

**HOSPICE
CARE NETWORK**
Because Every Day Counts

Hospice Care Network is regulated by the New York State Department of Health and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Dear Applicant,

Thank you for your interest in volunteering at Hospice Care Network. Our Volunteers are an integral part of our organization and provide either administrative support for HCN or visit clients in their homes, assisted living facilities, nursing homes and hospitals. We ask that volunteers make a minimum one year commitment to HCN, provide 2-4 hours per week of their time and be able to travel within 30 minutes of their home when visiting clients. For applicants applying to volunteer as a Licensed Haircutter, we require availability of 2-4 haircuts per month. For our Massage Therapy program, volunteers are required to complete 2-4 (two hour) shifts at one of our inpatient settings.

Attached you will find our Volunteer Application Form and Questionnaire. Once these are completed and returned to us, a member of the Volunteer Department will contact you in order to further discuss our program and to schedule an in-person interview.

Prior to start date, Volunteers must meet the requirements listed below:

- ✓ Health Examination to be conducted by your physician. This includes labwork and proof of Tuberculin screening.
- ✓ Initial Health Assessment Form - information supplied by applicant (no physician signature required).
- ✓ Evidence of completed Influenza vaccine for the current year (attach documentation) or declination of vaccine
- ✓ Photocopy of signed current professional license or certification (when applicable).
- ✓ Completion of a satisfactory background check.
- ✓ Attendance at an Orientation/Training Program.

Should you have additional questions, please contact us Monday through Friday between the hours of 9:00 and 5:00 at 516-832-7100, and ask to speak with someone in the Volunteer Department. You may also forward your application via the following:

Mail: HCN, 99 Sunnyside Boulevard, Woodbury, New York, 11797, Attn: Volunteer Department

Email: Sommer Allen at sthorne@hospicecarenetwork.org

Fax: 516-832-7160 – attach a cover sheet addressed to the Volunteer Department

Thank you,

The Volunteer Department

Application for Volunteer Service Program

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**99 Sunnyside Blvd
Woodbury, NY 11797**

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, martial or veteran status, or any other legally protected status. Please complete each item on this application and return it to the Volunteer Office. Thank you for your interest in volunteering at Hospice Care Network.

Date of Application: _____

Last Name		First Name			Middle Initial	
Address	Number	Street	City		State	ZIP Code
Home Telephone Number () -		Work Telephone Number () -		Cell Phone Number () -		
Email Address:						

POSITIONS AVAILABLE

<input type="checkbox"/> Administrative Volunteer	<input type="checkbox"/> Licensed Massage Therapy Volunteer
<input type="checkbox"/> Patient Support Volunteer	<input type="checkbox"/> Certified Pet Therapy Volunteer
<input type="checkbox"/> Hairstylist Volunteer (Licensed)	<input type="checkbox"/> Fundraising/Special Events Volunteer
<input type="checkbox"/> Special Skills Project Based Volunteer	<input type="checkbox"/> Children's Helping Hands Volunteer

TIME AVAILABLE

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

How did you learn about us?

Advertisement	Internet (specify site)	Volunteer	Relative/Friend	Other

In Case of Emergency, Notify:

Name	
Telephone Number () -	Cell phone Number () -
Relationship	

Have you ever filed a volunteer application with Hospice Care Network before? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you legally able to volunteer in this country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteers with Hospice Care Network may be asked to travel for more than 30 minutes. Will you be able to travel <i>if needed</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION

Highest Level of Education	Name of School	Course of Study
Other (please specify)		

PROFESSIONAL LICENSE

Type of License	
License Number:	Exp. Date:

PERTINENT WORK EXPERIENCE

Employer/Organization	
Responsibilities	
Starting Date	Final Date

PRIOR VOLUNTEER EXPERIENCE

Organization(s)
Volunteer Responsibilities (please list)

Describe any computer skills, specialized training, apprenticeship, office(s) held, extra-curricular activities, ect.

FOREIGN LANGUAGE SKILLS

Speak:	Understand:
Read:	Write:

Describe any computer skills and/or work-related training or volunteer-related training:

PERSONAL/PROFESSIONAL REFERENCES *Do not include family members.*

Name	Email Address	Address
1.		
2.		

Volunteer Applicant's Statement

I certify that answers given herein are true and complete. I authorize investigation of all statements contained in this application for Volunteer Service Program as may be necessary in arriving at a volunteer opportunity decision.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any volunteer relationship with this organization is of a non-paid "at will" volunteer relationship.

In the event of being accepted into volunteer service, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Hospice Care Network.

Signature of Applicant

Date



HCN Volunteer Questionnaire

Name: _____ Date: _____

Please answer the following questions so we may consider your needs.

What is your understanding of Hospice?

What experience do you have dealing with people that have a serious illness?

Please write about your grief or loss experience(s).

Additional questions for Patient Support applicants only:

Have you had any previous training in the area of death, grief or loss? Please explain.

What qualities/skills/life experience do you feel you can incorporate into your hospice volunteer work?

Do you have any fears or concerns about volunteering for those with a terminal illness? Please explain.

What are your sources of emotional support?

Volunteer Coordinator Signature

HOSPICE CARE NETWORK

INITIAL MEDICAL EVALUATION

[] Employee [] Volunteer [] Intern

Name _____ Date of Birth _____

Address _____

Tuberculin Screening within the past 12 months is required.

TST (Tuberculin Skin Test) Results: Positive _____ mm Negative _____ mm

Date Administered: _____ By: _____

Date Read: _____ By: _____

If TST positive, a Chest X-Ray within the past 12 months will be required – attach report

If using one of the IGRAs (Interferon-Gamma Release Assays) – lab report must be attached

Immunizations:

If born before 1/1/57 Lab Reports must be attached showing immunity (positive) to Mumps, Rubella, and Varicella (IGG).

OR

If born after 1/1/57 Lab Reports must be attached showing immunity (positive) to Measles (Rubeola), Mumps, Rubella and Varicella (IGG).

If named person is found to be non-immune in any of the above lab reports within this section, proof of immunization(s) given after lab reports, will be required.

The employee/volunteer/intern is able to perform the respective tasks, which may include but not limited to:

Traveling, stair climbing, lightweight carrying, assisting caregiver in providing services to a patient and light household tasks.

The above named person has been examined by me and may perform all tasks as stated above: yes [] or no []. IF no, please state limitations:

Physician's Signature & Stamp Date: _____

HCN Medical Director's Signature M.D. Date: _____

Lori Ann Attivissimo M.D.

The New York Department of Health (DOH) mandates that all Employees/Volunteers/Interns provide a personal, annual health assessment.

Instructions – In order to be compliant with the above regulation, this form must be completed by all Employees/Volunteers/Interns.

COMPLIANCE INSTRUCTIONS:

1. Completion of the attached Initial Health Assessment form.
2. Tuberculosis Screening Compliance for all new personnel:
 - Personnel with a history of negative Tuberculin Skin Testing (PPD/TST) will need a new PPD/TST placed and read or may submit lab reports of one of the IGRAs (Interferon-Gamma Release Assays – QuantiFERON® Gold)
 - Personnel with a history of positive Tuberculin Skin Testing (PPD/TST) are required to complete the Communicable Disease section, part B, on the attached Initial Health Assessment form and submit documentation of a chest x ray within the past 12 months, including documentation of history of a positive PPD/TST result.
3. If under the age of 18 or a special needs volunteer, an additional signature of a legal representative is required.

Employee Volunteer Intern

In accordance with HIPAA the information contained herein is confidential and will not be released without your consent. If employee/intern, return form to HR Department. If volunteer, return form to Volunteer Department.

Date: _____ Date of Birth: ____/____/____
 Last Name: _____ First Name: _____ MI: ____
 Street Address: _____ City: _____
 State: _____ Zip Code: _____
 Home #: _____ Cell #: _____

Health History: Select Yes or No

	YES	NO
Have you developed any allergy and/or sensitivity to LATEX? If yes , please specify reaction and tell your manager. HCN has latex free supplies available.		
Have you had any changes to your health or problems that may pose a potential risk to others or interfere with the performance of your duties and/or services? If yes , please explain.		

COMMUNICABLE DISEASE: Initial Tuberculosis Screening is required for all personnel.

Complete Either Box A or B as appropriate

A. For those with a negative Tuberculin Skin Testing in the past:

- 1. Tuberculin Skin Testing (PPD/TST)** - HCN can provide the PPD for you or you can submit proof of PPD screening within the past 12 months to the HR or Volunteer Department.
- 2. Interferon-Gamma Release Assays (QuantiFERON®) blood test** – lab results within the past 12 months must be submitted.
 (The HR, Volunteer Departments and Medical Director will be notified of all new PPD/TST or QuantiFERON® screening results that are positive.)

B. Only those who have had a **positive reaction to a PPD/TST** test should check any symptoms that may apply:

Symptoms review: Fever Weight Loss Night Sweats Cough Coughing Up Blood
 or No symptoms

Should you contract chicken pox or shingles, you will be unable to work. Notify your manager and the HR Department immediately.

To be read and signed by employee/volunteer/intern:

I certify that I have disclosed all known current health conditions or problems that may pose a potential risk to others or which may interfere with the performance of my duties and/or services. I also certify that I do not use illegal drugs, nor do I misuse/abuse controlled or other substances which may alter or impair my behavior and/or ability to function. I understand that failure to disclose requested medical information or giving false or misleading answers would be sufficient cause for my dismissal.

_____/_____/_____
 Print Name Signature Date: ____/____/____

_____/_____/_____
 Print Name of Legal Representative Signature of Legal Representative
 (For employee/volunteer/intern under the age of 18, or special needs volunteer.)

Lori Attivissimo M.D. _____/_____/_____
 HCN's Senior Medical Director Signature Date: ____/____/____

Referred To: _____