DEPARTMENT OF VOLUNTEER SERVICES
100 Patriots Rd, Stony Brook, NY 11790-3300
(631) 444-8590 Fax (631) 632-2481
Susan.Helmus@StonyBrook.edu

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 are interested in volunteering at the Long Island State Veterans Home. The Volunteer Department will do everything possible to make your experience meaningful and fulfilling.

What You Need To Get Started:

- Volunteer Orientation
- Volunteer Training
- Volunteer Application
- Parent Consent Form
- Working Papers (you obtain from your school)
- Health Questionnaire
- Medical Reference, including recent PPD. PPD has to be within three months of the orientation you attend or within three months of when you submit the application, which ever is later. *(This form needs to be completed and signed by your physician).*

To Get Started:
Call or email to find out about our next Volunteer Orientation.
Or you can simply fill out this application and send it in. And we will send you an invitation to Orientation.

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 nurse, John Vaughan at 444-8526.
Keep in mind when making your appointment; you then need to come back two days later to have the test read.

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 Susan.Helmus@StonyBrook.edu .

Best wishes,

Susan K. Helmus

Susan K. Helmus, MA
Director 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) _________________________________

____

____

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 at the Long Island State Veterans Home or University Hospital whom you know:

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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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.

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Parent/Guardian Consent And 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 it's 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

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
100 Patriots Road
Stony Brook, NY 11790-3300

MEDICAL REFERENCE

To Be Filled Out By Your Physician

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100 Patriots Rd, Stony Brook, New York 11790-3300
(631) 444-8590 Fax: (631) 632-2481
e-mail: Susan.Helmus@StonyBrook.edu

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,

Susan K Helmus

Susan K. Helmus, M.A.
Director 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 ______________________________