NYCH
NewYorkCommunityHospital
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Dear Volunteer:

We are very pleased to hear that you are interested in volunteering at New York Community Hospital.

I am enclosing an application and a medical evaluation form that you can take to your physician or to your schools Medical Department. If you are under 18 years of age, you will also require working papers from your school.

Please have these papers completed. When that is accomplished, either mail or leave the application with the medical information at the hospital for my attention. We will then have your application reviewed and will be able to call you for an interview to discuss your aims and goals. We will strive to have you assigned to an area that is of interest to you.

We are very appreciative of your interest in our patients and our hospital.

Sincerely,

Kristina Kofman
Director of Volunteer Services

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Hospital Dress Code and Volunteer Responsibilities

All employees and volunteers of the hospital are expected to be professional in attitude and work performance at all times. Part of this responsibility is your appearance and dress; which is a reflection on the hospital.

Volunteers should dress in clean, neat attire. The Hospital identification photo/badge is to be worn at eye level at all times while on duty. Hair should be neat, clean and appropriately styled.

INAPPROPRIATE ATTIRE

A. No tight clothing
B. No sweatshirts, halter, tank tops, tee shirts, see through or low cut tops, bare midriff, sundresses or very short attire.
C. No beach wear, jogging suits.
D. No jogging footwear, or beach type sandals, high platforms.
E. Please refrain from wearing excessive jewelry, headphones or any other electrical devices.
F. You are responsible for the smock or jacket you have been given, and I ask you to be sure to return it to me upon completion of your volunteer service.

We are very grateful to you for volunteering in our Hospital and want you to know that the departments you are assigned are counting on you for assistance. If you are unable to complete or arrive for your given assignment, we would ask you to contact your immediate supervisor and inform them of your unavailability. We also ask that you do not bring any valuables with you to the hospital, since we cannot be responsible for your personal items.

Thank you for choosing New York Community Hospital.

Sincerely,

Kristina Kofman
Director of Volunteer Services

Please complete the below questionnaire.

1. Are there any members of your family who currently work at New York Community Hospital (NYCH)?

YES _____ NO _____

If the answer to the foregoing question is "YES", please supply the following information: Name of the individual working at NYCH and the department they are assigned to.

_____

_____

2. Has any member of your family engaged in any business with NYCH?

YES _____ NO _____

If the answer to the foregoing question is "YES", please supply the following information: Name of the individual, relationship to the individual and the company they work in.

_____

_____

3. Are any members of your family currently employed in any healthcare institution other than NYCH?

YES _____ NO _____

If the answer to the foregoing is "YES" list the position(s) that they hold and the name of the healthcare institution.

_____

_____

4. What departmental areas are you interested in volunteering?

_____

5. If Applicable: Who recommended you or how did you hear about our program?

_____

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EMPLOYEE HEALTH SERVICE

Dear Applicant:

Due to your occupational exposure to blood or other potentially infectious materials, you may be at risk of acquiring Hepatitis B Virus (HBV) Infection. New York Community Hospital is offering Hepatitis B Vaccination free of charge to all employees who are at substantial risk of direct contact with body fluids as mandated by the Federal Occupational Safety and Health Administration (O.S.H.A). Those volunteers who are at substantial risk shall include all nursing personnel performing direct patient care, including Operating Room and Emergency Room personnel, respiratory therapists, laboratory personnel, house physicians and housekeeping staff.

CONSENT/REFUSAL FORM FOR HEPATITIS B SURFACE ANTIBODY TESTING AND IMMUNIZATION

I,_____, have been inserviced on the Recombivax HB Vaccine Program receiving verbal and written information with an opportunity to ask questions. I have been informed that I can receive a Hepatitis B Surface Antibody Test prior to immunization if I choose.

Having been fully informed of all benefits, risks and contraindications.

I WISH TO HAVE HBsAB TEST	☐	YES	☐	NO
I WISH TO HAVE HB IMMUNIZATION	☐	YES	☐	NO
I WILL SUBMIT WRITTEN PROOF OF HBsAB TITER OF HB IMMUNIZATION	☐	YES	☐	NO
I WISH TO DECLINE IMMUNIZATION UNTIL A LATER DATE	☐	YES	☐	NO

Having declined the HB Vaccination at this time, I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that the employee participation in the vaccination program is voluntary and initial refusal of the vaccine will not make me ineligible for further participation.

VOLUNTEER:_____ DATE:_____
WITNESS: _____ DATE: _____

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INFORMATION SHEET FOR THE HEPATITIS B VACCINATION PROGRAM

THE DISEASE

Hepatitis B is a viral infection caused by Hepatitis B Virus (HBV), which causes death in 1-2% of the cases. Although most people recover, approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms but continue to transmit the disease to others. Others infected with HBV develop active hepatitis and cirrhosis of the liver. HBV also appears to be a causative factor in the development of liver cancer.

HBV is most often transmitted by blood and blood products but the viral antigen has also been found in tears, saliva, breast milk, urine, semen and vaginal secretions. HBG is capable of surviving for days on environmental surfaces exposed to body fluids containing HBV. Infection may occur when HBV transmitted by infected body fluids is implanted via mucous surfaces or percutaneously introduced through accidental or deliberate breaks in the skin. This immunization against HBV can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer. There is no known cure once HBV infection is established. Therapy is directed toward relieving symptoms and making the patient comfortable.

THE VACCINE

HV Vaccine is a non-infectious subunit viral vaccine from Hepatitis B surface antigen produced in yeast cells. It is free of association with human blood or blood products. It has been mandated by OSHA that all health care workers who are at substantial risk of infection with HBV be offered the vaccine free of charge. Full attenuation requires 1.0 ml of the vaccine for 3 doses over a six month period. 1st dose: at elected date; 2nd dose: 1 month later; 3rd dose: 6 months after the 1st dose. Approximately 90% of healthy individuals who receive the three doses of HB vaccine, infected intramuscularly in the deltoid muscles, demonstrate immunity.

CONTRADICTIONS

HB Vaccine is contraindicated for persons with known hypersensitivity to yeast or any other component of the vaccine; mercury derivative, aluminum hydroxide, formaldehyde. HB Vaccine is not recommended for use during pregnancy. Persons with the following conditions should consult with their private physicians prior to receiving this vaccine: sever cardiopulmonary diseases, febrile or systemic illness, nursing mothers, immunodeficiency or immunosuppressive disorders.

ADVERSE REACTIONS

While the HB Vaccine is generally well tolerated, some adverse reactions may occur as a result of infection. Major reported side effects are swelling, warmth, tenderness, redness at the injection site; low grade fever, fatigue, headache. Fare reports of rash, nausea, join pain, vertigo/dizziness have been documented. Serious illnesses affecting the nervous system, including peripheral neuropathy and Guillain-Barre Syndrome have been observed in clinical trials with HB Vaccine.

Volunteer Application

Name: _____ _____ ☐ Single ☐ Married
Last First

Address: _____

Telephone: ( )___ - _____ Day 14-18 yrs. Old: _____
( )___ - _____ Evening Working Papers

Date of Birth __ / __ / ____
S.S.# _____ - _____ - _____

High School/College: _____
Specific Skills/Interests: _____

Present Employer _____ _____ _____
Position Held Hours/wk

Why did you choose to volunteer? _____
_____

Days Available: _____
Physical Handicaps: _____

Are you under medical care? If yes, explain: _____
_____
_____

_____ _____ _____
Dr.'s Name Address Phone #

Have you ever been convicted of a crime? If yes, explain: _____
_____

Personal References: (other than relatives)
(1) _____ ( ) - _____
Name Address Phone #
(2) _____ ( ) - _____
Name Address Phone #

In Case of Emergency, Contact: _____ ( ) - _____
Name Phone #

MEDICAL TREATMENT OF VOLUNTEERS: *New York Community Hospital will render only emergency treatment to volunteers. Any follow-up treatments will be the responsibility of the individual volunteer, not New York Community Hospital of Brooklyn. All volunteers must bring notes of good health from their physicians.*

Signature of Applicant: _____ Date: _____

For Office Use:
RSVP: [ ] Yes [ ] No
Department: _____
Physical: [ ] Pending [ ] Received

STUDENT VOLUNTEER PROGRAM
PARENT OR GUARDIAN PERMISSION FORM

DATE:_____

I/We the undersigned Parent(s)/Guardian(s)/request and authorize the enrollment of _____ in the New York Community Hospital student volunteer program, in conjunction with the High School for Medical Professions program.

_____
SIGNATURE

_____
ADDRESS

_____
CITY **STATE** **ZIP**

_____
RELATIONSHIP

_____
CONTACT TELEPHONE NUMBER(S)

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CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a volunteer at New York Community Hospital, I must hold medical information in confidence. I understand that any violation of the confidentiality of medical information may result in termination of my volunteer activities.

Signature of Volunteer: _____

Date: _____

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DEPARTMENT OF VOLUNTEERS

COMPLETION FORM FOR HISTORY & PHYSICAL OF VOLUNTEERS
To be completed by student health service or by private physician.

In compliance with New York State Health Code I have examined _____
and have found him/her to be free of any healthy impairment that would pose a potential risk to patients and hospital and personnel or which might interfere with performance of his/her duties including the habituation or addition to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individuals behavior. I am attaching a copy of this patient's medical history and recent physical examination. In addition I attest to the results of the required and recommended test listed below.

Signature and Title: _____

Print name and Title: _____

P.P.D. – Yearly P.P.D. testing is required for all previous non-responders. Chest X-ray is required for all recent convertors. Sputum for A.F.B. is indicated for all persons with symptoms of tuberculosis and a positive P.P.D. Persons who have a history of tuberculosis or past P.P.D. conversions must attest that the yare free of chronic fever, chills, night sweats, persistent cough and/or hemoptysis. Isoniazid prophylaxis is recommended for all recent convertors.

Planted _____ Read _____ Result _____

If patient is P.P.D. positive - Date of last Chest X-Ray _____

RUBELLA (German Measles)
Active immunity, as demonstrated by levels of circulating antibodies are required of all personnel in the hospital. Past evidence of immunity is acceptable.
Immune _____ Date _____
If negative for immunity, Rubella immunization is needed.
Rubella Immunization – Date Given _____

MEASLES – For those born on or after January 1, 1957

Titer		Date _____.
Disease documented		Date _____.
Immunizations	1st injection	Date _____.
	2nd injection	Date _____.

VARICELLA
HX: ☐ YES ☐ NO TITER: ☐ YES ☐ NO

HEPATITIS B VACCINE
Have you been vaccinated with Hepatitis B Vaccine? ☐ YES ☐ NO

Note: If you would like to receive Hepatitis B Vaccine, New York Community Hospital can provide you with the series at no cost if you are over 18 years of age. If you would like to receive the Hepatitis B Vaccine, check on below:

☐ I would like to receive the Hepatitis B Vaccine.
☐ I would not like to receive the Hepatitis B Vaccine at this time.

For information on Hepatitis B Vaccine refer to the attached information sheet.

Students or volunteer under the age of 18 years must submit proof of immunization for poliomyelitis, mumps, and diphtheria.