ROCHESTER
REGIONAL HEALTH
EASTERN REGION

LOCATION REQUESTED: _____

Student Volunteer Application

----- Please print -----

Date _____

Name _____ Age _____ Birth Date_____

CONTACT INFORMATION

E-mail Address _____

Cell Phone _____ Home Phone _____

Address/Town/Zip_____

Parent/Guardian Name_____Parent E-mail _____

Emergency Contact_____
(first name) (last name) (phone) (relationship to you)

Family Member(s) affiliated with Rochester Regional Health, if any:

_____
(name) (relationship) (location) (position)

_____
(name) (relationship) (location) (position)

EDUCATION AND EMPLOYMENT HISTORY

High School _____Current Grade Level _____

Name of Advisor/Mentor _____

Advisor Phone _____ Advisor e-mail _____

Current Employer_____ Position _____

Employment Schedule _____

Sports/Activity
Schedule_____

AVAILABILITY

Times Available: Morning Afternoon Evening

Days Available: Mon Tue Wed Thu Fri Sat Sun

Physical restrictions, if any _____

REFERENCE CHECKING INFORMATION

For reference purposes, have you ever been known by any other name?

Yes _____ No _____

If yes,
What was that name? _____

When were you known by that name? _____

Have you ever been convicted of a crime? _____

If yes, describe in full: _____

_____

PLEASE READ AND SIGN

- I understand that any falsification of information on this application may result in immediate termination of the application process or volunteer position with Rochester Regional Health.
- I authorize Rochester Regional Health to contact my references.
- I understand that my acceptance as a volunteer is contingent upon my passing NYS health requirements.
- I understand that volunteers are expected to observe confidentiality with respect to all patient information at all times, and that failure to do so may result in my personal liability to the patient and/or the hospital.
- I understand that I must complete orientation and mandatory education.
- I understand that volunteering at any affiliate of Rochester Regional Health is voluntary and not an offer of employment, will not be compensated, and may be terminated by Rochester Regional Health at their sole discretion at any time, without prior notice.
- Upon completion of internship, I will ensure that my timesheet is up-to-date .

Signature of Applicant _____ Date _____

_____ Date _____

Parent/Guardian Signature (if applicant is under 18 years of age)

THANK YOU FOR YOUR INTEREST IN THE RRH EASTERN REGION ☺

ROCHESTER REGIONAL HEALTH

CONSENT FOR MINOR VOLUNTEER

Employee Health Services

Clifton Springs Hospital and Clinic
Employee Health Services
2 Coulter Road
Clifton Springs, NY 14432
Phone: 315/462-1560
Fax: 315/462-6636

Newark-Wayne Community Hospital
Employee Health Services
1200 Driving Park Avenue
Newark, NY 146513
Phone: 315/332-2423
Fax: 315/332-2334-4790

Rochester General Hospital
Employee Health Services
1425 Portland Avenue
Rochester, NY 14621
Phone: 585/922-4026
Fax: 585/922-4790
Email: EHS@rochesterregional.org

Unity Hospital
Employee Health Services
1561 Long Pond Road, Suite 150
Rochester, NY 14626
Phone: 585/723-7880
Fax: 585/723-7447
Email: UEHS@rochesterregional.org

United Memorial Medical Center
Employee Health Services
16 Banks St,
Batavia, NY 14020
Phone: 585/344-5212
Fax: 585/815-6717
UMMC@rochesterregional.org

Dear Volunteer Candidate:

On behalf of Rochester Regional Health, thank you for your commitment to volunteer your time with us! Per RRH Onboarding Policy, all candidates must have:

- Completed Health Questionnaire.
- Fit for Duty physical exam, completed within the past 12 months.
- Immunity status for Measles, Mumps, and Rubella (MMR).
- Immunity status for Varicella (chickenpox) or documented history of the disease.
- Immunity status for Hepatitis B.
- Two-step PPD skin test or T-Spot blood test for Tuberculosis screening.

All of these services should be provided through your primary care office. If you do not have a primary health care provider, these requirements can be provided through RRH Employee Health Services Department, at no expense to you.

Proof of flu shot is required in flu season (or sign-off with masking).

Please make an appointment with Employee Health Services to bring all the above-mentioned documents when they are completed. Also, if you are under the age of 18, you must bring Consent for Minor Form signed by your parent or guardian.

All appointments in Employee Health Services require photo ID. Acceptable forms of ID are:

- Driver's License
- Passport
- School Picture ID

Thank you,

Employee Health Services
315-332-2423

REVISED: 01/29/2020

ROCHESTER
REGIONAL HEALTH

Employee Health Services

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Clifton Springs, NY 14432
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Newark-Wayne Community Hospital
Employee Health Services
1200 Driving Park Avenue
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Rochester General Hospital
Employee Health Services
1425 Portland Avenue
Rochester, NY 14621
Phone: 585/922-4026
Fax: 585/922-4790
Email: EHS@rochesterregional.org

Unity Hospital
Employee Health Services
1561 Long Pond Road, Suite 150
Rochester, NY 14626
Phone: 585/723-7880
Fax: 585/723-7447
Email: UEHS@rochesterregional.org

United Memorial Medical Center
Employee Health Services
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Phone: 585/344-5212
Fax: 585/815-6717
UMMC@rochesterregional.org

CONSENT FOR MINOR

Name of Minor: _____**Birth Date**: _____

Parental/Guardian Consent

I give consent to Rochester Regional Heath to provide blood testing for immunity status, seasonal influenza vaccine, and annual tuberculosis screening.

Signed _____ **Date**_____
(Parent or Guardian)

Relationship to Minor _____ **Phone #** _____

Revised 10/26/18
SG

ROCHESTER REGIONAL HEALTH
EMPLOYEE HEALTH SERVICES

Health Questionnaire Form

BIOGRAPHIC INFORMATION

Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Male: _____ Female: _____ Other: _____

Have you ever worked for RRH in the past? Yes_____ No_____

What will your position be at RRH? _____

Are you familiar with the physical and mental requirements of this position? Yes _____ No _____

HEALTH HISTORY

Do you have any health impairments that might interfere with the performance of your duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter your behavior? If Yes, please comment:_____ _____	☐	Yes	☐	No

List any medication allergies: _____

Are you allergic to Latex? Yes __ No __ If YES, may we share this allergy with your manager Yes __ No __

List all prescription/over the counter medications:_____

Females: Are you currently pregnant? Yes___ No_____

TUBERCULOSIS (TB) HISTORY:

- Have you ever been tested for TB: Yes _____ No _____
- Have you ever had a positive test? Yes _____ No _____
- Was a chest X-ray ever done because of a positive TB test? Yes _____ No _____
  Results: _____
- Have you ever had an allergic reaction to TB skin test (PPD)? Yes _____ No _____
- Do you have any of the following symptoms:
  ___cough, persistent, productive ___fever night sweats ___rapid weight loss _____none

- Have you ever been advised by a Health Care Provider not to perform certain types of work or tasks? Yes ____ No ____
  If yes, please explain: _____
- Do you have any restrictions that may impair your ability to perform the tasks of your new position? Yes ____ No ____
  If yes, please explain: _____
  _____

Name: _____ *Date of Birth:* _____/_____/_____

Have you EVER had any of the following:

	YES	NO		YES	NO
Acute/chronic skin problems, dermatitis, psoriasis			Heart disease, chest pain, angina, MI		
Amputation			Hernia		
Arthritis			Hospitalization, excluding childbirth		
Back pain, herniated disc			Kidney or bladder trouble		
Blood Pressure conditions			Migraine headaches		
Surgical operations			Multiple Sclerosis		
Broken bones or dislocated joints			Psychiatric treatment or counseling		
Cancer or tumors			Respiratory problems, asthmas, bronchitis, emphysema		
Carpel Tunnel Syndrome			Rheumatic fever		
Chemical dependency, drug, or alcohol			Seizures, epilepsy, convulsions		
Chronic cough			Stomach problems		
Circulatory problems of the extremities			Stroke		
Diabetes			Tendonitis		
Diseases of the liver, hepatitis, cirrhosis			Thyroid disease		
Dizziness, loss of balance, fainting			TIAs, temporary paralysis/weakness		
Environmental allergies			Tuberculosis		
Hearing problems or wear a hearing aid			Varicose veins		
Head injuries					

EXPLAIN ALL 'YES' RESPONSES

The statements made on these pages are true.

Signature: _____ Date: _____
(Applicant)

ROCHESTER REGIONAL HEALTH

Employee Health Services

Fit for Duty Physical Exam Form for Volunteer

Name:

_____ _____

Last Name *First Name* *Date of Birth*

To Be Completed by Physician/NP/PA:

History of TB Screening:

Month and year of the most recent PPD test if known: _____Results:_____

Month and year of the most recent IGRA test if known: _____Results:_____

If past positive TB test, a follow-up Chest X-Ray must be obtained.
Please attach a copy of the Chest X-Ray report to this form.

Immunization Record or Immune Titers

Vaccine	Date(s) Administered			
MANDATORY FOR ALL VOLUNTEERS: **Rubella** Titer or date of vaccination (attach immune titer)				
MANDATORY FOR ALL VOLUNTEERS: **Rubeola or Measles** Titer or dates of two vaccinations (attach immune titer)				
MANDATORY FOR ALL VOLUNTEERS: **Mumps** Titer or dates of two vaccinations (attach immune titer)				
MANDATORY FOR ALL VOLUNTEERS: **Varivax/Varicella** Titer or date of vaccination (attach immune titer**)**				
VACCINE OR DECLINATION **Hepatitis B Vaccination** (3 doses) or attach immune titer or declination				
Tdap Vaccination				
PneumovaxVaccination				

Name:

_____ _____

Last Name *First Name* *Date of Birth*

Physical Demands (check ALL limits that apply, please explain all checked items):

- ☐ Lifting 0-25 lbs_____
- ☐ Lifting 24-50 lbs_____
- ☐ Lifting over 50 lbs_____
- ☐ Standing_____
- ☐ Sitting_____
- ☐ Walking_____
- ☐ Pulling_____
- ☐ Pushing_____
- ☐ Stooping_____

Duration of Limitation:_____

The above-named individual is in good physical and mental health and is free from any health impairment which is of potential risk to patients or others, or which might interfere with the performance of his/her duties in the healthcare setting and the provision of safe patient care. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior or cognitive ability. ☐ **Yes** ☐ **No**

- ☐ Able to perform duties of Volunteer
- ☐ Able to perform duties of Volunteer with accommodation of the following restrictions (please specify the restrictions): _____

  _____

Duration of Restrictions:_____

- ☐ Not able to perform duties of Volunteer
- ☐ Decision pending further evaluation

Examining Physician's/NP/PA Signature: _____Date: _____

Examining Physician's/NP/PA Printed Name: _____

Examining Physician's/NP/PA Telephone Number: _____

- ✓ All medical documentation is returned to Employee Health for your medical clearance.
- ✓ Please call 315-332-2423 to make an appointment.
- ✓ They are located on the Basement level of NWCH, at the east end of the building.

RETURN TO: Employee Health Services
Newark-Wayne Community Hospital
1200 Driving Park Ave.
Newark, NY 14513

RBA STAFFING & SCREENING

A Greater Rochester Chamber Division

BACKGROUND SCREENING AUTHORIZATION

All information provided by me as part of my application to volunteer is accurate and true to the best of my knowledge. I understand and agree that any misrepresentation or omission of information by me may result in my rejection from volunteering or, if hired, in my discharge.

I understand and agree that as part of its evaluation of my suitability for volunteering, **Newark-Wayne Community Hospital** should receive consumer reports and/or investigative consumer reports, which will contain information and opinions pertaining to my behavior and character.

I acknowledge that I have received and read the *Fair Credit Reporting Act Background Check Disclosure*, *A Summary of Your Rights Under the Fair Credit Reporting Act*, as well as Article 23-A of the New York Corrections Law, and this authorization. I certify that I understand the documents I have received. I further understand that I have the right to request information from **Newark-Wayne Community Hospital.** about the nature and scope of any investigative consumer report on me that is requested by **Newark-Wayne Community Hospital.,** provided the request is made in writing and within a reasonable period after I have received this disclosure.

I, therefore, knowingly, and voluntarily, authorize law enforcement agencies, federal, state, and local agencies and courts, information bureaus, licensing agencies, governmental agencies, and other individuals and entities to provide any and all information that is requested by RBA.

I authorize RBA to access criminal background inquiries, public records, and public record databases, and driving records. I also authorize and consent to the disclosure by RBA to **Newark-Wayne Community Hospital** of any information and opinions it obtains about me. I understand that if I would like additional information about the investigation that may be done by RBA, I should contact RBA in writing at, 150 State St. Suite 400, Rochester, New York 14614.

This authorization, in original or copy, shall be valid for this and any future reports and updates that may be requested. These consumer reports and/or investigative consumer reports may be obtained at any time after the receipt of my authorization and, if I am hired by **Newark-Wayne Community Hospital,** and throughout my volunteer. I intend that a copy of this Authorization be as valid as the original.

I certify that the information provided on this form is true and correct. I understand that any information that I provide in a volunteer application or that I otherwise disclose during my volunteering may be used to obtain consumer reports and/or investigative consumer reports. I also understand that the information I provide regarding my date of birth will be used for the sole purpose of accurately gathering the above mentioned information, and will not be used to discriminate against me in violation of any state or federal law. RBA and **Newark-Wayne Community Hospital** will retain this form as required by law, in a secure location to ensure confidentiality.

RBA STAFFING & SCREENING
A Greater Rochester Chamber Division

Applicant Name PRINTED (First Name, MI, Last Name)	**Social Security Number**	
Other Last Names/Alias/AKAs used in last 7 years	**Applicant's Date of Birth**	**Date**
Driver License Number and State of Issue (if requested)		

Please list all **addresses** that you have lived in within the last seven (7) years including the current one.

Address	State	Years of Residency	Zip Code
		From: To:	
		From: To:	
		From: To:	
		From: To:	

_____
Applicant Signature

_____
Parent/Guardian Signature

RBA STAFFING & SCREENING
A Greater Rochester Chamber Division

BACKGROUND SCREENING DISCLOSURE

In connection with your volunteer application and for other volunteer purposes, **Newark-Wayne Community Hospital** may seek background information about you from RBA Staffing & Screening (RBA), a consumer reporting agency. This information may be in the form of a consumer report and/or an investigative consumer report.

These reports may be obtained at any time after **Newark-Wayne Community Hospital** receives authorization from you, including any time during the period of your volunteer if **Newark-Wayne Community Hospital** hires you.

Consumer reports include any written, oral or other communication of information by a consumer reporting agency bearing on your character, general reputation and other characteristics that is expected to be used for volunteer purposes. Consumer reports may include criminal records and driving records, among other resources.

You have the right to request information from **Newark-Wayne Community Hospital** about the nature and scope of any investigative consumer report on you that is requested by **Newark-Wayne Community Hospital.** The request must be made in writing and within a reasonable period after you have received this disclosure.

RBA will obtain the reports for **Newark-Wayne Community Hospital.**

A summary of your rights under the federal Fair Credit Reporting Act (FCRA), and a copy of Article 23-A of the New York Corrections Law, are being provided to you with this disclosure.

BACKGROUND & REFERENCE CHECKING
VOLUNTEER RELEASE OF CLAIMS

I understand that the information and opinions concerning me disclosed to RBA Staffing & Screening (RBA), and from RBA to **Newark-Wayne Community Hospital** may include both favorable and unfavorable material. I knowingly and voluntarily release to RBA, and their respective agents and employees, and all other individuals and entities providing information, from all claims and liabilities, including but not limited to claims for defamation, retaliation, discrimination, damages, costs and attorney's fees, which have arisen or may arise in the future related to the information and opinions provided to RBA and from RBA to **Newark-Wayne Community Hospital.**

I understand that my execution of this Release is a condition of my being considered for volunteering by **Newark-Wayne Community Hospital.** My execution of this Release is for the benefit of **Newark-Wayne Community Hospital,** and RBA, to assure that they are free to disclose information and opinions about me.

I intend that a copy of this Release be as valid as the original.

_____
Applicant Name PRINTED

_____
Applicant Signature

_____
Social Security Number

_____
Date

_____
Parent/Guardian Signature