Good Samaritan Hospital Medical Center
Catholic Health Services
At the heart of health

Welcome Applicant,

We are extremely pleased you have expressed interest in volunteering at Catholic Health Services of Long Island (CHS). Your commitment, hard work and unique skills will allow for an amazing healthcare experience for our patients and residents. Volunteering at a hospital or nursing home 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 is attached as well (medical consent is required for the health and safety of all our patients, residents and those working and visiting a CHS Entity). Please allow us approximately one week to review your application. You will only be contacted if we have an opening that fits the time, days, location and interest that you have indicated on your application. We ask your cooperation in being open to volunteering in an area that needs assistance.

When contacted, you will be asked to come to the CHS Entity you wish to volunteer for an interview. When all requirements have been met and your application has been accepted, you will be contacted regarding our volunteer orientation program.

For our volunteers, we ask that you commit to a minimum of 50 hours per year.

If you have any questions, you can call the Volunteer Office at 631-376-3659.

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

Thank you.
Brittany Colasanto
Manager of Volunteer Services

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VOLUNTEER APPLICATION

The information you provide in this application is strictly confidential.

Personal Information

Name _____ **Date** _____

Name to Appear on ID Badge _____ **Age (if under 18)** _____

Address _____

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

Home Phone _____ **Cell Phone** _____

Email Address _____

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 _____

CHS Entity Interested in Volunteering at (more than one can be checked):

☐ **Good Samaritan Hospital Medical Center** ☐ **Good Samaritan Nursing Home** ☐ **Good Shepard Hospice**

☐ **Mercy Medical Center** ☐ **Our Lady of Consolation** ☐ **St. Catherine of Siena** ☐ **St. Catherine of Siena Nursing Home**

☐ **St. Charles Hospital** ☐ **St. Francis Hospital** ☐ **St. Joseph Hospital**

Education

Are you currently attending school? ☐ **Yes** ☐ **No** **If yes, school attending:** _____

Education Level: ☐ **High School** ☐ **College** ☐ **Other** _____

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

☐ **Specific Medical Department of Interest** _____

☐ **Other (please list)** _____

Volunteering Questions

What is your purpose in becoming a volunteer? _____

_____

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

_____

Are you interested in a medical career? _____

How did you hear about our program? _____

Do you have a family member employed/volunteering at a CHS Entity? ☐ **Yes** ☐ **No** **If yes, please provide name of relative, CHS 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							

Volunteering Questions – Only applicants for Hospice must complete the following three questions:

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.** ____

_____

_____

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 disclosures:

☐ **Fair Credit Reporting Act Consumer Disclosure and Authorization** _____

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

☐ **Consent and General Authorization to Obtain Consumer Report** _____

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

☐ **Parental Consent Form** _____

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

_____

_____

Applicant Signature _____ **Date** _____

Catholic Health Services of Long Island
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FAIR CREDIT REPORTING ACT CONSUMER DISCLOSURE AND AUTHORIZATION

Facts You Need to Know:

In connection with your application for employment/medical staff privileges/volunteer services within Catholic Health Services of Long Island (CHS), CHS may obtain a consumer report on you, as defined in the Federal Fair Credit Reporting Act, 15 U.S.C. 1681 *et seq*. It may be an "investigative consumer report" that includes information as to your character, general reputation, personal characteristics and mode of living, whichever are applicable. If CHS obtains an investigate consumer report, you have the right to request disclosure of the nature and scope of the report, which involves personal interviews with sources such as your neighbors, friends or associates.

CHS may not obtain any consumer report on you for employment/medical staff privileges/volunteer services purposes without your written consent. Also, CHS may not obtain medical information about you without your express consent to the release of medical information. Consent to the release of medical information, is *not* covered by the authorization contained in this document.

State-specific information:

- California - If you are a California resident or applying for employment at a location in the State of California, in addition to this disclosure/authorization, please review and complete the "Disclosure and Acknowledgement Concerning Consumer Credit Report or Investigative Consumer Report Obtained for Employment Purposes Pursuant to California Law".

- Minnesota – If you are a Minnesota resident or applying for employment at a location within the State of Minnesota, you have a right to obtain a copy of the consumer report by checking this box. ☐

- Oklahoma – If you are an Oklahoma resident or applying for employment at a location within the State of Oklahoma, you have a right to obtain a copy of the consumer report by checking this box. ☐

_____ _____

Applicant Signature Date

_____

Applicant Name

Catholic Health Services of Long Island
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BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM

The applicant for employment/medical staff privileges/volunteer services acknowledges that Catholic Health Services of Long Island and its System Affiliates (collectively, CHS) may now, or at any time during employment/medical staff privileges/volunteer services, verify information within the application, resume or contract for employment/medical staff privileges/volunteer services. In the event that information from the report is utilized in whole or in part in making an *adverse decision*, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act, 15 U.S.C. 1681 *et seq*.

Please be advised that we may also obtain an *investigate consumer report* including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. 1681 *et seq*., is available at the Federal Trade Commission's website (www.ftc.gov). 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.

I understand the meaning of this Background Check Disclosure and Authorization Form, and I have had the opportunity to raise any questions about it before signing it. My signature below is completely voluntary, without coercion or duress of any kind, and I am signing this Background Check Disclosure and Authorization Form solely as a condition for consideration of current and continued employment/medical staff privileges/volunteer services.

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies and credit reporting agencies, to release such information to CHS. I acknowledge and agree that this Background Check Disclosure and Authorization Form shall remain valid and in effect during the term of my employment/medical staff privileges/volunteer services.

For Maine Applicants Only
Upon request, you will be informed whether or not an investigate consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all agencies copies of any reports.

For New York Applicants Only
You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

For Washington Applicants Only
If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

For California*, Minnesota, and Oklahoma Applicants Only: A consumer credit report will be obtained through Certiphi Screening, Inc., P.O. Box 541, Southampton, PA 18966. Telephone (800) 260-1680. www.certiphi.com.

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No _____
Initials Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No _____
Initials Initials

* **California Applicants:** If you chose to receive a copy of the consumer report, it will be sent within three (3) days of CHS receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of CHS' receipt of the report (unless you elected not to get a copy of the report). **Certiphi Screening's privacy practices with respect to the preparation and processing of investigative consumer reports may be found at www.certiphi.com (link at bottom of page entitled Legal/Privacy).**

_____ _____
Applicant Signature Date

_____
Applicant Name

PARENT OR LEGAL GUARDIAN ACKNOWLEDGEMENT AND AUTHORIZATION

The undersigned parent and/or guardian of the minor applicant hereby agree with the applicable statements in this Background Check Disclosure and Authorization Form. By signing below, I fully provide consent on behalf of my minor child to authorize a background check for purposes of this Disclosure and Authorization.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name

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Consent and General Authorization to Obtain Consumer Report

I hereby authorize Catholic Health Services of Long Island, now or at any time while I am employed by Catholic Health Services of Long Island, to obtain a consumer report, or an investigative consumer report, on me. This authorization does not authorize the release of medical information.

Other Names Used:

Name	From/To

First Name (Print)

Last Name (Print)

Middle Name (Print)

Social Security Number

Date of Birth

Please list all residences lived at in the past seven (7) years:

Address: Years at Address:

Street Address

City State Zip

Street Address

City State Zip

Street Address

City State Zip

Previous states/counties of residence:

*This information will be used for purposes of identification only. Federal law prohibits discrimination in employment on the basis of race, color, sex, national origin, religion, age, equal pay or disability. Additionally, New York State law prohibits discrimination in employment on the basis of creed, sexual orientation, military status or marital status.

Applicant's Signature Applicant's Name Printed Today's Date

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PARENTAL CONSENT FORM

I give permission for my child, _____, to join the Junior Volunteer Program at Catholic Health Services of Long Island. 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 Services of Long Island and I cannot be contacted or urgency dictates, I hereby authorize the qualified clinicians at Catholic Health Services of Long Island entities, to administer necessary treatment to my son/daughter.

_____ _____ _____
Print Name Signature Date

_____
Relationship to Applicant

EMPLOYEE HEALTH SERVICE

VOLUNTEER PRE-PLACEMENT 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 #:		Volunteer Area:	

Medical History

PLEASE COMPLETE THE FOLLOWING

Medical / Surgical History:

Current Medications include over the counter medications and herbal supplements:

Allergies (Drug, Food, Environmental, 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. N.Y.S. 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 516 562 6602. 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 perform volunteer service.

☐ At this time my patient **has** restrictions to perform volunteer service.

State Restriction: _____

Contraindications to receiving ☐ PPD, ☐ MMR, ☐ Hepatitis B

Date _____ **Examiner's Signature** _____ **Office Address** _____

Office Phone Number _____

Name _____

Immunization History: REQUIRED

Rubella: titer date _____
result _____

Rubeola: titer date _____
result _____

Mumps: titer date _____
result _____

MMR #1 date _____

MMR #2 date _____

Varicella: titer date _____
result _____

HbsAg: date _____
result _____

Hep C Ab: date _____
result _____

Hepatitis B antibody status requested: date: _____ results: _____

Hepatitis B vaccination started : ☐ Yes ☐ No Consent/Declination in chart

Mantoux PPD Test Record:

History of positive PPD: ☐ Y ☐ N ☐ Unsure Documentation received, TB Symptoms Sheet provided: ☐ Y

If yes, chest X-Ray : ☐ Provided Past Report ☐ Ordered

1 PPD 5 TU 0.1 cc ID _____ (Manufacturer) _____ (Lot #) _____ (Exp Date) LFA/RFA/LUE/RUE

Administered By: _____ Date: _____

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

2. PPD 5 TU 0.1 cc ID _____ (Manufacturer) _____ (Lot #) _____ (Exp Date) LFA/RFA/LUE/RUE

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 Service Clinician Authorized Signature**

_____ **Title**

_____ **Date**