Dear Prospective Volunteer

Thank you for expressing an interest in St. Mary's Hospital for Children. St. Mary's provides complex medical care and intensive rehabilitative services to children with special healthcare needs from birth to eighteen years of age. Volunteers are needed for many diversified activities such reading and playing with the children, helping with computer skills, homework or assisting children on trips or throughout the facility.

Enclosed please find an application and the health requirements for the Volunteer Program. Your health assessment must be no more than one year old. If you have any questions regarding volunteer services, please call Jillian Quinn at 718-281-8933 or email at JQuinn@stmaryskids.org.

Your completed application should include:

- A history and physical examination (no more than 1 year old)
- Update immunization record – including MMR, Varicella and a PPD
- Two reference letters (may be mailed separately)
- Parental Consent
- Photograph Release
- Working Papers(if under the age of 18)
- Background Check for volunteers 18 and above
- Medical Consent

Upon completing the full application and health requirements, please mail or drop off the documents to:

St. Mary's Hospital for Children
Volunteer Program, PDHC
29-01 216th Street
Bayside, New York

Once the documents are reviewed, you will be called to schedule an interview and be provided an orientation date. All documents, including history of vaccinations, must be complete in order for the application to be reviewed. Please note that if your application is incomplete, it may delay your start date. You will need to attend a training session prior to your start date. The Training sessions are held throughout the year.

Thank you for your interest in volunteering at St. Mary's. I look forward to facilitating a wonderful volunteer experience.

Sincerely,

Vivian Figueroa, MHA, LNHA
Assistant Vice President

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PRE-EMPLOYMENT/VOLUNTEER HEALTH REQUIREMENTS

As a Department of Health requirement for employment with St. Mary's, the following pre-employment documentation must be submitted prior to your anticipated start date. Please complete all required information requested in the "To Be Completed by Employee and Emergency Contact" section.

- **Physical Examination** by your private physician within the past 12 months with the form signed and stamped by the Healthcare Provider.
- **Proof of two negative PPD tests** – one must have been completed within **6 weeks** prior to your tentative date of employment. Additionally, if you do not have documentation of an additional negative PPD test within the past 12 months you will need to receive a 2nd step PPD by not more than 1-3 week after you begin to volunteer. This may be done at St. Mary's.
- **If your PPD has been positive** If your PPD has been *positive in the past and documented*, proof of a negative chest x-ray is required. A written radiologist's report of the x-ray is necessary. The chest x-ray must be done at the time of the positive PPD or after that time. Additionally, your physician needs to provide a statement that indicates a history of positive PPD or BCG, including date of last testing, the manufacturer, lot number, results in millimeters of induration, date read and names of person documented placing, reading and interpreting the test as well as documentation of treatment offered. If proof of this information is not obtain a PPD skin test or Quanitiferon TB Gold test is recommended. A Tuberculosis Assessment for Employees with a Positive PPD or BCG History form will also be required and yearly after if not treated with INH.
- **Proof of Rubeola, Rubella and Varicella immunity**. The proof may be 1 of the 4 options listed:
    1. An actual laboratory report including a numerical lab titer accompanied by a numeric interpretation chart, OR
    2. Official immunization record, OR
    3. Signed MD statement that vaccine was given on date indicated OR

Please Note:
If any of the above required medical documentation submitted is incomplete, the start date of your volunteer service with St. Mary's Healthcare System for Children will be delayed.

Application for Volunteers

Date of Application: _____________ Referred to St. Mary's By: ❒ Self ❒ Other: _________________________

Last Name: ________________________ First Name: ______________________ Middle: ____________________

Home Address: ____

Street *City* *State* *Zip Code*

Home Telephone: __________________ Cell Phone #: ___________________ SS#__________________________

E-mail: ___________________________________ Date of Birth: _____________________________

Are you volunteering to meet School Requirements? ❒ No ❒Yes

If yes, please respond to the following:

Current School Status: ❒ 9 (Freshman) ❒ 10 (Sophomore) ❒ 11 (Junior) ❒ 12 (Senior) ❒ College

Name of School: ____

Address: ____

Service Learning Instructors Name and Phone # ____

Program Start Date: __________ Program End Date: __________ Required # of Hours: __________

Please list any special program requirements the Volunteer Services Division should comply with.

For all applicants:

Do you have any experience working with children? ❒ No ❒ Yes

If yes, what? ____

Do you have any previous volunteer experience? ❒ No ❒ Yes

If yes, where and what? ____

Why would you like to volunteer at St. Mary's? ____

Have you been a patient or do you know a patient at St. Mary's? ❒ No ❒ Yes, explain_______________________

____

What dates and times are you available to volunteer? ____

References

Please be advised that we require **two written references** (either personal or professional) **from teachers, guidance counselors, or employers.** The 2 references may be typed or handwritten. The letter may include; your relationship, how long they have known you, why they recommend you for volunteer service, and your qualities that may be important.

1. I confirm that I am at least 14 years of age.
2. I confirm that I will perform my volunteer duties during non-school hours.
3. Wage Exemption: I understand that I will not receive any form of payment for my volunteer work at St. Mary's.

Applicant's Signature: ________________________________ Date: ______________

PARENTAL CONSENT FORM - (For volunteer applicants under the age of 18)

_______________________________ has my permission to participate in the High School Volunteer Program at St. Mary's. I, _______________________________________ offer my support with their volunteer services and will ensure that he/she adheres to his/her schedule and responsibilities. ______________________________________

Name of Parent/Guardian *Date*

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St. Mary's Hospital for Children
Volunteer Health Assessment

Name: ____ Date: _____________ Date of Birth: ___________

Address: ____

Home Telephone:___________________________ Cell/Pager: ______________________________

Emergency Contact: In the event of an emergency please indicate two individuals you wish to have us call

Name: _____________________________Relationship: ___________________Telephone: _________________________________

Name: _____________________________Relationship: ___________________Telephone: _________________________________

I certify to the best of my knowledge that I am free from any health impairment that may be of potential risk to the patient or may interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter my behavior. I also certify that to the best of my knowledge, I do not pose any risk to myself or others and that the above information is accurate.

VOLUNTEER
SIGNATURE:____PARENT/GUARDIAN:____

TO BE COMPLETED BY A MEDICAL PROVIDER

B/P:	Weight:	Height:

Mantoux (PPD) Test date planted: _______________ Manufacturer ___________, Lot #___________, Exp. Date _______________

Date Read: ___________Results (mm): _____________ Comment: ____

If PPD is positive, separate form required (TB Assessment for Employees with a Positive PPD or BCG History)

Skin: _______________________ Vision: __________________ Corrective lenses? (Yes/No) __________

Hearing: (R) _________________ (L) _____________________ Nose: ___________________ Teeth:_______________________

Tonsils:__________________ Cervical:_________________

Thyroid:_____________________ Lungs:___________________ Heart:___________________

IMMUNIZATIONS REQUIRED

- ❑ Rubella:_____________,_______________ ❑ Lab report showing proof of immunity
- ❑ Measles:_____________,_______________ ❑ Lab report showing proof of immunity
- ❑ Mumps:_____________,_______________ ❑ Lab report showing proof of immunity
- ❑ Varicella:_____________,_______________ ❑ Lab report showing proof of immunity OR ❑ Physician's report of prior illness
- ❑ Influenza____________________________ ❒ Declined
- ❑ Hep B____________,______________,________ ❒ Declined
- ❒ Pneumococcal __________________ ❒ Declined

Is there a history of:

Headaches	☐ No	☐ Yes	Digestive disorders	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes	Chronic cough	☐ No	☐ Yes
Cardiac Disease	☐ No	☐ Yes	Nervous disorders	☐ No	☐ Yes
Back injury	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
History of tuberculosis	☐ No	☐ Yes	Infectious disease	☐ No	☐ Yes

Has the employee any physical or mental impairment that might interfere with his/her ability to work with children? ☐ No ☐ Yes

Examining Medical Provider- MD, NP, PA (**please include office stamp):**

Signature: ____ Date: _________________________Physicians UPIN:_________________

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ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN
Tuberculosis Assessment with a Positive PPD or BCG History
CONFIDENTIAL

TO BE COMPLETED BY THE EMPLOYEE

Name: ______________________________ Date: __________ Date of Birth: _________

Address: ____

Home Telephone:____________________ Cell/Pager: _______________________

TO BE COMPLETED BY A MEDICAL PROVIDER
PLEASE COMPLETE ALL SECTIONS

INDICATOR	DATE	COMMENT
Recent Positive PPD (within the last 12 months)	Date planted: Date Read:	Induration:
History of Positive PPD	Date of conversion:	Induration:
History of BCG in past	Date:	
Quantiferon Gold Test	Date:	Results:
Chest X-ray	Date:	Copy of radiology report must be attached.
Symptoms: Chronic cough: ☐ No ☐ Yes Night sweats: ☐ No ☐ Yes Weight loss: ☐ No ☐ Yes Fatigue: ☐ No ☐ Yes	Date of onset of symptoms:	Comments:
Treatment		
☐ INH was prescribed.	Start date: End date:	
☐ INH was offered and declined.	Date:	
☐ INH was not offered. If so, why?	Date:	

PRINT Examining Medical Provider- MD, NP, PA (please include office stamp):

Signature:_________________________________Date:____________________

UPIN:___________________________________Physician Stamp:

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REFERENCE LETTER

Dear ________________________________

Your name has been given to us as a reference by
____________________________, who has applied for volunteer services with our children. Please answer the questions below, using the reverse side if necessary, and return this form to:

St. Mary's Hospital for Children
29-01 216 Street
Bayside, New York 11360
Attn: Volunteer Coordinator, PDHC

Please comment on the candidate's skills, dependability, cooperation, ability to relate to children and similar traits. You should be known to this applicant for at least two years. Please give examples where possible.

____
____
____
____
____
____

Does the applicant have any problems that we should be aware of before we give him/her an assignment at St. Mary's? ❑ No ❑ Yes, Describe below

____
____
____
____

Please print your name: ____
What is your relationship to the applicant? _________________________________
How long have you known the applicant? __________________________
Your address: ____
Telephone number: ____
Signature: ____
Date: ____

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____
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____

Does the applicant have any problems that we should be aware of before we give him/her an assignment at St. Mary's? ❑ No ❑ Yes, Describe below

____
____
____
____

Please print your name: ____
What is your relationship to the applicant? ______________________________
How long have you known the applicant? __________________________
Your address: ____
Telephone number: ____

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Signature: ____

Date: ____

Consent for Medical Treatment

I grant consent to St. Mary's Hospital for Children and its medical and nursing staff to treat me/my child in the event of accident or illness that may occur during the course of performing duties as a volunteer at St. Mary's Hospital for Children.

I also give my consent to St. Mary's Hospital for Children to perform health assessments/screenings as a required by hospital policy.

High School Volunteers:

- ❑ I have read this letter and I give permission for my child _______ ____________________ to receive medical treatment at St. Mary's Hospital for Children.
- ❑ I do not want my child to receive medical treatment.

Parent/Guardian:___________________________Parent/Guardian Signature:___________________________

Adult Volunteers:

- ❑ I have read this letter and I ____________________________ would like to receive medical treatment at St. Mary's Hospital for Children.
- ❑ I do not want to receive medical treatment.

Applicant's Signature:___________________________________

Release Form for Taking and Utilizing of Photographs, Photocopies, tape Recordings, and Video Tapes and Films

Name: ____

I hereby grant permission to St. Mary's, its agents and employees, and to any person, firm or organization that St. Mary's may designate or authorize to take and utilize photographs, photocopies, tape recordings, video tapes and films (collectively, the "materials") of me.

This consent includes the use of materials with or without my name and biographical data by St. Mary's of anyone else on its behalf, without limitations as to time or frequency of use, for any or all of the following purposes:

- Newspaper release
- Publicity or fund-raising
- Release of communication to other media
- Educational, instruction or teaching purposes

I grant this consent voluntarily and hereby waive any and all rights I may have to royalties or other compensation in connection with publication or other use of the materials.

______________________________________ ________________

Signature of Volunteer/Parental Consent Date

I **DO NOT** grant this consent. However, I hereby acknowledge that I may not refuse to have my picture taken and displayed within the workplace for purposes related to volunteer services. I further acknowledge that, should I wish to refrain from having my photo or video published, I am responsible to communicate my wishes to the photographer or videographer at the time the picture or video is taken. I acknowledge that St. Mary's will make a reasonable attempt to honor my wishes; however, I hereby hold St. Mary's, its agents and employees and any person, firm or organization that St. Mary's may designate or authorize harmless in the event that my photo, video or other likeness is used for any of the above purposes.

______________________________________ ________________

Signature of Volunteer/Parental Consent Date