Long Island
State Veterans Home

AT STONY BROOK UNIVERSITY

DEPARTMENT OF VOLUNTEER SERVICES
100 Patriots Rd, Stony Brook, NY 11790-3300
(631) 444-8590 Fax (631) 706-4662
samantha.calandrino.@lisvh.org

Dear Prospective Volunteer:

Thank you for your interest in volunteering at the Long Island State Veterans Home.

To Get Started:

Fill out as much of the application as possible then mail/fax or email to the Veterans Home. Once we receive the application we will invite you to our next Volunteer Orientation and Training. We hold orientation and trainings every 4-6 weeks, alternating between days and evenings. There is a lot of interest in volunteering at the Home and space is limited, you will need to RSVP in order to attend.

Besides the Application This Packet Also Includes:

- Photo Release Form
- Confidential Information Form
- Health Questionnaire
- Medical Reference- see additional information

These will need to be submitted before you can start volunteering.

Benefits of Volunteering:

Learn new skills, learn about what makes a quality nursing home and how it runs, meet interesting people, feel good about helping others and give back to our Nation's heroes.

Benefits We Offer You:

Educational workshops, volunteer meal program, holiday and recognition luncheons, newsletter, reference letters, annual flu shot (optional), training and support.

We look forward to hearing from you and being able to welcome you to our volunteer family. Please contact me with any questions 631-444-8590 or samantha.calandrino@lisvh.org .

Best wishes,

Samantha Calandrino

Samantha Calandrino, LMSW
Coordinator of Volunteer Services

Long Island
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Dear Prospective LISVH Volunteer,

Welcome to the Long Island State Veterans Home!

Please provide the records below so we can streamline the timeliness of your acceptance to the Volunteer Program. Please bring All Immunization Records and any of the following Blood Work Results as it will expedite your hiring process.

Required Vaccine Information:

• MMR Vaccine record

• Varicella Vaccine record

- **Please note- if you are unable to provide documentation of vaccine administration, you must provide Laboratory evidence of Varicella and measles mumps and rubella immunity**

Required Testing:

• QuantiFERON Titer result within 1 year or less

OR

• PPD 2-step results within 1 year or less

• Chest-Xray, if you have a +PPD or +QuantiFERON

Recommended Vaccine Information:

• Proof of Influenza Vaccine for the current season (recommended)

• Covid Vaccination record (recommended)

As per the New York State Department of Health, the New York State Public Health law, the Occupational Safety and Health Agency and the Advisory Committee on Immunizations, immunity to measles and rubella is Required for Employment for all Health Care Personal. If a vaccine is needed the series must be administered prior to employment. The MMR vaccine is a 2-step series separated by at least 28 days. You can obtain the vaccine from your Primary Care Physician or Community Pharmacy.

Any questions regarding volunteer health requirements please call 631-444-8526.

Thank you,

Employee Health Long Island State Veterans Home

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Volunteer Application (18 years +)

Name_____ Gender _____ Marital Status _____
(Last First Middle Initial)

Address _____
Street Address City State Zip

Phone Number _____ e-mail Address _____

For SUNY SB Students: Local/Campus Address and Phone *School Year* _____

Address _____ *Phone* _____

Present Occupation _____ Length of Time: _____
Current Employer (or College) _____ Phone _____
Can you be called at work? _____ Regular Work Schedule_____

Education (highest grade completed and school attended): _____

Previous Volunteer Experience (including dates, location and duties): _____

_____

_____

Do you have a set area that you are interested in volunteering in?
❑ Yes (please specify) _____ ❑ No, I'd like to explore the options

Community Organizations to which you belong: _____

_____

_____

Do you have any limitations that might affect your volunteering? If yes, please explain:

_____

_____

In Case of Emergency Contact:

_____

Name *Phone* *Relationship*

PHYSICIAN'S NAME _____

Address _____ *Phone* _____

Have you ever been arrested? Please circle: YES NO If yes, please explain:

_____

_____

List the names of employees or volunteers or residents/registrants at the Long Island State Veterans Home or University Hospital whom you know:

Please note we are unable to accept prospective applications of current residents/registrants

Name	Department/ facility	Relationship

REFERENCES: Please Provide Two References Who We May Contact *(No family members):*

Name: _____ Phone:_____

Email: _____

Relationship: _____ How long have you known him/her?: _____

Street/ City Address: _____ State: _____ Zip Code:_____

Name: _____ Phone:_____

Email: _____

Relationship: _____ How long have you known him/her?: _____

Street/ City Address: _____ State: _____ Zip Code:_____

DAYS AND TIMES YOU MAY BE AVAILABLE TO VOLUNTEER

Monday	Thursday	Sunday
Tuesday	Friday	Number of hours you are interested in volunteering each week _____
Wednesday	Saturday	

The information I provided on this application is accurate and complete to the best of my knowledge. By submitting an application, I understand that I am not obligated to volunteer at the Long Island State Veterans Home, nor is the Long Island State Veterans Home obligated to accept me as a volunteer. I understand I will need an interview and medical clearance before I can be considered for acceptance as a volunteer.

I understand that in the performance of my duties as a volunteer at the Long Island State Veterans Home, I may be required to have access to personal health information of the residents. Or I may be involved in the processing or inputting of resident care data. I understand that I am obliged to maintain the confidentiality of this information at all times, both at work and off duty. I agree that I will not share this information with anyone, including other volunteers and staff, unless required as a part of my volunteer duties. I understand that a violation of this confidentiality may result in disciplinary action.

_____ _____

Signature Date

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Confidential Information

Dear Volunteer Applicant:

Your privacy is important to us. Under no circumstances will the Long Island State Veterans Home share your contact information with any other organization. All medical information obtained from you will be kept locked in confidential files in our Medical offices (not with your volunteer file).

As you notice on this form, we do ask for your Social Security number and date of birth. This is needed to issue you an official Long Island State Veterans Home/Stony Brook University, Volunteer ID Badge. We realize in this day and age people are reluctant to constantly share their SS# and we understand that. In an effort to protect your privacy while meeting our administrative needs, we have removed the Social Security number from the Volunteer Application. We are asking you to fill it out on this separate sheet of paper. This way the number will not be kept in your volunteer file, it will be shredded once we have issued you your official ID badge. The number will not be used as a volunteer ID number and it is not used in the volunteer data system.

We hope this system addresses everyone's concerns regarding their privacy and safety.

Volunteer's Name: _____

Social Security Number: _____

Date of Birth ____/____/____

This page will be treated as confidential information and will be properly disposed of (shredded) and not maintained with your volunteer file.

VOLUNTEER HEALTH QUESTIONNAIRE

Date: _____/_____/_____ *New Volunteer*

Volunteer: fill out this form yourself and send it in to Volunteer Services.

Name _____ Phone Number _____
(Last First Middle Initial)

Address _____
Street Address City State Zip

Date of Birth: _____/_____/____ Place of Birth: _____ Marital Status: _____

In Case Of Emergency, contact:

_____
Name Phone Relationship

Physician's Name _____ Phone _____

MEDICAL HISTORY

Do you smoke? _____ How Much? _____ For How Long? _____

Do you drink? _____ How Much? _____

HAVE YOU EVER BEEN TREATED FOR ANY OF THESE DISEASES? PLEASE CHECK:

High Blood Pressure	Heart Problems	Hepatitis
Tuberculosis	Pneumonia	Skin Diseases
Thyroid Disease	Anemia	Diabetes
Neurological Problems	Seizure Disorder	Emphysema
Eye or Visual Problems	Kidney Problems	Cancer
Psychiatric or Emotional Problems	Major Injuries	Arthritis
Sexually Transmitted Diseases	Hearing or Ear Problems	Stroke
Ulcers or Gastrointestinal Problems	Chickenpox/ Shingles	
Back Problems or Any Muscle or Bone Disorder		

Other: _____

Please Explain: _____

Are you under medical treatment of any kind? _____ If yes, please explain: _____

_____

_____

Medications (Current/ Recent):

_____

_____

Allergies: _____

Have you ever had any operations? _____ If so, please list: _____

_____

(Go To Next Page)

Family History: Please list any medical problems your immediate family members have, including cause of death, if deceased:

_____

_____

TUBERCULOSIS SCREEN

1. Do you or have you had any of the following problems:

   Diabetes Mellitus Yes ❑ No ❑

   Blood/lymph Disease such as Leukemia or Hodgkins Yes ❑ No ❑

2. Do you take corticosteroids (prednisone, cortisone)?

   Yes ❑ No ❑

   If yes, please explain: _____

3. Are you taking any immunosuppressive drugs (azathioprine, cyclosporine, muromonab)?

   Yes ❑ No ❑

   If yes, please explain: _____

4. Do you have any of the following symptoms:

	No	Yes	If YES, Please Explain
FEVER			
TIREDNESS			
WEAKNESS			
NIGHT SWEATS			
LOSS OF APPETITE			
UNEXPLAINED WEIGHT LOSS			
SWELLING IN NECK, ARMPITS, GROIN			
COUGH WITH SPUTUM			
BLOOD TINGED SPUTUM			

To the best of my knowledge, I have completed this information accurately and completely.

_____
Volunteer's Signature

_____
(If under 18) Parent or Guardian's Signature

Send To:

Volunteer Services
Long Island State Veterans Home
100 Patriots Road
Stony Brook, NY 11790-3300

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MEDICAL REFERENCE

To Be Filled Out by Your Physician

Volunteer Applicant's Name:

_____

The above individual has applied to become a volunteer at the Long Island State Veterans Home and has given us your name as a medical reference. Please provide us the following information; it will be treated as confidential. You can ***fax or mail back*** the completed form to the Department of Volunteer Services at the above contact information. Thank you for your assistance.

Sincerely,

Samantha Calandrino LMSW
Samantha Calandrino, LMSW
Coordinator of Volunteer Services

Volunteer; do NOT write below this line. Bring to your Physician and have him/her fill this out.

1. Does the applicant have any condition or disability that may be of potential risk to patients or personnel at the Long Island State Veterans Home?

❑ Yes ❑ No

REMARKS: _____

_____

2. Does the applicant have any condition or disability that might interfere with the performance of his/her duties as a volunteer?

❑ Yes ❑ No

REMARKS: _____

_____

3. Mantoux (PPD) within the past three (3) months:
[If having his/her PPD done at the Veterans Home, do not fill out this question].

Date: _____ Results: _____ CXR: _____

Physician Office Stamp and License Number are Required

Physician's Signature _____

Name _____

Address _____
Phone _____

Date: _____/_____/_____

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Consent Form

To Interview, Photograph, Film, Videotape or Record

Date: _____/_____/_____

Name of Volunteer: _____

I hereby give my consent and permission to the Long Island State Veterans Home, its employees and authorized agents to interview, take photographs, motion pictures, videotape and/ or sound recordings of me.

The interviews, photographs, films, videotapes or recordings obtained by the Long Island State Veterans Home may be used, together with the use of my name, for educational, public relations or advertising purposes as determined by the Home.

Signature of Volunteer: _____

If under 18, Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____

Do Not Write Below This Line

Authorized Signature: _____