GURWIN HEALTHCARE SYSTEM

Caring for Generations

68 Hauppauge Rd • Commack, NY 11725 • 631-715-2555 • www.Gurwin.org

VOLUNTEER/ INTERN APPLICATION

APPLICATION DATE: _____

APPLICANT INFORMATION:

NAME: _____

ADDRESS: _____
NUMBER AND STREET

_____
TOWN STATE ZIP CODE

TELEPHONE NUMBER: (HOME) _____ (CELL) _____

E-MAIL: _____

DATE AVAILABLE TO BEGIN: _____

PLEASE INDICATE DAYS/TIMES THAT YOU ARE AVAILABLE TO VOLUNTEER/INTERN:

DAY	**MORNING** (9:30AM - NOON)	**AFTERNOON** (1:00PM - 4:00PM)	**EVENING** (4:00PM - 7:00PM OR 6:30PM - 8:45PM)
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

EMPLOYMENT AND VOLUNTEER EXPERIENCE:

CURRENTLY EMPLOYED OR ENROLLED IN SCHOOL: _____

FULL TIME: _____ PART TIME: _____ OCCUPATION: _____

EMPLOYER: _____

SCHOOL: _____

OVER

VOLUNTEER EXPERIENCE (ONLY FOR VOLUNTEERS):

ORGANIZATION/AGENCY	DATES: TO/FROM	POSITION

EDUCATION:

SCHOOL: _____

HIGHEST LEVEL COMPLETED: _____ DEGREE/DIPLOMA: _____

SKILLS/HOBBIES/INTERESTS: _____

OTHER LANGUAGES SPOKEN: _____

SEASONS/MONTHS UNAVAILABLE FOR SERVICE: _____

PHYSICAL LIMITATIONS WHICH REQUIRE ACCOMODATION: _____

REFERENCES (ONLY VOLUNTEERS):(PLEASE LIST TWO **UNRELATED** REFERENCES WHOM WE CAN CONTACT)

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

TELEPHONE: _____ TELEPHONE: _____

Have you ever been convicted as an adult offender of a misdemeanor or felony, excluding traffic violations? ❑ YES ❑ NO

Conviction record will not automatically make you ineligible for volunteering

STATEMENT OF UNDERSTANDING

I understand the importance of volunteer work at the Gurwin Jewish Nursing & Rehabilitation Center; I agree to observe the rules and regulations of the Center and the Volunteer Services Department; to notify the appropriate personnel when I am unable to come on my assigned day; and to perform my duties with dignity, courtesy, confidentiality, and consideration.

_____

SIGNATURE OF APPLICANT

OFFICE USE ONLY:

Interview Date: _____ Orientation Date: _____ State Date: _____

Assignment: _____

PPD #1 _____ Read _____ PPD#2 _____ Read _____

Registry: _____

GURWIN HEALTHCARE SYSTEM
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GURWIN JEWISH NURSING & REHABILITATION CENTER
NEW VOLUNTEER/INTERN HEALTH ASSESSMENT

TO BE COMPLETED BY VOLUNTEER/INTERN (PLEASE USE PEN)

Name_____

Male__Female_____Date of Birth_____

Address_____

_____

Telephone_____

Contact in Case of Emergency:

Name_____

Telephone #_____
Relationship_____

Name / telephone number of your Doctor/Clinic:

Name_____

Telephone_____

1. Are you currently under a doctor's care for any health condition? No___ Yes___
(describe)_____

_____

2. Are you aware of any health conditions/impairment which you **currently** have but for which you are not under a doctor's care? No____ Yes____
(describe)_____

_____

3. List any health impairments or disabilities which may be of potential risk to patients or other personnel or which might require the Center to provide reasonable accommodations in order for you to perform your duties.

_____

_____

4. Please list all medications you take regularly (include non-prescription or "over the counter" medications):

_____

_____

5. Are you habituated or addicted to depressants, stimulants, alcohol, narcotics or other substances which may alter your behavior? _____Yes _____No

6. Have you ever had or been treated for tuberculosis? No____ Yes____ (explain)

_____

_____

Do you suffer from: Unusual cough? Yes____ No____
Coughing up blood? Yes____ No____
Unexplained: fever Yes____ No____
Chills Yes____ No____
Night sweats Yes____ No____
Weight loss Yes____ No____

6. Have you ever received the Hepatitis B Vaccine (3 dose series)? ____Y ____N
If yes, date of 3rd Vaccine_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS (check every item).

	Yes	No		Yes	No
Fainting Spells or Blackouts			Epilepsy (Fits)/convulsions		
Shortness of Breath			Tightness in Chest/Chest Pain		
Asthma			Rupture of Hernia		
Hepatitis/Liver Trouble			Heart Trouble/Heart Attack		
Back Trouble/Back Aches			Knee Injury		
Allergies			Ruptured Disk		
Skin Trouble/Rashes/Etc.			Alcoholism		
Diabetes			Have you ever had any occupational illnesses or injuries?		
Are you now, or have you been disabled?			Have you ever been hospitalized for any illness or injury?		
Have you ever had any Military Service connected illness or injury?			Have you been hospitalized for any surgery?		
Have you ever had the chicken pox or 2 doses of the Varicella vaccine?			Have you ever had the Mumps or 2 doses of the Mumps Vaccine?		

If you have answered "YES" TO ANY OF THE QUESTIONS, PLEASE EXPLAIN FULLY BELOW.

_____

_____

I HEREBY CERTIFY: THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE; THAT I AM NOT AWARE OF ANY PERSONAL HEALTH IMPAIRMENT WHICH MAY POSE A RISK TO NURSING HOME RESIDENTS OR PERSONNEL; AND THAT I AM NOT HABITUATED OR ADDICTED TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL, OR OTHER DRUGS OR SUBSTANCES WHICH MAY ALTER MY BEHAVIOR.

Attached to this application, please provide proof of your first and second Measles-Mumps-Rubella inoculations.
A physician's note on letterhead, prescription pad, school health records or lab tithers will suffice.
You will be contacted by the Department of Volunteer Services to arrange your interview.

_____ _____

Volunteer Signature Date

(Parent or Guardian required if under the age of 18)

Reviewed by:

_____ _____

Medical Director/Designee Date

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Authorization for Administration of Mantoux Tuberculin (PPD)

To be completed by Volunteer/Intern:

Name: _____ Department:_____

Have you ever been told you have a positive reaction to a PPD?	YES	NO
Have you ever had a severe reaction to a PPD?	YES	NO
Female – Are you pregnant?	YES	NO
Have you had **ANY** exposure to a person known to have Tuberculosis?	YES	NO
Have you had **ANY** vaccine within the last (6) weeks?	YES	NO

If "yes" please give details, including dates:

_____

_____

_____ _____
Volunteer Signature Date
(Parent/Guardian required if under 18)

**********FOR OFFICE USE ONLY**********

To be completed by Employee Health, MD, or NP prior to Administration:

I authorize administration of a one or two stage (P.P.D.) Purified Protein Derivative, 5TU intradermally, as medically appropriate, to the above named volunteer, provided there is no medical contraindication.

_____ _____
Signature/Title Date

GURWIN
HEALTHCARE SYSTEM
Gurwin Jewish Nursing & Rehabilitation Center

PHOTO CONSENT

I give the Gurwin Healthcare System (Gurwin), its agents and employees permission to photograph me. With respect to these photographs/video, I give Gurwin permission to use, re-use, publish and re-publish these photos in print, online and video-based marketing materials, print advertising and broadcast advertising campaigns, social media, as well in the news media and other Gurwin publications.

I understand that each person is asked for verbal permission any time a photograph is taken, in addition to this signed consent. Photos will be taken by authorized personnel only.

I hereby release and discharge Gurwin from any and all claims and demands arising from the use of the photographs, including any and all cases of libel. I have read the foregoing and fully understand the contents thereof. I hereby release and agree to indemnify the licensed parties and their respective successors and assigns, from any and against any and all liability arising out of the exercise of the rights granted by the above release.

_____

VOLUNTEER/INTERN NAME

(please print)

_____

VOLUNTEER/INTERN SIGNATURE