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)
- ☐ Background Check Disclosure & Consent Form (APPLICANTS 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)

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

- □ Adult
- □ College Student
- □ High School Student

Volunteer Application

(Please print clearly)

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

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. _____

Kaleida Health

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.***

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			

Kaleida Health

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 (WCHOB 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 _____

Kaleida Health

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

Kaleida Health

Disclosure Form:
KALEIDA HEALTH May Procure Consumer Reports

(Applicants 18+ Only)

I acknowledge that I have been provided with a document called "Disclosure Concerning Consumer Reports". The disclosure states that **KALEIDA HEALTH** may obtain consumer reports pertaining to me, for employment purposes now or in the future. It is contained in a separate document that consists solely of the disclosure. The disclosure (reduced in size) is reproduced below.

I acknowledge that I have read the "Disclosure Concerning Consumer Reports", that I understand it, and that I have been asked to keep it for my future reference.

I hereby authorize **KALEIDA HEALTH** to obtain consumer reports pertaining to me, as explained in the "Disclosure Concerning Consumer Reports".

Date: ..... Signature: .....

Printed Name: .....

DISCLOSURE CONCERNING CONSUMER REPORTS

This is to inform you **KALEIDA HEALTH** may obtain a "consumer report" pertaining to you as part of its consideration of your application for employment. **KALEIDA HEALTH** may also obtain additional "consumer reports" pertaining to you from time to time in the future, in the event that you are hired as an employee.

The "consumer report" refers to information about you, including information bearing on your character, general reputation, personal characteristics or mode of living, which may be used in whole or in part as a factor in making employment decisions. **KALEIDA HEALTH** may request this information from one or more agencies or persons who regularly assemble or evaluate information of this kind.

If **KALEIDA HEALTH** decides to take adverse employment action against you based in whole or in part on a "consumer report," we will first provide you with a copy of the report as well as a statement of your rights as prescribed by the Federal Trade Commission. Your rights would include the ability to contact the agency that provided the "consumer report" to us, and the right to advise them of any dispute that you may have regarding the accuracy of information contained in their files.

KALEIDA HEALTH will not obtain any "consumer report" pertaining to you unless you sign an authorization permitting this. However, you will not be considered for employment unless you sign an authorization.

Please make a copy of this *Disclosure* for your future reference.

Kaleida Health

Applicants 18+ Only

Volunteer Consent Form
CF-012914

Disclosure In relation to your application for employment, volunteer status or your current employment, your prospective employer or present employer may obtain a consumer report and or an investigative consumer report. Such reports may include information as to your character, general reputation, personal characteristics, and or mode of living. Also, subsequent reports may be requested to update, renew or extend employment. This disclosure is given to you in compliance with the Federal Fair Credit Reporting Act and applicable state law. You have the right to request additional disclosures as to the nature and scope of the investigation from your prospective or present employer. Such request must be made in writing.

The following information is for the sole purpose of conducting a volunteer position background investigation

Current Name First Name	Middle Name	Last Name
Maiden First Name	Middle Name	Maiden Last Name
Alias/Other First Name	Middle Name	Alias/Other Last Name

Date of Birth – Month/Day/Year *

* *The Age Discrimination Act in 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.*

Social Security Number

Driver's License Number

State of Issue

Current ZIP Code

Daytime Phone Number

Male

Female

List Current and all Counties and States you have lived in for the past 7 Years

County	State	ZIP Code	From Month	From Year	To Month	To Year

Have you ever been convicted of crime? Yes ☐ No ☐ Misdemeanor ☐ Felony ☐ Any pending criminal charges? Yes ☐ No ☐

If yes, give location of Court: City _____ County _____ State _____

Type of Offense _____ Date of Offense _____ Case Number _____

Explain _____

*** *(IF YOU HAVE MORE THAN ONE CONVICTION OR NEED ADDITIONAL SPACE, LIST ALL INFORMATION ON A SEPARATE SHEET OF PAPER)* ***

Authorization Release: I certify receipt of this notice and give permission to my prospective employer and or current employer and its agents to verify the information submitted by me and to conduct a background search on me. I understand this search may include social security number verification and address history, criminal history, driving history, education history, license/certification verification, past employment information, and/or reference checks. Such verification shall not constitute a violation of my right to privacy in any manner and I hereby release them from all liability whatsoever for actions related to this information. I understand that the sole purpose for obtaining this information is for employment/volunteer purposes.

Print Name of Applicant/Employee _____ Signature of Applicant _____ Date _____

***** For Employer Use Only *****

Company Name _____ Requested By _____ (PRINT NAME CLEARLY)

DMV Driving History ☐ Drug Screen ☐ Date _____

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you – such as if you pay your bills on time or have filed bankruptcy – to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (http://www.ftc.gov.). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you – such as denying an application of credit insurance, or employment – must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.

- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve month upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.

- **You can dispute inaccurate information with the CRA.** If you tell a CRA that you file contains inaccurate information, the CRA must investigate the items (usually with 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source must also advise national CRAs – to which it has provided the data - of any error).The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.

- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, The CRA cannot reinsert into your file a disputed item and must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number or the information source.

- **You can dispute inaccurate items with the source of the information.** If you tell anyone such as a creditor who reports to a CRA that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.

- **Outdated information may not be reported.** In most cases, a CRA may not report negative information which is more than seven years old; ten years for bankruptcies.

- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA – usually to consider an application with a creditor, insurer, employed, landlord, or other business.

- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or your prospective employer without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.

- **You may choose to exclude you name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.

- **You may seek damages from violators.** If a CRA, user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

FOR QUESTIONS OR CONCERNS REGARDING:	PLEASE CONTACT
CRA's creditors and others not listed below	Federal Trade Commission Consumer Response Center – FCRA Washington, DC 20580 202-326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name).	Office of the comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks).	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appears in federal institution's name).	Office of Thrift Supervision Consumer Programs Washington, DC 20552 800-842-6269
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 800-934-FDIC
Air, surface or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 202-3661306
Activities subject to the Packers and Stockyards Act. 1921	Department of Agriculture Office of Deputy Administrator – GIPSA Washington, DC 20250 202-720-7051

Kaleida Health

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, Mumps and Varicella**.

Last Name: _____First Name:_____ SS#: _____ Sex: □ M □ F DOB: _____

Address: _____Phone #: _____

INFECTIOUS DISEASE HISTORY

History of any of the following :	Yes	No
Measles		
German Measles		
Chicken Pox		
Mumps		
Tuberculosis		
Hepatitis		
Yellow Jaundice		
Polio		
Herpes Simplex (oral or hand)		

IMMUNIZATION HISTORY (VACCINES) ATTACH IMMUNIZATION RECORD

	Date (s)
Tdap: _____ Td:	Flu vaccine:
Hepatitis B Vaccine: yes / no	#1: #2: #3
Rubeola & Mumps /2 MMR vaccines (or positive titer)	**(2 Doses required)** # 1: #2
Rubella/ MMR vaccine (or positive titer)	**(1 Dose required)** #1:
Varicella Vaccine (or positive titer)	#1: #2:
PPD/TB Skin Test (2 PPD's administered in the past 12 months.	
PPD #1 Date Placed:	Date Read: Results in mm:
PPD #2 Date Placed:	Date Read: Results in mm
• **If known history of positive PPD, provide date of conversion and last chest x-ray:** Positive PPD Date:	Results in mm: Date of X-Ray: □ Normal Chest X-Ray □ Abnormal Chest X-Ray

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

□ Asymptomatic-denies all symptoms
□ Symptomatic-fatigue, Anorexia, Weight loss, Low grade fever, Productive cough (circle any that pertain)

REVIEW OF SYSTEMS

For the following items, check the appropriate column:

	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				
ILLICIT DRUG USE				
MAJOR ILLNESSES/HOSPITALIZATIONS				
MENTAL HEALTH CONDITIONS				
DO YOU DRINK ALCOHOL?				
DO YOU SMOKE?				

	Normal	Abnormal
SKIN		
EYES		
EARS		
NOSE		
MOUTH/THROAT		
NECK , THYROID LYMPH NODES		
CHEST		
HEART		
ABDOMEN		
BACK		
NEURO		
EXTREMITIES		
HERNIA	❑ None	❑ Present

Provider: please comment on abnormalities

Vision	Distance	Near
Uncorrected	20/	20/
Corrected	20/	20/
Blood Pressure :		
Pulse :		
Height:	**Weight:**	
General Appearance: □ Good □ Fair □ Poor		

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

MD/DO/NP/PA SIGNATURE: _____ DATE: _____

Provider's Address & Phone number _____ **16-05/30/2017**