Dear Prospective Volunteer:

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

**To Get Started:**
**Fill out as many paper as possible and then mail/fax or email it to the Veterans Home.** Once we receive the application we will invite you to our next Volunteer Orientation. We hold orientation and trainings every 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, including recent PPD [PPD has to be within three months of the orientation you attend]. *This form needs to be completed and signed by your physician.*

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

** Regarding the Medical Information:**
State law requires all volunteers to show proof of a recent PPD (Tuberculosis test), no more than 3 months old. As a courtesy, we offer the PPD test to you free of charge at the Veterans Home, however hours may be limited. Your doctor will still need to fill out the first 2 questions on the Medical Reference and sign the form. We protect your confidentiality with all this information. **Stony Brook University Students** can submit a current school physical instead of the Medical Reference, but will still need an up to date PPD.

**To schedule an appointment for the TB test, call the LISVH Employee Health office, at 631-444-8526.**
*Keep in mind when making your appointment; you then need to come back two days later to have the test read. You MUST submit the results of the TB test to VOLUNTEER SERVICES, do NOT leave it with the nurse!*

**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, give back to our Nation’s heroes, get experience for your future.

**Benefits We Offer You:**
Volunteer support groups, educational workshops, volunteer meal program, holiday and recognition luncheons, quarterly 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.myers@lisvh.org

Best wishes,

Samantha Myers
Samantha Myers, LMSW
Coordinator of Volunteer Services
**Volunteer Application (18 years and over)**

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**

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:

_________________________________________________________________________________

_________________________________________________________________________________

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In Case of Emergency Contact:

Name ____________________________  Phone __________________  Relationship _______

PHYSICIAN’S NAME ____________________________
Address _________________________________________________ Phone ___________________

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

List the names of employees, volunteers, residents or registrants at the Long Island State Veterans Home or University Hospital whom you know:
**Relatives of current residents/registrants are ineligible to volunteer while their loved resides/attends program at LISVH**

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/ facility</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

REFERENCES: Please Provide Two References Who We May Contact (Not 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

<table>
<thead>
<tr>
<th>Monday</th>
<th>Thursday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>Saturday</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Number of hours you are interested in volunteering each week ________</td>
</tr>
</tbody>
</table>

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 __________________________
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. Instead 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: 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
____________________________________________________________________________
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: ______________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
Family History: Please list any medical problems your 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:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes</th>
<th>If YES, Please Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEVER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIREDNESS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEAKNESS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>NIGHT SWEATS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LOSS OF APPETITE</td>
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<td></td>
<td></td>
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<tr>
<td>UNEXPLAINED WEIGHT LOSS</td>
<td></td>
<td></td>
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<tr>
<td>SWELLING IN NECK, ARMPITS, GROIN</td>
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<tr>
<td>COUGH WITH SPUTUM</td>
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<tr>
<td>BLOOD TINGED SPUTUM</td>
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</table>

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
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 Myers, 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’s Signature _________________________________________________
   Name ________________________________________________________________
   Address ______________________________________________________________
   Phone __________________________________________________________________
   Date: _____/_____/_____

Physician Office Stamp and License Number are Required
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: ________________________________

Authorized Signature: _____________________________________________