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

Long Island
State Veterans Home

AT STONY BROOK UNIVERSITY

Dear Prospective Volunteer:

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

## To Get Started:

**Fill out as many papers as possible then mail/fax or email in to** the Veterans Home. Once we receive the application and a copy of your COVID 19 vaccination, we will invite you to our next Volunteer Orientation and Training. 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.*
- ***A copy of COVID 19 vaccination proof, please submit prior to Orientation and Training***

***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 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. **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.calandrino@lisvh.org .

Best wishes,

*Samantha Calandrino*

Samantha Calandrino, LMSW
Coordinator of Volunteer Services

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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 *(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**

| | | |
|---|---|---|
| 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

Long Island
State Veterans Home
AT STONY BROOK UNIVERSITY

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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 |
| 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**

# MEDICAL REFERENCE

***To Be Filled Out by Your Physician***

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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: _____