Dear Prospective Volunteer,

Thank you for your interest in volunteering for Kaleida Health. In joining our team, you will perform a vital service by helping our staff provide the best care to our patients.

All of Kaleida Health's volunteer activities are coordinated through our Volunteer Services offices located at:

Buffalo General Medical Center
100 High Street, Buffalo, NY 14203
Fr. Richard Augustyn: 859-2603
859-1625 (fax), raugustyn@kaleidahealth.org

John R. Oishei Children's Hospital
818 Ellicott Street, Buffalo, NY 14203
Kristen Williams: 323-2420
323-1351 (fax), Krwilliams1@kaleidahealth.org

DeGraff Medical Park &
Millard Fillmore Suburban Hospital
1540 Maple Road, Williamsville, NY 14221
Heidi Hall: 568-3820
568-3832 (fax), HXHall@KaleidaHealth.org

HighPointe on Michigan &
DeGraff Skilled Nursing Facility
1031 Michigan Ave
Buffalo, NY 14203
Jordan Bidwell: 748-3242
748-3294 (fax), JVBidwell@KaleidaHealth.org

If you would like to be considered for a volunteer position at Kaleida Health, please complete the attached forms (checklist provided below) and send to the volunteer office of the site in which you are interested.

- ☐ Application
- ☐ Volunteer Availability Form
- ☐ Recommendation Form (APPLICANTS UNDER 18 ONLY)
- ☐ High School students must also supply **Working Papers** (APPLICANTS UNDER 18 ONLY)
- ☐ Physical Exam Form (Health Screening must be completed by personal physician with documentation of MMR and two-step PPD – must have been performed within the last year; vaccine record)

After completing the required paperwork, you may be considered for assignment at one of our sites. We will make every effort to match your volunteer assignment with your skills, your interests, and your schedule. If considered, we will contact you for a personal interview, and once a final decision is made, you must complete a required physical from your personal physician (including documentation of MMR and two-step PPD). Once this requirement is completed, you will attend a mandatory orientation at your site. On-the-job training is also provided under the supervision of department staff or an experienced volunteer.

Thank you for your interest in volunteering for Kaleida Health. We hope to hear from you soon!

Sincerely,

The Volunteer Managers of Kaleida Health

Kaleida Health

Volunteer Application

(Please print clearly)

Check one: ☐ Adult ☐ College Student ☐ High School Student

Check one: ☐ Buffalo General Medical Center ☐ DeGraff Medical Park ☐ HighPointe on Michigan & DeGraff Skilled Nursing Facility
☐ Millard Fillmore Suburban Hospital ☐ John R. Oishei Children's Hospital

Name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name First Name Middle Initial

Address

Number & Street

City State Zip

Telephone, Home

E-mail Telephone, Cell

What is the best way to reach you? ☐ Home ☐ Work ☐ Cell ☐ E-mail

Name of Employer Telephone, Work

Business Address

Work Experience

Volunteer Experience

Education/Special Training/
Certifications

Hobbies/Interests/Skills

Have you ever been convicted of a crime? ☐ Yes ☐ No If "Yes," explain when, where, and disposition of case.

It is your responsibility to self-report any future infractions to your immediate supervisor as soon as they occur.

Why did you decide to volunteer at Kaleida Health?

How did you learn about our program?

Is volunteer work a requirement for school credit? ☐ Yes ☐ No If so, what number of hours are required?

School Name Grade

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.

Volunteer Application *(continued)*

Name

In case of an emergency, please notify:

Name _____

Relationship _____

Phone, Home _____ Work _____ Cell _____

- ***The Volunteer Service Department is not obligated to provide a placement, nor are you obligated to accept the placement offered. Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.***
- ***Your Volunteer Services Manager reserves the right to terminate your volunteer status if expectations are not met.***
- ***I agree that the above information is correct as of the date it has been filed. I also agree to the rules, regulations, and policies of the Volunteer Department of Kaleida Health.***
- ***I agree that typing my name constitutes my electronic signature and is the legal equivalent of my handwritten signature(s) within this application***

Signature of Applicant _____ Date _____

Parental Consent for Program Participation (required if applicant is under 18)

I give consent to my child's participation in the Kaleida Health Student Volunteer Program. I authorize Kaleida Health to give emergency medical treatment to my son/daughter. I agree that the above information is correct as of the date it has been filed.

Signature of Parent/Guardian	**Date**

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

Date Received		Volunteer Number	
Training		Interview Date and Time	
Department		Day/Time	
TB Test Taken			
Picture Taken			

Volunteer Availability Form

(Please print clearly)

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

STUDENTS: Please discuss this schedule with your parents and consider your transportation needs and work schedule BEFORE completing this form.

Please provide 3 instances of availability by placing check marks (✓) in the calendar below.

(Shift times may vary by site.)

Time	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
8:00 a.m. - 12:00 p.m.							
12:00 p.m. - 4:00 p.m.							
4:00 p.m. - 8:00 p.m.							

Please check your areas of interest:

- ☐ Book Cart (OCH only)
- ☐ Office Support
- ☐ Errands/Escort
- ☐ Greeter
- ☐ Information/Waiting Area
- ☐ Women's Board/Auxiliary
- ☐ Long-Term Care Support (HighPointe & DeGraff only)
- ☐ Patient Interaction
- ☐ Pharmacy Support
- ☐ Spiritual/Pastoral Care
- ☐ Other

RECOMMENDATION FORM

(Applicants Under 18 Only)

Student: Please provide a stamped envelope addressed to the Director of Volunteer Services at the hospital of your choice for the convenience of the person recommending you.

Thank you for your invaluable help in selecting suitable candidates for this community hospital program. Please mail this form directly to the hospital in the envelope provided by the applicant. Please be certain to sign this form and list your telephone number should 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 follow through and do a job thoroughly?	☐ Yes	☐ No	
4.	Is he/she apt to drop out of the program before its completion?	☐ Yes	☐ No	
5.	Is the applicant responsible and dependable?	☐ Yes	☐ No	
6.	Can he/she work independently?	☐ 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	

Additional comments:

_____

_____

Signature Telephone No.

_____

Relationship to Applicant Date

NEW VOLUNTEER SCREENING AND MEDICAL CLEARANCE CHECKLIST

Thank you for choosing to volunteer at one of our Kaleida Health facilities. As a new volunteer, you must comply with both New York State's Department of Health requirements and Kaleida Health's policies. The following pages are required and must be returned to an Employee Health office before you can be cleared to volunteer.

Please use the below checklist to guide you in completing all the necessary requirements. The Employee Health Volunteer Medical Clearance Form (page 5 part B) **must** be completed and signed by a medical provider. All remaining pages need to be completed by you. Please submit proof of immunizations/tests with this packet. Any immunization/test printouts must be signed and dated by a medical provider and/or stamped.

Employee Health will not accept incomplete/partial applications.

☐ Completed and signed Employee Health Volunteer Medical Clearance Form

REQUIRED IMMUNIZATIONS/TESTS

☐ Two **MMR Vaccines** (measles, mumps, rubella) or (1 Rubella, 2 measles & 2 mumps) given 4 weeks apart, with the first dose given on or after your first birthday **OR** positive titers

☐ **Tuberculosis Testing** (complete one option below)

A. Two-step **Tuberculosis Skin Test** (TST) (date placed & read, MM induration, signature of reader must be included in the documentation) proof within the last 12 months
   - The 1st & 2nd test must have a **minimum** of 1 week between each plant, with each read being 2-3 days after plant.

B. **Interferon Gamma Release Assay** (IGRA) tuberculosis blood assay; proof within the last 12 months (*Other names may be T-SPOT or quantiFERON- TB Gold)*

C. **History of Positive TB testing or disease** (one option below is required)
   - Positive result with chest x-ray
   - Proof of completed treatment

RECOMMENDED IMMUNIZATIONS

☐ Completed **Hepatitis B Vaccine** series, positive IgG titer or Hepatitis B waiver (waiver included in this packet if applicable)

☐ Two **Varicella Vaccines** given 4 weeks apart, with the first dose given on or after your first birthday, positive IgG titers or Varicella waiver (waiver included in this packet if applicable)

☐ **Tdap Vaccine** (tetanus, diphtheria, acellular pertussis) received within the last 10 years or Tdap waiver (waiver included in this packet if applicable)

☐ **Influenza Vaccine** given during the current flu season (July - April) or Influenza waiver (waiver included in this packet if applicable)

LAST NAME: _____ FIRST NAME: _____ D.O.B.: _____

WAIVERS

Please use the following waivers if a vaccine/proof of immunity is unavailable.

HEPATITIS B (Please check one)

☐ I understand that by volunteering I am at risk of exposure to blood and other potentially infectious materials and I may be at risk of acquiring Hepatitis B viral infection. I am aware that I do not have the proper documentation and/or proof of related to Hepatitis B immunity. I understand that by signing this waiver, I am at risk of acquiring Hepatitis B.

☐ **PREVIOUS INFECTION:** I have had the Hepatitis B infection.

**I have been made aware there is a risk of occupational exposure to Hepatitis B while working in an environment where blood and body fluids are present. I could be at risk of exposure to potentially infectious materials. I do not have proof of completed Hepatitis B vaccination (s) or positive titer for immunity. By signing below, I understand the possible risk of exposure and wish to continue to volunteer. I am aware that if is have any additional questions related to Hepatitis B vaccination and immunity to Hepatitis B; this can be explained to me.*

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature *(if under 18)*: _____ Date: _____

VARICELLA (Please check one)

☐ I understand that evidence of immunity against Varicella is recommended for all healthcare personnel/volunteers by the New York State Department of Health (NYSDOH) and Kaleida Health. I am aware that I do not have the appropriate documentation and/or proof as required by NYSDOH related to varicella immunity. I understand that by signing this waiver, I am at risk of acquiring the varicella disease.

☐ **PREVIOUS INFECTION:** I have had the Varicella/Chickenpox infection.

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature *(if under 18)*: _____ Date: _____

Tdap

☐ I understand that the Tdap vaccine is recommended for all healthcare personnel/volunteers. The vaccine can prevent tetanus, diphtheria and pertussis. Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds. I understand that the CDC recommends that adults should receive a booster dose of Tdap every 10 years, or after 5 years in the case of a severe or dirty wound or burn. I am aware that I do not have the appropriate documentation and/or proof at this time. I understand that by signing this waiver, I am at risk of acquiring tetanus, diphtheria or pertussis.

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature *(if under 18)*: _____ Date: _____

NYSIIS

☐ I give my consent to Kaleida Health to obtain/release my immunization(s) and any identifying information from/to the New York State Immunization Information System (NYSIIS).

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature *(if under 18)*: _____ Date: _____

LAST NAME: _____ FIRST NAME: _____ D.O.B.: _____

WAIVER

Please use the follow waiver if a vaccine/proof of immunity is unavailable.

INFLUENZA

I have been advised that I should receive the influenza vaccine to protect myself and others. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients and coworkers in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life threatening consequences to my health, and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- **Because I have refused vaccination against influenza, regardless of the reason, I will be required to wear a surgical mask in areas where patients or residents are typically present during the period of time that influenza is designated "prevalent" by the Commissioner of the NYSDOH.**

I have read the information regarding the Seasonal Influenza Vaccine.

☐ I am declining the vaccine at this time. I have been informed of the risks and benefits of the vaccine. I understand that by signing this waiver, I am at risk of acquiring influenza.

Volunteer Signature: _____ Date: _____

Parent/Guardian Signature *(if under 18)*: _____ Date: _____

Kaleida Health

EMPLOYEE HEALTH VOLUNTEER MEDICAL CLEARANCE FORM

Please complete the below up to part B. A medical provider **MUST** review part A, complete part B and sign off on the bottom of this form in order for you to volunteer.

Last Name:	First Name:	
Date Of Birth:	Phone:	Sex: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female

A) VOLUNTEER TO COMPLETE (Medical Provider to Review)

TUBERCULOSIS SCREENING	YES	NO
Are you aware of being exposed to anyone with active TB? (family, friends, co-workers, patients)		
Have you ever had any previous TB exposure, disease or diagnostic testing for active infection?		
Have you ever received treatment for active TB or a Latent TB infection? ***If yes, when/where/treatment received?***		
Have you held temporary or permanent residence of >1 month in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand, Northern Europe or Western Europe? ***If yes, where/when/how long?***		
Do you have any of the following signs and symptoms of active TB disease?	**YES**	**NO**
• Cough: more than 3 weeks?		
• Night Sweats?		
• Loss of appetite?		
• Unplanned weight loss of more than 10 pounds?		
• Blood streaked sputum?		
• Persistent low grade fever?		

B) MEDICAL PROVIDER TO COMPLETE

Disabilities: To the best of your knowledge, does this volunteer have any physical or emotional disabilities we should consider prior to volunteer placement: _____ YES _____ NO

If yes, please explain: _____

_____

_____

I have personally examined the above named volunteer and find them free from any physical/emotional health impairment which is a potential risk to patients or which might interfere with the performance of volunteering and/or service duties; including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances.

NP/PA/Physician Name: _____ Phone: _____
(Please Print)

NP/PA/Physician Signature: _____ Date: _____

Kaleida Health

MANTOUX TB SKIN TEST (PPD)

VOLUNTEER

Name: _____ D.O.B.: _____

Department: Volunteer _____

Date PPD Placed: _____ By (please print): _____

☐ Right Forearm ☐ Left Forearm Lot #/Exp. Date: _____ / _____

Comments: _____

PPD MUST BE READ 48-72 HOURS AFTER PLACEMENT

Date PPD Read: _____

Results: ☐ 0mm. Induration ☐ _____ mm. Induration

Comments: _____

Read By (please print): _____

Signature & Title: _____

Site	Phone #	Fax #
☐ **Larkin** **726 Exchange St., Floor 3**	**716-859-8500**	**716-859-8555**
☐ **BGMC** **100 High Street; Bldg. A; Basement**	**716-859-2180**	**716-859-1495**
☐ **MFS** **1540 Maple Road; Basement**	**716-568-3791**	**716-568-3005**

Please forward sheet to Employee Health.
Retain a copy for your records.