

**K A L E I D A
H E A L T H**

Volunteer Services

Student Volunteer Program – Academic Year

**For more information about volunteerism during the academic year
and how you can join our Kaleida Health team,
please contact the Director of Volunteer Services at the hospital of your choice.**

Fr. Richard Augustyn

Buffalo General Hospital
100 High Street, Buffalo, NY

raugustyn@kaleidahealth.org

859-2603

Pat Bagley

Deaconess Center
1001 Humboldt Pkwy., Buffalo, NY 14208

pbagley@kaleidahealth.org

887-8010

MaryBeth Kupiec

DeGraff Memorial Hospital
445 Tremont Street, N. Tonawanda, NY 14120

mkupiec@kaleidahealth.org

690-2088

Christine Stry

Millard Fillmore Gates Circle Hospital
3 Gates Circle, Buffalo, NY 14209

cstry@kaleidahealth.org

887-4900

Kathy D. Gorski

Millard Fillmore Suburban Hospital
1540 Maple Rd., Williamsville, NY 14221

kgorski@kaleidahealth.org

568-3820

Martha Hickey

Women & Children's Hospital
219 Bryant Street, Buffalo, NY 14222

mhickey@kaleidahealth.org

878-7241

***** REMINDER-Please forward all completed paperwork, phone calls or e-mails to the
Director of Volunteer Services at the hospital of your choice. *****



K A L E I D A H E A L T H

Dear Prospective Volunteer:

You have expressed an interest in becoming a student volunteer for **KALEIDA HEALTH**. It gives us pleasure to consider you for our program. As you perhaps know, many more apply than can be accepted. Therefore, those who are chosen can be very proud.

Enclosed are the following: Application Form, Recommendation Form, Consent Form, and Health Screening Form for you to complete.

The following checklist is prepared for your convenience:

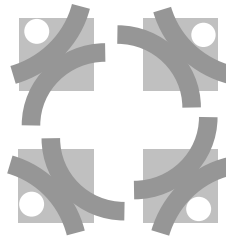
- Take the Recommendation Form with a stamped, addressed envelope immediately to the person recommending you. Check shortly thereafter to be sure it has been sent to the appropriate address on the form.
- Pick up an application for a working certificate in your school office or guidance dept.
- The Application, Consent Form, Work Schedule and Work Certificate should be sent to:
The Kaleida Health site at which you want to volunteer.
- The health screening form must be sent to your personal physician. Documentation of MMR vaccines and the two-step PPD needs to be current (i.e., performed in the last calendar year). ***These forms must be complete*** and received in the volunteer office of the site that you want to volunteer A.S.A.P. ***It is your responsibility to complete this portion of the application.***
- Once you have been accepted...attend the ***mandatory orientation class***. Arrangements are made through the Volunteer Office at the Kaleida Health site that you want to volunteer.

Requirements for this program are:

- Genuine desire to perform community service.
- Minimum age of 15 years.
- Attend the mandatory orientation.
- Proof of working certificate (*under 18 years of age*).
- Parental consent (*under 18 years of age*).
- Written recommendation.
- Completion of NYS Health Department requirements at time of application:
 - Health form (**completed by your primary physician**);
 - Documentation of MMR vaccines, and
 - Two (2) Tuberculosis tests (PPD).
- Background check (*18 years and older*).
- Interview with Manager of Volunteer Services.
- You must make a minimum commitment of 4 hours per week.

All forms must be completed and returned to the Volunteer Office,
as soon as possible, prior to interview.

- Check one: Buffalo General Hospital
 Deaconess
 DeGraff Memorial Hospital
 Gates Circle, Millard Fillmore
 Suburban, Millard Fillmore
 Women & Children's Hospital of Buffalo



**K A L E I D A
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Student Application for Volunteer Services

* Please print clearly. *

Name	Date of Birth	Age	P E R S O N A L T I M E R E Q U I R E M E N T S
Last First Middle			
Address	Home Telephone		
City / /	Cell Phone		
	Soc. Security #		
E-Mail			
Father's Name/Occupation	Telephone		
Mother's Name/Occupation	Telephone		
In case of Emergency, notify	Telephone		
School	Grade		
Extra-Curricular Activities			
Work/Volunteer Experience			
Career Interests			
Hobbies/Skills/Special Interests			
Personal Reference			
	Name	Address	Telephone
School's Reference			
	Name	Address	Telephone

Have you ever been convicted of a crime? _____ If yes, explain when, where, and disposition of case. _____

Is volunteer work a requirement for school credit? _____ If so, number of hours required. _____

Time Available:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Requirements:

- A genuine desire to do community service.
- Minimum age-**15 years**.
- Attend the mandatory in-service program (date to be determined).
- Working certificate (*under 18 years*).
- Parental consent (*under 18 years*).
- Background check (*18 years and older*).
- Written recommendation.
- Completion of NYS Health Department requirements at time of application:
 - Health Form (completed by your primary physician)
 - Documentation of MMR vaccines, and Two(2) tuberculosis tests (PPD)
- Interview with manager of volunteer services.
- Commitment of 4 hours per week minimum.

Date _____ Signature _____

Over →

Student Volunteer Application *(continued)*

Physical and Medical Background

Do you have any physical condition or medical problem which may limit your ability to perform the work of a volunteer?

Yes

No

If "YES" please explain.

.....
.....

In case of an emergency, please notify:

Name

.....

Relationship

.....

Phone

.....

Consent for Program Participation

*I authorize KALEIDA HEALTH to give emergency medical treatment to my son/daughter.
I also give consent for my child's participation in the KALEIDA HEALTH's Student Volunteer Program.*

Signature of Parent
or Guardian

.....

Date

.....

*I agree that the above information is correct as of the date it has been filed.
I also agree to the rules and regulations of the Volunteer Department
of the KALEIDA HEALTH system as they are outlined in the Volunteer Orientation Manual.*

Signature of Applicant

.....

Date

.....

***** For Office Use Only *****

Date Received

.....

Volunteer Number

.....

Training

.....

Interview Date and Time

.....

Department

.....

Day/Time

.....

TB Test Taken

.....

Picture Taken

.....



**K A L E I D A
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RECOMMENDATION FORM

***NO PROSPECTIVE HIGH SCHOOL VOLUNTEER MAY BE CONSIDERED
WITHOUT THIS FORM.***

(Student: Please provide a stamped, addressed envelope to the person recommending you.)

Please complete and send this form directly to:

Director of Volunteer Services at the Kaleida Health site that you want to volunteer.

Thank you for your invaluable help in selecting suitable candidates for this community hospital program. We would appreciate it if you would mail this form directly to the hospital, in the envelope provided by the applicant, as soon as possible. Please also be sure to sign this form should the need arise and we wish to contact you.

1. Name of applicant. _____
2. How long have you known this applicant? _____
3. Does the applicant have the willingness to learn and then complete a job thoroughly? Yes No
4. Is he/she apt to drop out of the program before completion? Yes No
5. Is the applicant responsible and dependable? Yes No
6. Does he/she need constant supervision? Yes No
7. Does he/she have a good attitude toward the community which will be reflected within the hospital? Yes No
8. Do you think this applicant will be an asset to the Student Volunteer Program, offering his/her service to help others while learning about hospital careers? Yes No

Comments:

.....
.....

.....
Signature

.....
Telephone No.

Return completed form to Kathy D. Gorski, CAVS,
 Dir. Volunteer Services, Millard Fillmore Suburban
 Hospital, 1540 Maple Rd., Wmsvl. NY 14221



Employee Health Department Volunteer Physical Examination Form

New York State Department of Health **requires** the following to medically clear you to volunteer at a hospital: **Physical, 2 step PPD**, proof of immunization/immunity to **Rubella, Rubeola, and Varicella**.

Name: _____ SS#: _____ Sex: M F DOB: _____

Address: _____ Phone #: _____

INFECTIOUS DISEASE HISTORY				IMMUNIZATION HISTORY (VACCINES)	
History of any of the following :	Yes	No	If yes, approx year	Indicate the approx. dates of the following:	Date (s)
Measles				Diphtheria/Tetanus	
German Measles				Hepatitis B Vaccine: yes / no	#1: #2: #3
Chicken Pox				Rubeola Vaccine (or positive titer)	(2 Doses required) # 1: #2
Mumps				Rubella Vaccine (or positive titer)	(1 Dose required) #1:
Tuberculosis				Varicella Vaccine (or positive titer)	#1: #2:
Hepatitis				PPD/TB Skin Test 2 PPD's administered in past 12mos.	PPD #1: results in mm:
Yellow Jaundice					PPD #2: results in mm:
Polio				<ul style="list-style-type: none"> If known history of positive PPD, provide date of conversion and last chest x-ray: <input type="checkbox"/> Asymptotic-denies all symptoms <input type="checkbox"/> Symptomatic-fatigue, Anorexia, Weight loss, Low grade fever, Productive cough (circle any that pertain)	
Herpes Simplex (oral or hand)					

List any medications (over the counter or prescribed by a physician): _____

	Now	Past	Never	Comments filled in by Provider
ALLERGIES (Latex, Medications, etc)				
CHRONIC COUGH (more than 3 weeks)				
ASTHMA				
HEART TROUBLE (chest pain, heart attack, etc)				
HERNIA				
NECK/BACK INJURY OR PAIN				
ARTHRITIS				
WEAKENED IMMUNE SYSTEM (such as leukemia, HIV+, chronic steroid use, chemotherapy)				
FAINTING SPELLS				
SEIZURES				
SKIN PROBLEMS				
DIABETES				
SHORTNESS OF BREATH				
CHEST PAIN				
HEARING PROBLEMS				
VISION PROBLEMS				
ILLEGAL DRUG USE				
MAJOR ILLNESSES/HOSPITALIZATIONS				
MENTAL HEALTH CONDITIONS				
DO YOU DRINK ALCOHOL				
DO YOU SMOKE				

*** To be completed by physician ***

	Normal	Abnormal	Provider: please comment on abnormalities	Vision	OD	OS
SKIN				Uncorrected	20/	20/
EYES				Corrected	20/	20/
EARS				Blood Pressure :		
NOSE				Pulse :		
MOUTH/THROAT				Height:		
NECK, THYROID				Weight:		
LYMPH NODES				General Appearance:		
CHEST				<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
HEART						
ABDOMEN						
BACK						
NEURO						
EXTREMITIES						
HERNIA	<input type="checkbox"/> None	<input type="checkbox"/> Present				

PLEASE OUTLINE ANY LIMITATIONS: _____ **MEDICALLY RELEASED TO BEGIN VOLUNTEERING ON: / /**

NP/PA/PHYSICIAN SIGNATURE: _____ DATE: _____