

# Long Island State Veterans Home

## DEPARTMENT OF VOLUNTEER SERVICES

100 Patriots Rd, Stony Brook, NY 11790-3300

(631) 444-8590

Fax (631) 706-4662

[Samantha.myers@lisvh.org](mailto:Samantha.myers@lisvh.org)



AT STONY BROOK UNIVERSITY

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 as many 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 completed application and consent/acknowledgment forms 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, 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)

### **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.

**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 [Samantha.myers@lisvh.org](mailto:Samantha.myers@lisvh.org) .

Best wishes,

*Samantha Myers*

Samantha Myers, LMSW

Volunteer Services Coordinator

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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, 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 one resides/attends program at LISVH

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     |
| 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: \_\_\_\_\_

\_\_\_\_\_





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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 Myers*

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.**

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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: \_\_\_\_\_