### New Volunteer Candidate Processing Form

_(DO NOT WRITE ON THIS PAGE – FOR OFFICE USE ONLY)_

<table>
<thead>
<tr>
<th>Procedure</th>
<th>✓</th>
<th>Date</th>
<th>Staff Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picture I.D.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working Papers (If under 18 yrs.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Reference</td>
<td></td>
<td></td>
<td>Reference #1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reference #2</td>
</tr>
<tr>
<td>Physical Clearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Cleared: <strong><strong>/</strong></strong>/____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer Orientation Attendance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Uniform</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipt #: ____________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital I.D. Issued</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entered into Computer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer Approved to Start</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
# Volunteer Applicant Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth: ___ / ___ / ___ (year is optional)</th>
<th>Social Security Number: ___ ___ - ___ - ___ ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you at least 14 years of age?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
</tr>
</tbody>
</table>

| Home Telephone Number: ( ) | Cell Number: ( ) |

<table>
<thead>
<tr>
<th>E-mail Address:</th>
</tr>
</thead>
</table>

# Emergency Contact Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
</tr>
</thead>
</table>

| Home Telephone Number: ( ) | Cell Number: ( ) |

<table>
<thead>
<tr>
<th>Relationship to You:</th>
</tr>
</thead>
</table>

# Employment Information

<table>
<thead>
<tr>
<th>Are you currently employed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

# Education Information

<table>
<thead>
<tr>
<th>I have completed:</th>
<th>Junior High School</th>
<th>High School</th>
<th>Some College</th>
<th>College</th>
<th>Graduate School</th>
<th>Other</th>
</tr>
</thead>
</table>

If applicable, please list the school you are **currently** attending:

<table>
<thead>
<tr>
<th>I need volunteer hours for school:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If Yes, how many?</th>
<th>Less than 150 hours</th>
<th>150 hours</th>
<th>More than 150 hours</th>
</tr>
</thead>
</table>
Interview Questions

1. Why do you wish to volunteer at NYC Health + Hospitals/Coney Island? (e.g., academic, personal, experience, etc.)

2. What is/are your area(s) of interest?
   - Office Team
   - Palliative Care
   - Pre-Health Professional Track
   - Comfort Specialist
   - ER Frontline
   - Coney Surgery Services Liaison (CSSL)
   - Healing Without Borders
   - CIH Council
   - Virtual Volunteer
   - Other: _____________________________

3. Please describe relevant work skills or personal experience:

4. Do you have any hobbies or special talents?

5. Do you speak, write or read a second language? If yes, what language?

I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, includes termination by, NYC Health + Hospitals/Coney Island and or possible legal action by patients, families or this facility. I also understand that any training given is solely for volunteer services and not lead to paid employment.

Applicant Signature: ____________________________________ Date ____/____/_____
Dear Potential Volunteer:

As a prospective volunteer, you will need two (2) people give an objective and candid opinion about you. These references may be written by either professional or personal contacts over the age of 18 (e.g., employer, co-worker, professor, teacher, guidance counselor, friend, neighbor, pastor—no family members please). Please use the attached forms and return via email, fax, or regular mail.

Please be assured that the information will be kept strictly confidential in accordance with the Federal Privacy and Confidentiality Guideline Laws.

Kindly,

Julianne Rich
Director
Volunteer Services

I hereby authorize release of reference:

________________________________________________________________________________________

Print Name

________________________________________________________________________________________

Signature

____/____/____
Date
BEHAVIORAL STANDARDS

We are committed to providing the highest quality of service and meeting our customers need with utmost care and courtesy.

Attitude & Appearance

- We will introduce ourselves to patients, their families and visitors with a smile.
- We will wear our identification badge so that it can be easily seen.
- Rudeness is never acceptable. We must at all times treat one another with courtesy and respect.
- We recognize that our customers have a sense of urgency and show them we value their time.
- We know and follow the Dress Code policy.
- We do not say, “It’s not my job.” If you are unable to meet a request, be responsible for finding someone who can.

Communication

- We will answer calls within three to five rings.
- We will answer all calls by providing our department and name, asking “How may I help you?” or the equivalent. Speak clearly.
- We will get the caller’s permission before putting him or her on hold, and then thank the caller for holding when we return to that line.
- We will not use our cell phones, Bluetooth devices, iPod or any other electronic devices while providing services to our patients or fellow staff members.

Teamwork

- We will show consideration. Be sensitive to fellow employee’s inconvenience.
- We will be supportive of fellow employees. Offer help when possible. Cooperation is expected in the workplace.
- We will treat every co-worker as a professional. Recognize that we each have an area of expertise.
- We will welcome new employees. Be supportive by offering help and setting an example of the cooperation expected in the workplace.

Privacy, Confidentiality & HIPAA

- Information about our patients is strictly confidential. We are all responsible for ensuring that patient confidentiality is never compromised.
- We do not discuss patient treatment information care in public areas (i.e., elevators, hallways, cafeteria, etc.)
- We will always knock before entering a patient’s room.
- We will close patient bed curtains or room doors during examinations, procedures or when otherwise needed.
- We respect our co-workers’ privacy by eliminating gossip. Our customers also hear this unprofessional talk.
- Patient records must be kept confidential.

___________________________________________  ______/_____/____
Print Name              Date

___________________________________________
Signature
I, ____________________________, authorize the physicians, medical staff, and personnel of
this hospital to conduct such medical assessments and physical tests as I may be required to have under
the New York State and City Health Codes, or as a qualification or condition of volunteering with NYC
Health + Hospitals or as a condition of continued volunteering with NYC Health + Hospitals.

I understand that a medical layman’s assessment may include, but is not limited to:

- Immunity to Rubella, followed by immunization as appropriate;
- Test for tuberculosis including a chest x-rays if test is positive.
- Stool examination and/or culture for enteric pathogens.
- Blood test for hepatitis virus’ antigen and identification of immunity to hepatitis.
- Primary immunization against diphtheria (and tetanus) as appropriate.
- Screening or testing for use of depressants, stimulants, narcotics, alcohol, or other substances, to
  be completed by Occupational Health Services at NYC Health + Hospitals/Coney Island.

I understand that if I have been previously immunized for any of the above, I may present proof of my
immunity in a statement by my private physician, school, clinic, health agency, etc. This statement,
which must identify the date(s) and source(s) of such immunization, must be found acceptable by the
hospital’s examining physician.

I acknowledge that no guarantees have been made to me as the result of these assessments or tests. This
consent has been fully explained to me, and an offer has been made to me to answer any questions I may
have.

_____________________________     __/____/____
Print Name                  Date

_____________________________
Signature

Volunteer Department Representative Signature: ________________________________
CONFIDENTIAL

New York City Health and Hospitals Corporation
APPLICATION FOR EMPLOYMENT

CONVICTION RECORD
(Conviction of a violation of law or ordinance is not necessarily a bar to employment)

Were you ever convicted of a violation of any law or ordinance in this state or elsewhere? (Convictions for juvenile delinquency, youthful offender or wayward minor need not be reported. Traffic violations must be included.)

YES ☐   NO ☐

If yes, explain each violation, setting forth the date, charge, court and action taken in the boxes below: (if you need additional space, please use the back of this form)

<table>
<thead>
<tr>
<th>Violation</th>
<th>Date of violation</th>
<th>Charge</th>
<th>Court and action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please attach a copy of the final disposition (for each violation).

CERTIFICATION

I hereby certify that all the facts set forth above are true, complete and correct to the best of my knowledge and belief. I understand that if arrested or convicted after my employment, I must report this to the facility Human Resources Director.

Signature of Applicant

Date

Print Name

Last 4 digits of Social Security #

This information and any document received by the Corporation as part of a background criminal record investigation are strictly confidential and shall not be available for copying after inspection, except as expressly provided by law.
TERMS AND CONDITIONS OF APPOINTMENT

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #:</td>
<td>Start Date:</td>
</tr>
</tbody>
</table>

VOLUNTEER □   INTERN □   AGENCY □   OTHER ___________________________

I, the above named individual, hereby accept assignment to the above position subject to the following terms and conditions.

1. I understand that my appointment to the above position is subject to my being cleared by NYC Health + Hospitals which will include a background investigation and a medical assessment which will include screening for the presence of drugs or alcohol. I may also be obligated to take a physical test or other qualifying test, if required for the position. I shall willingly undergo such examinations.

2. I hereby authorize NYC Health + Hospitals to commence its clearance procedure by making any investigation of my background deemed necessary. I give NYC Health + Hospitals permission to secure all necessary personal data from sources governmental and private. I further agree to cooperate in all phases of the clearance procedure and to pay any related fees.

3. I have completed the required forms and have answered all questions fully truthfully. I understand that any misrepresentation of material fact on these forms or any other documents submitted in connection with my service may result in my dismissal.

4. I hereby agree to hold NYC Health + Hospitals and the City of New York, its agencies, employees, and agents harmless with respect to any personal claims for damages, expenses or injuries that may arise should the above-mentioned procedure not be completed satisfactorily and my service terminated.

5. If my position requires a training program, I must successfully complete that training program. If my position requires a valid license, certification or permit, I must obtain and maintain such credential(s) on my own time.

6. I understand that I serve at the pleasure of the appointing officer and acquire no tenure or vested rights to a position. I understand that I may be terminated at any time, with or without cause.

7. I understand that failure to fulfill any of the above conditions may result in the revocation of my services and my immediate termination.

8. I understand this is an application only. This does not guarantee acceptance into the volunteer program.

9. I hereby agree that, if accepted, my volunteer services are donated to NYC Health + Hospitals/Coney Island without contemplation of compensation.

10. I understand I must complete 150 hours, unless discussed otherwise, to receive verification or recommendation.

______________________________   __________/_____/_____  
Signature                        Date

Parent/ Guardian (If applicant is under 18 years of age)

______________________________
Program Director