



Member
NewYork-Presbyterian
Healthcare System

APPLICATION FOR VOLUNTEER SERVICES

Date _____

Name _____

Telephone _____ Cell Phone _____

Mailing Address _____

E-mail Address _____

Date of Birth _____ Social Security Number _____

EDUCATION: High School _____ College _____ Degree _____

Other Schools/Training _____

REFERENCES: Present Employer _____

College Attending _____

Primary Physician _____

EMERGENCY CONTACT _____

HOW DID YOU HEAR ABOUT THE VOLUNTEER PROGRAM _____

REASON FOR VOLUNTEERING _____

AVAILABILITY: Days I am most available _____

Times I am most available _____

Seasonal Volunteer? _____ What Months? _____

BUSINESS AND/OR VOLUNTEER EXPERIENCE _____

SKILLS:

Please circle all that apply: Computer Bookkeeping Clerical Copy Machine
Public Relations Fundraising Other_____

PREFERENCES:

Please circle all that apply: Patient Contact Emergency Department Office Work
Gift Shop Thrift Shop Other_____

DO YOU PRESENTLY HAVE ANY PHYSICAL LIMITATIONS THAT WILL KEEP YOU FROM PERFORMING TASK AS A VOLUNTEER SUCH AS STANDING, BENDING, PUSHING A CART OR WHEELCHAIR? Please circle: Yes No

If Yes, Please explain_____

ACCEPTANCE OF PROBATIONARY PERIOD

I understand that I have been enrolled in the Volunteer Services Program on a three (3) months' probationary period. At that time, my performance will be reviewed and I may request a transfer to another department or, if my performance is not satisfactory, I may be excused from the Volunteer Service.

Signature of Director of Volunteers

Signature of Volunteer

SOUTHAMPTON HOSPITAL
VOLUNTEER SERVICE CONFIDENTIALITY STATEMENT

Volunteers have access to a wide variety of confidential information regarding a patient, the Hospital, its Medical Staff and employees. Under no conditions can this information be disclosed. All patient care information is to be regarded as confidential. Access to medical records is limited to our medical staff and any other person the patient may allow. Information obtained by any volunteer in the course of his/her service is strictly confidential, and the volunteer shall not divulge such information to any person either orally or in writing.

I understand and agree to the above and know that any violation of this policy is grounds for immediate dismissal.

Volunteer Signature

Date

PLEASE PROVIDE 2 PERSONAL REFERENCES:

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

NAME _____

PHONE _____

ADDRESS _____

RELATIONSHIP _____

SOUTHAMPTON HOSPITAL
 PERSONNEL HEALTH PROGRAM
 VOLUNTEER PHYSICAL EXAMINATION

Name _____

Date of Birth _____

CHECK NORMAL (N) OR ABNORMAL (ABN):

	(N)	(ABN)	COMMENTS
Head and Neck	_____	_____	_____
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth and Throat	_____	_____	_____
Glands	_____	_____	_____
Breasts, Chest Wall	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
<u>Extremities:</u>			
Edema	_____	_____	_____
Varicose Veins	_____	_____	_____
Deformities	_____	_____	_____
Skin	_____	_____	_____

Hernia _____ Inguinal _____ Femoral _____
 Back: Deformities _____ Tenderness or Palpation _____
 Limitation of Motion _____ Other Abnormalities _____

Remarks:
 Describe any work limitations _____

Any evidence of addiction to depressants, stimulants, narcotics? _____

Observations _____

Volunteer is/is not fit for employment. If unfit, please explain _____

Physician's Signature _____ Date _____