVE AND BEYOND**
Set high standards and strive to be the best.

Volunteer Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

If you have any questions or concerns please feel free to discuss them with the Director of Volunteer Services at 516-572-6588. *Volunteers make a difference every day!*

PARENT/GUARDIAN PERMISSION FORM

I hereby give my son/daughter _____ permission to participate in the student volunteer program at Nassau University Medical Center. I understand that my child is responsible for notifying the Volunteer office for any absence, planned or unplanned, as soon as possible.

I endorse and support my child’s agreement to fulfill at least a 100 hour volunteer commitment for the **2016-2017** school year.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Date: _____

PARENT/GUARDIAN CONSENT AND MEDICAL AUTHORIZATION

Date: _____

I, _____, the parent/guardian of
_____ give consent to Nassau University Medical Center 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 Student Volunteer at the Nassau University Medical Center.

I also give my consent to Nassau University Medical Center to perform health assessments/screenings as
requires by hospital policy.

Parent/Guardian Name Printed

Parent/Guardian Signature

Parent/Guardian Address:

Street

City, State Zip

PARENT/GUARDIAN CONSENT FORM TO RELEASE SCHOOL RECORDS

Your daughter/son is applying to the Student Volunteer Program at Nassau University Medical Center.

To be accepted into our program, we require:

- He/She be 14 years of age or older
- Submit a completed current application
- Attend and be interviewed for a position in the Volunteer Program
- Submit a copy of completed working papers (form and papers to be obtained from student's high school)
- Submit a completed recommendation form from a teacher or guidance counselor, returned with the application in a sealed, signed envelope
- Be medically cleared for volunteer service
- Attend a mandatory orientation

The law requires that when a student is under 18 years of age, parental permission must be obtained before school records can be released. We will not process an applicant without this form. We will only request school records on an as needed basis. This form should be returned with the application packet.

Students Name: _____

Year of Graduation: _____

Parent/Guardian Signature: _____

Date: _____

Date: _____

School: _____

RE: _____
Student's Name

Dear Guidance Counselor/Teacher:

The student named above at your high school has applied to the Student Volunteer Program at Nassau University Medical Center. To help us evaluate the potential of this applicant for volunteer services, we would appreciate your completing the enclosed recommendation form.

Please return the recommendation form directly to the student in a **sealed, signed envelope**. We are unable to process his/her application until this information is received. If you have any questions, please contact me in the Volunteer Services Department any weekday at 516-572-6588.

Thank you for your time and cooperation.

Sincerely,

Michele Silvestri, ATR-BC, LCAT
Department of Therapeutic Recreation & Volunteer Services

EVALUATION: STUDENT VOLUNTEER PROGRAM

Student's Name: _____

Please evaluate the above named student on a scale 1 to 5, according to the recommendation criteria given below. Your responses will be held in strict confidence.

Recommendation: 1-not recommended, 2-recommended with reservation, 3-recommended, 4-recommended with confidence, 5-highly recommended

1. **Cooperation:** Includes ability to get along with others, accept authority and follow instructions, adaptability, tactfulness, flexibility.

1 2 3 4 5

2. **Character:** Includes loyalty, integrity, sincerity, concern for others.

1 2 3 4 5

3. **Industry:** Includes willingness to work, perseverance, work habits, attention.

1 2 3 4 5

4. **Initiative:** Includes intellectual curiosity, willingness to attempt new things, resourcefulness

1 2 3 4 5

5. **Reliability:** Includes dependability, good judgment, honesty, ability to function with minimal supervision.

1 2 3 4 5

6. **Emotional Control:** Includes maturity, poise, stability, self-confidence.

1 2 3 4 5

7. **Leadership Ability:** Includes objectivity, patience, ability to accept responsibility.

1 2 3 4 5

8. **Academic Standing:** The student is in good academic standing.

1 2 3 4 5

9. In your general opinion, is this student mature enough as well as capable of assuming the responsibilities required in a healthcare setting?

1 2 3 4 5

Additional Comments:

Guidance/Teacher's Name: _____

Guidance/Teacher's Signature: _____

Date: _____

Employee Health Services: *Physician Attestation Instructions for Non-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 after you have been interviewed for the Volunteer Program.

The completed Physician Attestation may be returned to the **Employee Health Office, which is located in 'E' Building Room #132**. They may be contacted at 516-572-6308 for any questions regarding the process for medical clearance. Office hours are: Monday through Thursday 8:00am to 3:30pm (closed between 1:00pm-2:00pm) & Friday 6:00am-1:30pm (call for lunch or updated business hours).

You will need to sign in and wait to be seen for review of the form to obtain the medical clearance. Once you have obtained medical clearance, you may bring a copy to the Volunteer Office for your file. Please keep a copy for your file as well.

Employee Health Services: Physician Attestation for Non-Employees

Name print last/first: _____/_____

Address print: _____

Date of Birth: ____/____/____

Phone #: (____) _____

Below to be **completed**, signed and **stamped** by a Licensed Practitioner: **Attach copy of laboratory results.**

Proof of immunity to Measles, Mumps, Rubella (Required)

Rubella vaccine _____ Rubella virus IgG Ab titer (results attached) _____
 Measles vaccine #1 _____ #2 _____ or Rubeola virus IgG Ab titer (results attached) _____
 Mumps vaccine #1 _____ #2 _____ Mumps virus IgG Ab titer (results attached) _____
 Or
 MMR vaccine #1 _____ #2 _____

Proof of immunity to Varicella

Varicella vaccine #1 _____ #2 _____ or *If declined, declination form must be signed*
 Varicella virus IgG Ab titer results (attached) _____

Proof of immunity to Hepatitis B

#1 Hepatitis B vaccine _____ or *If declined, declination form must be signed*
 #2 Hepatitis B vaccine _____ Hep B SAb titer (results attached) _____
 #3 Hepatitis B vaccine _____ Refused Hepatitis B vaccine series _____

Td / Tdap: (circle) **Date** _____ (within 10 years)

Influenza vaccine Date: _____ **Provide proof of vaccination or a signed declination**

TWO-STEP Tuberculin Skin Test required for initial appointment (one yearly thereafter)

TST #1 Date _____ **TST #2** (within 6 months of application) Date _____
 Date evaluated _____ Date evaluated _____
 Result: _____ mm induration Result: _____ mm induration

Or Quantiferon TB Gold result: _____ Date: (within 6 months) _____

Has a positive reaction to the TST. A normal chest X-Ray report **within three years** is required (attach report).

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 check) 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: _____ License #: _____ State _____

Practitioner's name (print): _____ Phone #: (____) _____

Address: _____

Date this certificate was completed: ____/____/____

Practitioner's Stamp:

APPLICATION CHECK LIST

- ALL APPLICATION FORMS ARE SIGNED AND DATED BY ALL REQUESTED PARTIES

- I HAVE ENCLOSED A COPY OF MY WORKING PAPERS

- I HAVE ENCLOSED MY TEACHER/GUIDANCE COUNSELOR EVALUATION FORM IN A ***SEALED, SIGNED ENVELOPE***

- I HAVE KEPT THE MEDICAL FORM AND INFORMATION AND PLAN TO BEGIN TO START WORKING ON MY MEDICAL CLEARANCE AFTER I HAVE BEEN INTERVIEWED. ***I HAVE NOT ENCLOSED ANY MEDICAL FORMS OR MEDICAL INFORMATION***

- I HAVE PROVIDED AN ACCURATE EMAIL ADDRESS, SOCIAL SECURITY NUMBER AND PHONE NUMBER

- I HAVE NOT MISSED ANY VOLUNTEER SERVICES DEADLINES