

The Brooklyn Hospital Center

Keeping Brooklyn healthy.

VOLUNTEER SERVICES

121 DeKalb Avenue,
Brooklyn, NY 11201
Patient Relations – B101
Tel: 718.250.8393
tbhc_volunteers@nyp.org

REQUIREMENTS FOR VOLUNTEERS

Please **DO NOT** send anything via fax, mail or email

1. Application (see next page)

Complete front and back. Please sign and date.

2. One Professional Letter of Reference (Typed)

3. Age Requirement – 16 Years Old and Over.

If you are under 18 years of age, you must have a parental consent section of the application form signed (see page 2 of the application). Please bring in a copy of current working papers.

4. Medical Clearance

- Most up-to-date Titers (Lab Reports): Measles/Mumps/Rubella (MMR), Varicella (Chicken Pox)
- Immunization Record for Tuberculosis (2 PPD tests required: for current year) One may be done here at TBHC

5. Proof of Citizenship/Residency (Original for One of the Following):

- Birth Certificate
- Passport

6. Photo Identification (Original for One of the Following):

- School Identification
- Employee Identification
- New York State ID/Driver License

7. Social Security Card (Original) Applicants must have a SS card to be processed

**Please Note: INDIVIDUALS WITHOUT SOCIAL SECURITY WILL NOT BE ACCEPTED
NO EXEPTIONS WILL BE MADE!**

8. Working Papers (for Individuals under 18)

9. Background Check (coordinated by Human Resources for Individuals 18 and over)

10. Drug Test (coordinated by Human Resources for Individuals 18 and over)

11. Attend Orientation (upon acceptance)

When you complete your application AND have the rest of the required documents, please call Volunteer Office for appointment (718-250-8393)

Please Note: To be cleared for work, AFTER your appointment in the Volunteer Office, you will be sent to Human Resources: 240 Willoughby St. 7th Floor, Brooklyn, NY 11201, 718-250-6217

**IMPORTANT NOTICE: IF YOU ARE OFFERED A VOLUNTEER POSITION,
THERE IS A 6 (SIX) MONTHS COMMITMENT
(There is also a 150 hours minimum during the 6 months period)**



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For Office Use Only:

Application Rec'd: _____

Appt: _____

Time: _____ With: _____

Referred to HR: _____

Volunteer Service Application

PERSONAL INFORMATION

Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security #: (required) - - - - -	
Address: Street & No.		Apt #		City/Town		State		Zip	
Home Telephone No.		Work Telephone No.		Cell Phone No.		Email:			
Have you ever volunteered at The Brooklyn Hospital? When? What Department? <input type="checkbox"/> YES <input type="checkbox"/> NO									
Do you have previous volunteer experience? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, where? _____									
IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT? Name: _____ Relationship: _____ Phone: _____									
Are you 18 years of age or older? <input type="checkbox"/> YES <input type="checkbox"/> NO If you are under 18, your parent/guardian's signature is required (See next page)									

TELL US ABOUT YOURSELF

Day(s) you are available to volunteer? (Check all that apply) <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		What program are you most interested in? (Check all that apply) <input type="checkbox"/> Clerical aide <input type="checkbox"/> Emergency Room aide <input type="checkbox"/> Pediatric Playroom <input type="checkbox"/> Patient Care aide <input type="checkbox"/> Hospitality Program <input type="checkbox"/> Physical/Occupational Therapy <input type="checkbox"/> Pastoral Care <input type="checkbox"/> Other _____	
Time(s) you are available:		From _____ To _____ <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening From _____ To _____	
What departments/programs are you most interested in? _____ _____		What population would you like to work with? (Check all that apply) <input type="checkbox"/> Hospital Personnel <input type="checkbox"/> Community <input type="checkbox"/> Medical Staff <input type="checkbox"/> Patients' Families <input type="checkbox"/> Visitors <input type="checkbox"/> Patients	
Have you ever been convicted of a crime(s), misdemeanor(s) or felony <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please give date(s) and detail:</i> _____ _____		Do you have any physical, mental or medical condition, which would limit your ability to perform function of a volunteer job? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please describe:</i> _____ _____ _____	
Please note: Disclosure of a criminal record will not automatically disqualify you from volunteer consideration. Additionally, falsification or omission of information on this application may result in immediate dismissal.			
I am currently (check one that applies and fill in the information): <input type="checkbox"/> A high School student - High School: _____ <input type="checkbox"/> A College student - College: _____ <input type="checkbox"/> Employed - Name & Address of Employer: _____ <input type="checkbox"/> Retired <input type="checkbox"/> Currently Unemployed			

Skills (Check the skills that you have to offer):

- | | | |
|--|---|---|
| <input type="checkbox"/> Able to alphabetize | <input type="checkbox"/> Neat, legible handwriting | <input type="checkbox"/> Nursing experience |
| <input type="checkbox"/> Systematic | <input type="checkbox"/> Endurance | <input type="checkbox"/> Self motivation |
| <input type="checkbox"/> Planning abilities | <input type="checkbox"/> Public speaking | <input type="checkbox"/> Leadership skills |
| <input type="checkbox"/> Organizational skills | <input type="checkbox"/> Light office skills | <input type="checkbox"/> Sense of direction |
| <input type="checkbox"/> Listening skills | <input type="checkbox"/> Steady hands and feet | <input type="checkbox"/> Manual dexterity |
| <input type="checkbox"/> Fluency in English | <input type="checkbox"/> Bilingual (<i>Fluent in:</i> _____) | |

Check the following characteristics that best describe you:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Calmness | <input type="checkbox"/> Patience | <input type="checkbox"/> Common sense |
| <input type="checkbox"/> Poise | <input type="checkbox"/> Compassion | <input type="checkbox"/> Positive attitude |
| <input type="checkbox"/> Conscientious | <input type="checkbox"/> Tactfulness | <input type="checkbox"/> Courtesy |
| <input type="checkbox"/> Understanding | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Warmth |
| <input type="checkbox"/> Outgoing personality | <input type="checkbox"/> Other | |

Personal Reference (not a relative):

Name: _____ Phone: _____

Address: _____ Zip Code: _____

PLEASE NOTE: One professional letter of reference (typed) must be provided

Are you a high school student volunteering for the summer only? YES NO

High School Summer Only Application Deadline: May 1st

If you are only volunteering for the summer you must commit to volunteering for at least 15 hours each week for 8 – 10 weeks.

I have answered each question fully and correctly. I understand that any deliberate misstatement will disqualify me, or will cause immediate termination of my volunteer assignment. I authorize The Brooklyn Hospital Center's Volunteer Services Department to fully investigate my references.

- I understand that in accordance with New York State law, if I am offered a volunteer position, I may be fingerprinted and that such offer and continued volunteer placement are conditional upon satisfactory clearance by this institution's Employee Health Service, which includes drug testing and satisfactory reference verification.
- I hereby agree that I will keep confidential all materials I may read or learn about during my work here as a volunteer. In this regard, I will only discuss this information with appropriate staff and will never, under any circumstances, reveal the name of a patient. If I keep a journal or write a term paper of my experiences, I agree to submit a copy of this written material upon the request of my clinical supervisor or the of Volunteer Services Department in order to protect the confidentiality and legal rights of the patients.
- I understand that, if I am offered a volunteer position, I agree to remain in that position for at least 150 hours or 6 months.

Signature: _____ Date: _____

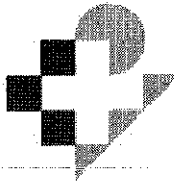
IF UNDER 18 YEARS OLD, PARENT/GUARDIAN SIGNATURE REQUIRED:

I give my consent to my son/daughter _____ to serve as a volunteer at The Brooklyn Hospital Center

Parent Signature: _____ Date: _____

PLEASE NOTE: All students under the age of 18 years must obtain Working Papers; have proof of their most up to date Titers (Lab Reports) – Measles/Mumps/Rubella (MMR), Varicella (Chicken Pox), and Immunization Records for Tuberculosis (PPD) test (2 PPD required: for previous AND current year)

*** PLEASE NOTE THAT THIS APPLICATION MUST BE THOROUGHLY COMPLETED IN ORDER TO BE PROCESSED AND IT TAKES 4-6 WEEKS BEFORE YOU CAN BEGIN VOLUNTEERING ***



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CRIMINAL BACKGROUND HISTORY

Please complete the following with regards to your criminal background history.

HAVE YOU EVER BEEN CONVICTED OF OR EVER PLEAD GUILTY TO A CRIME OR OFFENSE OTHER THAN A TRAFFIC VIOLATION?	YES or NO
<i>If yes, please state the nature of any offense, the date and jurisdiction of any offense, and any rehabilitative efforts that you have made related to such offense or otherwise. A conviction or guilty plea will not necessarily be a bar to employment.</i>	

ATTESTATION - NEW YORK CORRECTION LAW

Effective 11/1/2015

ARTICLE 23-A

I, _____ attest that I have received and read the New York Correction Law – Article 23-A document regarding licensure and employment of persons previously convicted of one or more criminal offenses.

Other Names used, if any: _____

Date of Birth: _____

Social Security: _____

Signature: _____

Date: _____

Received By: _____
Human Resources Representative

Date

Tuberculin Test Results

Name _____

Had a PPD placed RFA / LFA on the date of ____ / ____ / ____

Manufacturer _____ Product Name _____

Lot Number _____ Exp. Date _____

Signature

Had a PPD read on the date of ____ / ____ / ____

Results _____ (Read in millimeters, NOT positive or negative)

Signature

PPD's are to be read 48-72 hours after placement. They may be read by any Registered Nurse, NP, PA, or MD (just not yourself). Remember, do **not** have results recorded as positive or negative. Instead, all results should be recorded in millimeters.



QUEST DIAGNOSTICS INCORPORATED

SPECIMEN INFORMATION
 SPECIMEN: AN393343
 COLLECTED: 02/21/2012 15:34
 REPORTED: 04/09/2012 13:03

PATIENT INFORMATION

DOB: [REDACTED] AGE: [REDACTED]
 GENDER: [REDACTED]

REPORT STATUS FINAL

REPRINT
 ORDERING PHYSICIAN

CLIENT INFORMATION

12066420

Test Name	In Range	Out of Range	Reference Range	Lab
MEASLES AB (IGG)	2.48		>=1.10 Index Value	TBR
Interpretation: Positive or Immune				

A positive result indicates that the patient has antibody to Rubella. It does not differentiate between an active or past infection. The clinical diagnosis must be interpreted with the clinical signs and symptoms of the patient.

Index Value

- <0.01
- 0.01-1.09
- >=1.10

- Antibody detected.
- Antibody detected.

VARICELLA-ZOSTER AB (IGG)
 Interpretation

A positive result indicates the presence of VZV. It does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient.

The presence of Igg
 Index Value Result

- <0.01 Negative
- 0.01-1.09 Equivocal
- >=1.10 Positive - VZV IgG antibody detected.

>=1.10 Index Value TBR

Antibody to past infection detected in the serum.

Antibody to past infection detected in the serum.

Antibody detected.

RUBELLA AB (IGG)

Interpretation: No Rubella IgG antibody detected.

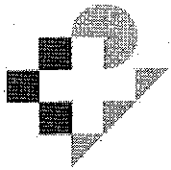
Index Value Result

- <0.01 Negative - No Rubella IgG antibody detected.
- 0.01-1.09 Equivocal - Presence or absence of Rubella IgG antibody cannot be discerned.
- >=1.10 Positive - Rubella IgG antibody detected.

<0.01, 1.10 >=1.10 Index Value TBR

Interpretation

Examples of Lab Slips



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PARENTAL CONSENT FORM

Date:

Dear Parent/Guardian

We are considering your son/daughter _____ for volunteer services at The Brooklyn Hospital Center. Before we can act on his/her application, we require parental approval, as well as, working papers for all applicants under the age of eighteen (18). Most important, we require parental approval for your son/daughter to receive a medical examination, including a PPD if needed, from The Brooklyn Hospital Center's Employee Health Services Department.

If you approve, please sign the consent from below and return it as soon as possible.

Parent/Guardian Name

Today's Date

Signature of Parent/Guardian

Home Telephone

Street Address

Work Telephone

City State Zip Code



Clinical Affiliate of The Mount Sinai Hospital
Academic Affiliate of The Icahn School
of Medicine at Mount Sinai

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