St. Catherine of Siena Medical Center-Volunteer Services

Dear Applicant:

Thank you for your interest in the St. Catherine of Siena Medical Center Volunteer Program. We respond to those applicants we feel we can appropriately match to a program and invite them to make an appointment for an interview. After the interview, if accepted, you will need to attend all orientations and complete the requirements for medical clearance. The process usually takes 3-5 weeks to get started. Volunteering is year round -- St. Catherine asks that you commit to a minimum of 150 hours. Generally the hours of volunteering are: 8am-Noon/9am-1pm Noon-4pm/1pm-5pm 4pm-8pm and after 5pm. Please review the following:

- Complete the application –please provide an email
- Sign the authorization to conduct a background check-social security and birth date are required before a badge is issued.
- If you have had a PPD in the last year please attach documentation of this as this will save you from having two PPD's which is a NYS health requirement (PPD tests for Tuberculosis)
- Teens need to provide documentation of immunization history.

When your completed application is reviewed by Volunteer Services, you will be scheduled for an interview appointment and given directions to the Human Resources building. If you have any questions please call the Volunteer Office at 631-862-3959 or email me at heather.reynolds@chsli.org –Thank you for your interest!

VOLUNTEER DRESS CODE

As a member of the St. Catherine of Siena Volunteer Department you are expected to come to work in clean and neat attire. In order to have a truly professional look and be recognized by our patient's, residents, visitors, and staff all volunteers must dress as described:

- All young adults are to wear the purple T-shirt with logo and any of the following pants are acceptable (dark denim, khaki, black, white). No shorts, ripped jeans, tight pants. Your appearance should be reflective of a business environment.
- Adults may wear business casual dress with the stone/purple T-shirt or SCS jacket with logo. Low comfortable rubber soled shoes or sneakers-do not wear sandals you will be sent home (this is a safety regulation)
- The volunteer name tag is part of the uniform and must be worn above the waist and visible at all times.
- Avoid wearing large, sharp or long jewelry or strong perfume or cologne.
- Try to bring only what you can carry in your pockets-St. Catherine can't be held liable for loss of personal items. Lockers are available and require a lock.
- Uniform purchases can be made in cash or check-made out to cash

Prices are: Teen shirts $20.00 (Note: XXL (2X) $22.00)

We look forward to working with you!

ST. CATHERINE OF SIENA HOSPITAL AND NURSING
AND REHABILITATION CARE CENTER
JUNIOR VOLUNTEER APPLICATION

PERSONAL INFORMATION:

_____
Last Name First Name Middle Initial Name to appear on badge

_____
Address (Apt/lot #) (City) (Zip Code)

Phone: _____E-Mail _____Birthday :___/____/_____(month, day, year)

SCHOOL ATTENDING: _____Graduation Year: _____

VOLUNTEER EXPERIENCE: _____

HOBBIES/SPORTS/FOREIGN LANGUAGES: _____

IN AN EMERGENCY PLEASE NOTIFY:
Parent/Guardian: _____
Address: _____
Home Phone: _____Cell Phone: _____
Physician: _____Phone: _____

ARE YOU INERESTED IN A MEDICAL CAREER? _____

VOLUNTEER AVAILABILITY: (days/times) _____

_____

What is appealing to you about volunteering in a healthcare setting? _____

_____

SERVICE AREA OPPORTUNITIES: (Please check any that would interest you)
_____Working with patients/residents ____Prefer no patient/resident contact _____In the Community _____Behind the scenes (administrative/clerical) _____Reception/Waiting Room _____Retail _____Virtual (newsletter, brochure, flyers) _____ Special Interest _____

As a teen volunteer I understand that I am required to:

- be a student between the ages of 14 and 18
- have a written consent form a parent or guardian
- have a referral from a school counselor, teacher or adult non-family member
- work one regularly scheduled shift per week during the school year and two shifts per week during the summer over 6-8 weeks
- contact the Volunteer Director regarding any absences form duty

Signature_____Date:_____

Catherine of Siena Medical Center-Junior Volunteer

CONSENT OF PARENT/GUARDIAN
Parents/Guardians please complete the following: Please make sure we also have the person who will be emergency contact listed

Parent/Guardian_____

Address_____

Phone Number_____Business/Cell_____

Relationship to volunteer_____

I give my permission for_____to become a teen volunteer at St. Catherine of Siena Medical Center.

I give my permission for any necessary treatment to be given in the event of illness or injury.

Emergency Contact _____

I give my permission for the required PPD tests and necessary laboratory work which requires blood draw for titer's of childhood illnesses (rubeola, rubella, chicken pox, mumps)

In the event of illness, injury or emergency, contact:

Name_____Telephone_____

Name_____Telephone_____

Signature of Parent/Guardian _____Date_____

To assure that volunteers are free from communicable disease, all volunteers will be required to have two TB skin tests before beginning of their assignment. These can be done here at the hospital. Applicants can provide results of a negative TB skin test administered within the past 12 months by their own physician to cover one of those tests.

All Teens: Remember to include a copy of your immunization record, a letter of recommendation, a current transcript, and your parent's signatures on the application and sign the teen volunteer pledge form. We will not accept incomplete applications.

St. Catherine of Siena Medical Center –Junior Volunteer

Junior Volunteer Agreement

I, _____agree to the following:

- agree to complete the volunteer orientation and training until I am competent to perform the required duties
- agree to compete Health/TB screening as well and any service-specific training that may be deemed necessary
- I understand I will not be paid for my volunteer services to SCMC
- While a volunteer at SCMC, I will conduct myself in accordance with ALL Rules, guidelines, instructions, policies and procedures

CONFIDENTIALITY: It is the belief of this medical center that all medical, financial, and personal information pertaining to a patient is confidential and is protected from unauthorized viewing, discussion, and disclosure. Therefore volunteers may look at, use, or disclose patient information ONLY as it relates to performance of their duties. Any unauthorized viewing, discussion, or disclosure will provide ground for immediate dismissal. Whenever it is questionable as to what information is confidential, it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs. I acknowledge and have read the statement above and agree to abide by the expectations of the Hospital, Nursing and Rehabilitation Care Center and Department of Volunteer Services

Dismissal: I understand that my volunteer service is a privilege and not a right. If I fail to maintain confidentiality or if I fail to conduct myself in accordance with the policies of the Hospital or Nursing Home, I may be dismissed from volunteer service. I may also be dismissed from volunteer service at the sole discretion of St. Catherine of Siena Medical Center.

Once volunteers reach the 50 hour milestone they will become eligible for documentation of Hours completed!

I have read this document, I understand its contents, and I agree to its terms.

_____ _____

Signature of Signature Date

Consent and General Authorization to Obtain Consumer Report

I hereby authorize St. Catherine of Siena Medical Center, now or at any time while I am employed by St. Catherine of Siena Medical Center, to obtain a consumer report, or an investigative consumer report, on me. This authorization does not authorize the release of medical information.

First Name (Print) _____

Last Name (Print) _____

Middle Name (Print) _____

Social Security #: _____

Other Names Used:

Name	From/To

BIRTH DATE_____

Please list all residences lived at in the past 7 years:

Address:	Years at address:
Street Address City State Zip	
Street Address City State Zip	
Street Address City State Zip	

Previous states/counties of residence:

_____

_____

* This information will be used for purposes of identification only. Federal law prohibits discrimination in employment on the basis of race, color, sex, national origin, religion, age, equal pay or disability. Additionally, New York State law prohibits discrimination in employment on the basis of creed, sexual orientation, military status or marital status.

_____ _____

Applicant's Signature Today's Date

_____

Applicant's Name Printed

Rev. 2.11.14

By signing below, together with my parent(s) or guardian approval, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Background Check Disclosure and Authorization Form shall remain valid and in effect during the term of my contract.

For New York Applicants Only

You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

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If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____

Initials Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____

Initials Initials

***California Applicants**: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report). **Certiphi Screening's privacy practices with respect to the preparation and processing of investigative consumer reports may be found at www.certiphi.com (link at bottom of page entitled, "Legal/Privacy").**

_____ _____

Minor Applicant Signature Date

_____

Minor Applicant Name

PARENT OR LEGAL GUARDIAN ACKNOWLEGMENT AND AUTHORIZATION

The undersigned parent(s) and/or guardian(s) of the applicant/employee hereby agree with the applicable statements in this BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM. By signing below, I/we fully provide consent on behalf of my/our minor child to authorize a background check for purposes of this Disclosure and Authorization.

_____ _____

Parent Name or Guardian Signature Date

_____

Printed Parent or Guardian Name