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
www.LISVH.org

Dear Prospective "Volun-Teen":

Thank you for your interest in the Long Island State Veterans Home. Our "Volun-Teen" program is for those young people ages 14-17 who want to volunteer at the Veterans Home.

To Get Started:
Fill out and many of the papers as possible then mail/fax or email and have your parent or guardian fill out and sign the parent consent form and the parent acknowledgment form, then mail it in to the Veterans Home. Once we receive the application and consent/acknowledgment forms and COVID 19 vaccination, 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 You Will Also Need to Submit:
You can attend orientation without these items, (except the vaccination) but you will need to be submitted before you can start volunteering.

- 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.*
- Working Papers (you obtain from your school)
- ***Copy of COVID 19 vaccination, please submit prior to Orientation and Training***

Regarding the Medical Information:
State law requires all volunteers to show proof of a recent PPD (Tuberculosis test), no more 1year 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.

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, career exploration, 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 meal program, quarterly newsletter, training and support, volunteer support groups, educational workshops, reference letters, proof of hours, holiday gift and recognition luncheon.

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 Samanatha.calandrino@lisvh.org .
Best wishes,

Samantha Calandrino

Samantha Calandrino, LMSW
Coordinator of Volunteer Services

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Junior Volunteer Application (14 – 17 years old)

Name _____ Gender _____
(Last , First Middle Initial)

Address _____
Street Address City State Zip

Phone Number _____ e-mail Address _____

School's Name and Mailing Address _____

Grade _____ Guidance Counselor _____

Current Employer (if applicable) _____ Telephone: _____

Job Title _____ Number of hours per week _____

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

Clubs and Organizations to which you belong _____
_____
_____

Do you have any limitations that might affect your volunteering? _____

If yes, please explain: _____
_____
_____

Have you ever been arrested for anything? Please circle: YES NO

If yes, please explain: _____
_____

IN CASE OF EMERGENCY, contact:

_____
Name *Phone* *Relationship*

PHYSICIAN'S NAME _____

Address _____ *Phone* _____

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 volunteers of current residents/registrants**

Name	Department/ facility	Relationship

REFERENCES: Please Provide Two References Who We May Contact *(Not family members or peers)*
Examples of appropriate references would be a teacher, guidance counselor, community leader, religious instructor, employer, coach, youth group leader or neighbor who you have assisted or worked for.

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 am required to have access to and am involved in the processing 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 understand that a violation of this confidentiality may result in disciplinary action.

As a Junior Volunteer, I agree that I will serve regularly as assigned, accept supervision gracefully, and agree to abide by all rules and policies of the facility and the Department of Volunteer Services.

_____ _____
Junior's Signature Date

_____ _____
Parent or Guardian's Signature Date

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Parent/Guardian Consent & Medical Authorization

Date: _____/_____/_____

Participation Consent

I give consent for my child, _____, to participate in the Junior Volunteer program at the Long Island State Veterans Home at Stony Brook, New York. I realize that volunteering is a responsibility and my child is making a commitment. I agree to assume responsibility for my child's transportation to and from the Home.

Medical Authorization

Furthermore, I give my consent to the Long Island State Veterans Home and the University Hospital at Stony Brook and to its medical and nursing staff to examine or treat my child, named above, in the event of any accident or illness that may occur in the course of performing duties as a volunteer at the Long Island State Veterans Home.

I also give my consent to the Long Island State Veterans Home at Stony Brook to perform health assessments and/or screenings as required by the Home's policies.

_____

Parent/Guardian's Signature

_____

Parent/Guardian's Printed Name

_____

Parent/Guardian's Address

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Junior Volunteer Parent Acknowledgment

The Long Island State Veterans Home is part of Stony Brook University and builds learning into many aspects of our care and service.

We view the Junior Volunteer program as a great learning experience for those youth who choose to participate. We find that it is important to review a few things with the parents when their child applies to become a volunteer.

It is important for the parents to realize that volunteering imparts important skills for a young person's future. By letting the child navigate the world of volunteering s/he is learning important skills s/he will later use in his/her higher education and career. To help the child learn these skills we kindly ask that the volunteers contact us directly and not the parents. We find that this direct communication assists in building skills for the volunteer and eliminates any miscommunication.

Some Guidelines That You Should Be Aware Of:

- We will be in contact directly with your child.
- Your child is expected to fill out appropriate papers and hand them in in a timely fashion.
- Your child is expected to communicate directly with the Volunteer Department and directly with his/her supervisor of the assigned department.
- If there are any papers your child needs to fill out along the way these will be sent directly to your child.
- Any communication we have will be directly with your child.

We appreciate your cooperation with us in regards to your child's volunteer and learning experience. Please complete this form below indicating that you have read the above and send it in to Volunteer Services to be included in your child's application. Thank you greatly.

Junior Volunteer's Name: _________

Parent's Name: _____

Parent's 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. 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 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
Turberculosis	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 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
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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

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: _____