Northwell Health
Hospice Care Network

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 administrative support for HCN, visit clients in their homes, assisted living facilities, nursing homes and hospitals, provide support to bereaved individuals, and utilize specialized skills to provide practical help. 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.

Attached you will find our Volunteer Application, Questionnaire and Medical Clearance form. Once the application and questionnaire 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 interview. Please note, the Medical Clearance Form is not to be completed until after an applicant has been interviewed and an applicant is moving forward with the volunteer process.

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

- ✓ Health Examination to be conducted by your physician. This includes lab reports or dates of immunizations, proof of Tuberculin screening and proof of COVID vaccine. Please note the COVID vaccine now has the booster requirement. You must submit proof of initial vaccination and booster.
- ✓ 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.

If you have additional questions, please contact us Monday through Friday between the hours of 8:30 and 4:30 at 516-832-7100, and ask to speak with someone in the Volunteer Department, or send an email to the email address below.

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 sallen10@northwell.edu
Fax: 516-832-7160 – attach a cover sheet addressed to the Volunteer Department

Thank you!

Northwell Health*

# APPLICATION FOR VOLUNTEER SERVICE

Northwell Health is an Equal Opportunity Employer and a Voluntary Not-for-Profit Health System

**Today's Date:** _____ **Please Print in Ink**

**Please write below which Northwell Hospital/Facility are you interested in volunteering at?**

_____

☐ **I am 18 years of age or older** ☐ **I am between the ages of 14 & 17**

***Each Hospital/Facility has their own minimum age requirement****

**Last Name:** _____ **First Name:** _____ **Mid. Int:** ____

**Home Address:** _____

Street Apt. # City/Town State Zip

**Phone: Home:** (____) _____ **Business:** (____) _____ **Cell:** (____) _____

**E-Mail Address:** _____

**How did you hear about the Northwell Health Volunteer Program?**

_____

**Emergency Contact:** _____

Name Phone # Relationship

**Foreign Languages Spoken:** _____

**Do you currently have any friends or relatives employed, volunteering, or on the Board of Trustees at any Northwell Health location (formerly known as North Shore LIJ Health System)?**

**Yes** _____ **No** _____ **If yes, please provide information:**

| Facility | Department | Name | Relationship |
|---|---|---|---|
| | | | |
| | | | |

**Are you currently on the federal government's exclusion list for any reason, including having defaulted on a Health Education Assistance Loan (HEAL)?**

**Yes _____ No _____ If yes, please provide information:**

_____

**Are you the subject of a pending action or proceeding involving fraud or abuse in Medicare, Medicaid or other healthcare program?**

**Yes _____ No _____ If yes, please provide information:**

_____

**Have you ever been sanctioned as a result of alleged Medicare or Medicaid fraud or abuse?**

**Yes _____ No _____ If yes, please provide information:**

_____

**Have you previously worked or volunteered at Northwell Health (formerly known as North Shore LIJ)?**

**Yes _____ No _____ If yes, please specify:**

(*Circle One*)
**Worked or Volunteered** _____
Hospital/Facility Department Beginning Date End Date

(*Circle One*)
**Worked or Volunteered** _____
Hospital/Facility Department Beginning Date End Date

**I am currently: Employed _____ Unemployed _____ Student _____ Retired _____**

**Employer's Name (if applicable):** _____
Name Address

**Highest Level of Education (if applicable): High School _____ College/University _____ Degree _____**

**Business/Trade** _____

**School Presently Attending (if applicable):** _____ **Major:** _____

**Expected Graduation Date:** _____

**Why are you interested in volunteering?**

_____

_____

_____

_____

_____

_____

**I prefer:** **Patient contact** _____ **Non-patient contact** _____ **Clerical** _____ **Where needed** _____

**Please provide two (2) references who are not family members:**

_____

**Name** **Relationship** **Phone #**

_____

**Name** **Relationship** **Phone #**

**I am interested in the following area(s):**

_____

**I am available for summer only** _____

**I am available to start volunteering on** _____

**I am available to volunteer on the day/times indicated below:**

| Sunday | | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AM | | AM | | AM | | AM | | AM | | AM | | AM | |
| PM | | PM | | PM | | PM | | PM | | PM | | PM | |
| Eves | | Eves | | Eves | | Eves | | Eves | | Eves | | Eves | |

**Please be aware that certain Hospitals/Facilities may <u>not</u> offer evening, weekend or summer only hours**

**I understand that I will not be paid for my service as a volunteer. I understand that I must complete _____ hours of service before any information regarding service hours is released.**

**Do you already have a definite placement? Yes** _____ **No** _____

**If yes, please give name of supervisor, department and phone number:**

_____

## NORTHWELL HEALTH VOLUNTEER APPLICATION SIGNATURE PAGE

**Please read the following statement carefully, and then acknowledge that you have read and agreed to it by providing your signature and/or eSignature at the bottom of the page. Please note that an eSignature is the electronic equivalent of a handwritten signature.**

**It is Northwell Health's policy to provide equal opportunity and treat all individuals equally regardless of their age, race, creed/religion, color, national origin, alienage or citizenship status, sexual orientation, military or veteran status, sex/gender, gender identity, gender expression, disability, genetic information or genetic predisposition or carrier status, marital status, partnership status, victim of domestic violence, or other characteristics protected by applicable law.**

### Applicant's Certification

**I certify that all matters contained in this application are true, authorize their investigation, and agree that any misleading or false statements would render this application void and would be sufficient cause for my immediate dismissal. I understand that my volunteer engagement with Northwell Health ("engagement") is dependent on providing all necessary documentation as required for my position including, but not limited to, the following: verification of education, employment history, professional licenses and certifications, required regulatory checks (including without limitation a check under the Sex Offender Registration Act), satisfactory completion of a medical examination, receipt of satisfactory references and attendance at required orientations and trainings.**

**I understand that as a condition of my proposed engagement, I may be required to undergo and pass a screening for alcohol and/or drugs. Should the screening reveal the presence of an illegal drug, misuse or abuse of a controlled substance, or use of other substances which may impair my behavior and/or ability to function, I may not be allowed to volunteer with Northwell Health.**

**I understand and agree that Northwell Health may share Personal Information with other companies acting on the Northwell Health's behalf to provide employment verification services, may include assessment test providers, if applicable.**

**Northwell Health may share my Personal Information in connection with the sale or transfer of part or all of the business or, as appropriate, in connection with any legal requirement such as a court order or regulatory obligation. Northwell Health may also share my Personal Information upon request from a law enforcement agency. Northwell Health will not share, trade, rent or sell my Personal Information to other third parties without my consent, unless such possible sharing, trading and selling was disclosed to me when the information was originally collected.**

**I understand that I have the right to request access to my Personal Information in order to correct, update, modify, or ask for the deletion and blocking of my data. I can do this by contacting Northwell Health through my respective volunteer coordinator. If I request the deletion of my data, I acknowledge that applicable legal obligations may require that Northwell Health maintain such data.**

**I agree, if accepted, to provide acceptable proof of my age and identity, and to abide by Northwell Health's policies, procedures and rules.**

**I understand that my engagement with Northwell Health will be at-will, meaning that I or Northwell Health may terminate the relationship at any time, or for any reason, with or without cause or notice.**

**By my signature below, I certify under penalty of perjury that all my statements in this completed application are true and complete, that I have read, understood, and agree to this entire application, including the foregoing statement above, and that I was given as much time as I needed to read and complete this application. I understand that any falsification or omission shall be sufficient cause for termination of my volunteer engagement with Northwell Health (which I acknowledge is at-will). My typed name shall have the same force and effect as my written signature.**

_____

Applicant's Signature — Date Signed

_____

Parent/Legal Guardian Signature (*If under 18 Years Old*) — Date Signed

Northwell Health
Hospice Care Network

## 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

Northwell Health

# Employee Health Services Medical Clearance for Volunteers

*Your medical clearance will be delayed if this form is not complete. Please contact an EHS Quality Team member @ (718) 470-4371 for questions.*

Name: _____ Current Hospital/School: _____
(First Name, Last Name)

DOB: ____ /____ /____ Telephone: ( ) _____ Email: _____

## TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

**Tuberculosis (TB) Screening:** 2-Step Tuberculin Skin Testing (TST) or Blood Assay

**Instructions:** The 1st TST needs to be within 1 year of start of service. The 2nd TST needs to be within 3 months of the start of service. The 2nd TST needs to be completed no less than 7 days after the 1st TST.

2-Step TB Skin Tests

#1 ___ / ___ / ___ Date 1st placed (within last 12 months) ___ / ___ / ___ Date Read _____ Result

#2 ___ / ___ / ___ Date 2nd placed (no less than 7 days after the 1st) ___ / ___ / ___ Date Read _____ Result

OR Blood Assay (within 3 months) Attach Lab Report: Date of Review: ___ / ___ / ___ Results: ☐ Negative ☐ Positive

**Positive TST History:** If you have a history of a positive TST, complete the chest x-ray and signs and symptoms section below.

You **must have had a chest x-ray** with no active disease

Chest X-Ray Date: ___ / ___ / ___ Results: ☐ No Active Disease TB Treatment given: Date(s): _____
☐ Other _____

**Tuberculosis Signs and Symptoms Evaluation**
Date of Review: ___ / ___ / ___ Results: ☐ Negative ☐ Positive

| Vaccination History | Vaccine #1 Date | Vaccine #2 Date | | Lab reports Attached |
|---|---|---|---|---|
| **MMR Vaccine** Two doses of MMR | ___ / ___ / ___ | ___ / ___ / ___ | | ☐ |
| **OR** | | | | |
| **Measles** *(Rubeola)*: Two immunizations | ___ / ___ / ___ | ___ / ___ / ___ | OR | ☐ |
| **Mumps:** Two immunizations | ___ / ___ / ___ | ___ / ___ / ___ | | ☐ |
| **Rubella:** *(German Measles)* One immunization | ___ / ___ / ___ | *Intentionally left blank* | | ☐ |
| **Varicella:** Two immunizations or Disease History Date: ___ / ___ / ___ | ___ / ___ / ___ | ___ / ___ / ___ | | ☐ |
| **Tdap/DTaP:** Pertussis containing vaccine within last 10 years | ___ / ___ / ___ | *Intentionally left blank* | | |
| **Influenza:** Vaccinated within the current flu season. | ___ / ___ / ___ | ☐ Declined Vaccination | | *Intentionally left blank* |
| **COVID-19:** Must attach proof of vaccination | ___ / ___ / ___ | ___ / ___ / ___ | | ☐ |

**Health Assessment**: The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individuals behavior. ***The office that is completing this form will be responsible for maintaining updated records for the duration of participant's and/or faculty's interactions within the Northwell Health facilities and provide appropriate supporting documentation upon request.***

Health Care Provider or Facility: _____ Phone: _____
(Please Print) (School designee if applicable)

Health Care Provider or Facility Signature: _____ Date: _____

Provider/Facility Stamp with Address and Telephone Number: OFFICE STAMP

**For Office Use Only:** Department: _____
Program Name: _____
Northwell Health Program Contact Name: _____
Program Contact _____ Number: _____
Medical Clearance to be sent to (Email address): _____
Northwell Health EHS Reviewer Signature: _____ Date: _____