

DEPARTMENT OF VOLUNTEER AND COMMUNITY SERVICES
445 LENOX ROAD BROOKLYN NY 11203
Volunteer Coordinator: Gem McCalman-Oxley (718) 270-2844
Volunteer@downstate.edu
VOLUNTEER APPLICATION PACKET

Volunteering is open to all who wish to participate. Minimum age requirement is 16. We offer clerical/administrative, based assignments which are based on availability. You do not need to have prior experience, however if you do have experience it would be helpful.

**PLEASE KEEP IN MIND THAT WE DO NOT OFFER PATIENT CARE OPPORTUNITIES,
VOLUNTEERS HAVE NO DIRECT PATIENT CONTACT.**

You can be placed in most **non-clinical** areas within the **hospital** and/or including the **university**. Some clinics and nursing units may need assistance performing **clerical duties only** and consideration will be made. If you do not know where it is you would like to be placed, a site will be recommended for you. **There is no volunteering during evenings and weekends**

ITEMS NEEDED TO COMPLETE VOLUNTEER REGISTRATION:

1. Two current letters of reference from anyone **outside** of Downstate, **relatives are not acceptable**. If you are a student, please obtain your two reference letters from two teachers, professors, mentors, guidance counselors, work, or program coordinator.
Applicants who are internally referred or requested by a department, must also submit a letter of Acceptance from the Department Head, Chair, Administrator or Supervisor.
This letter must state that the volunteer (name) is being accepted into the Department (name), list the responsibilities the volunteer will have, and state who will be supervising the volunteer.
2. Medical Clearance must be obtained from Employee/Student Health Services (440 Lenox Road, Suite #1S Brooklyn, NY 11203) All applicants must be fully vaccinated. Take proof of all immunizations and an updated PPD/TB test (taken within a six- month period) If you have a chest X-RAY that should be updated as well. If you do not have proof of all your immunizations, a Medical History Form is provided in this packet and can be filled out by your doctor, you may then take the form over to Employee/Student Health Services.
3. Complete the on-line institution-wide orientation. (**GENERAL AME**) The link is <http://www.downstate.edu>
Review all Power Point slides for **Annual Mandatory Exam** and complete the post test. You **must pass** the post-test and print out the Acknowledgement form.
4. **Final Steps:** Complete the on-line HIPAA Compliance and Deficit Reduction Act: False Claims & Employee Protections Modules. **A code will be requested for you once all of the above is submitted.** Once you have your code, you can find directions to access HIPAA Compliance included in this packet, the option for HIPAA Compliance you should select is: **"Administrative Support"** unless otherwise instructed. Upon completion print and submit all certificates. The issuance of your volunteer ID will follow.

Please be aware that the Department of Volunteer Services Office will keep all documents. Please submit copies that we can keep. Once all of your documents have been submitted and you have completed the application process, you will be assigned.



DOWNSTATE
HEALTH SCIENCES UNIVERSITY

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VOLUNTEER APPLICATION

APPLICANT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: ___/___/_____
Street Address: _____ Apartment/Unit #: _____ City: _____ State: _____
Zip code: _____ Home Phone: _____ Cell Phone: _____ E-mail: _____
Emergency Contact Name: _____ Phone: _____

Are you a citizen of the United States? Yes ___ No ___
Have you ever worked for this organization? Yes ___ No ___
Have you been convicted of a felony? Yes ___ No ___

AVAILABILITY (PLEASE ONLY WRITE DOWN THE EXACT DAYS AND TIME YOU ARE AVAILABLE TO VOLUNTEER)

Position Applied for VOLUNTEER _____

Monday	From _____ To _____	Departments of Interest (If Any)
Tuesday	From _____ To _____	1. _____ 2. _____
Wednesday	From _____ To _____	3. _____
Thursday	From _____ To _____	FOR OFFICE USE ONLY: ID ISSUE DATE: _____
Friday	From _____ To _____	DEPARTMENT ASSIGNED TO: _____ SUPERVISOR: _____

EDUCATION

High School: _____ Address: _____ From: _____ To: _____ Graduated? Yes ___ No ___
Degree: _____
College: _____ Address: _____ From: _____ To: _____ Graduated? Yes ___ No ___
Degree: _____
Other: _____ Address: _____ From: _____ To: _____ Graduated? Yes ___ No ___
Degree: _____

IF YOU ARE COMPLETING HOURS AS PART OF AN EDUCATIONAL REQUIREMENT PLEASE FILL OUT THE SECTION BELOW

School Name: _____ Phone: _____ Contact Person: _____
Hours to be completed: _____ Expected Completion Date: ___/___/_____

MILITARY SERVICE

Branch: _____ From: _____ To: _____

PREVIOUS EMPLOYMENT

1. Company: _____ Phone: _____ Job Title: _____ From: ___/___/___ To: ___/___/___
Address: _____
Responsibilities: _____

May we contact your previous supervisor for a reference? Yes ___ No ___

2. Company: _____ Phone: _____ Job Title: _____ From: ___/___/___ To: ___/___/___
Address: _____
Responsibilities: _____

May we contact your previous supervisor for a reference? Yes ___ No ___

3. Company: _____ Phone: _____ Job Title: _____ From: ___/___/___ To: ___/___/___
Address: _____
Responsibilities: _____

May we contact your previous supervisor for a reference? Yes ___ No ___

COMPUTER SKILLS (CHECK ALL THAT APPLY)

Microsoft Word ___ Microsoft Excel ___ Microsoft PowerPoint ___ Microsoft Access ___

SPECIAL SKILLS OR QUALIFICATIONS: Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

LANGUAGE: Please specify if you speak any other language other than English: _____

Would you be interested in Volunteering as an interpreter? Yes ___ No ___

OUR POLICY: Volunteers and observers are **not** permitted to administer medication to patients nor render services to patients; including diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition. According to the NYS Education law, section 86522, "only a person licensed or otherwise authorized under this article shall practice medicine or use the title "physician". It is vital that this regulation is respected for the advantage of our patients. **Failure in following this decree shall result in dismissal from the volunteering department.**

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. By signing this application, I certify that my answers are true and complete to the best of my knowledge.

SIGNATURE: _____

DATE: ___/___/___



WORKFORCE CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION ATTESTATION

This statement applies to all University Physicians of Brooklyn employees, physicians, volunteers, students, trainees, residents, interns, temporary personnel, consultants, contractors and any other workforce members.

University Physicians of Brooklyn is committed to protecting the privacy and confidentiality of health information about its patients while complying fully with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected health information is strictly confidential and should never be given, nor confirmed, to anyone who is not authorized under our policies or applicable law, statute, and/or regulation to receive this information.

University Physicians of Brooklyn workforce members should never remove protected health information from Downstate's premises. If protected information must be removed for the performance of your job duties, you are responsible for ensuring that all of the reasonable and appropriate safeguards, including those listed below, are implemented at all times.

Definitions:

Protected Health Information (PHI)- Any patient information, including very basic information such as their name or address, that (1) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual, and (2) either identifies the individual or could reasonably be used to identify the individual.

Our policies apply to protected health information in any form, including spoken, written or electronic form. It is the responsibility of every member of the hospital's workforce and medical staff to protect the privacy and preserve the confidentiality of all protected health information, whether onsite or offsite. This includes implementation of reasonable and appropriate safeguards at all times and compliance with the protective procedures below.

1. Public Viewing/Hearing

All University Physicians of Brooklyn workforce members are required to keep protected health information out of public viewing and hearing. Protected health information should not be left in conference rooms, out on desks or on counters or other areas where the information may be accessible to the public or to other employees who do not have a need to know the protected health information. University Physicians of Brooklyn workforce members must also refrain from discussing protected health information in public areas, such as elevators and reception areas. Curtains should be drawn in semiprivate patient rooms and treatment related discussions should be held in lower tones. University Physicians of Brooklyn workforce members must review the patient's record for documented patient restrictions or objections before sharing information with friends and family of the patient, even if the individual is at the patient's bedside.

2. Databases and Workstations

University Physicians of Brooklyn workforce members are required to exit any confidential database upon leaving their workstations so that protected health information is not left on a computer screen where it may be viewed by individuals who are not authorized to see the information. Monitors should never be facing a public view. University Physicians of Brooklyn workforce members are not to disclose or release to other persons any item or process which is used to verify their authority to access or amend protected health information, including but not limited to, any passwords, personal identification numbers, access cards or electronic signatures. Workforce members will be held responsible and accountable for all activities occurring under his/ her account. These activities may be monitored.

3. Downloading, Copying or Removing

University Physicians of Brooklyn workforce members are not to download, copy or remove any protected health information, except as necessary to perform their duties. All University Physicians of Brooklyn faculty and other workforce members are required to encrypt files, documents, and messages containing sensitive or confidential information for protection against unauthorized disclosure while in process, storage or transit. USB drives & portable devices that are not encrypted are only authorized for temporary storage or file sharing between authorized users while the drives/devices are on-site. Drives & portable devices may not be taken off-site without the data either being permanently deleted or encrypted in accordance with University Physicians of Brooklyn standards. Long term or permanent storage of University Physicians of Brooklyn related files on USB drives and portable devices must meet University Physicians of Brooklyn encryption standards. Portable devices include but are not limited to, laptops, notebooks, hand-held computers, tablets (i.e. iPads), Personal Digital Assistants (PDAs), smart phones, and USB drives. Upon termination of employment or contract with University Physicians of Brooklyn, or upon termination of authorization to access protected health information, workforce members must return any and all copies of protected health information in their possession or under their control. In addition, workforce members must ensure that all protected health information is disposed of in an appropriate manner, either by shredding or placing the PHI in assigned, secure bins. Health information stored in old PC's that are being removed must be properly and permanently deleted.

4. Emailing and Faxing Information

It is mandatory that only SUNY DMC Lotus Notes / Office 365 email messages be used for confidential communication purposes. Personal email accounts must never be used in the transmission of any PHI. University Physicians of Brooklyn workforce members are not to transmit protected health information over the Internet (including email) and other unsecured networks unless using the secure encryption procedure offered via Lotus Notes. Appropriate policies must be followed when faxing patient information, including using a cover sheet containing a confidentiality notice, ensuring that the fax machine is located in a secure location and verifying receipt with the intended recipient, when appropriate.

5. Curiosity/ Concern/ Personal Gain/ Malice

University Physicians of Brooklyn workforce members are not to access, review or discuss information for purposes other than their stated duties. Workforce members may not look up birth-dates, addresses of friends or relatives or review the record of a public personality. University Physicians of Brooklyn workforce members are not to access, review or discuss patient information for personal gain or for malicious intent.

6. Policies & Procedures

University Physicians of Brooklyn workforce members are required to adhere to all of University Physicians of Brooklyn’s HIPAA Privacy policies and procedures, including campus and department specific policies. All HIPAA Privacy policies can be located at www.downstate.edu/hipaa. The appropriate supervisor should be consulted if a workforce member is unsure how to proceed in a specific circumstance.

7. Training

University Physicians of Brooklyn workforce members are required to complete Downstate’s HIPAA training program within two (2) weeks of orientation.

8. Violations

Violators of this policy are subject to employment, civil and criminal penalties.

9. Reporting a Violation or Concern

All workforce members must report activities that may involve ethical violations or criminal conduct. Reports can be made to the Compliance Line: (877) 349-7869 – Toll Free, 24-hours-a-day, 7-days-a-week; or Click on the “Compliance Line” link at www.downstate.edu to make a report via the web.

I acknowledge that I have received University Physicians of Brooklyn’s Workforce Confidentiality of Protected Health Information Attestation and will abide by the policies and safeguards described herein.

Workforce Member Name

Workforce Member Signature

Date

History and Physical Examination Form for Volunteers



**University
Hospital of
Brooklyn**

***** INSTRUCTIONS *****

This form is to be filled out by the volunteer and the examining physician.

When complete, please bring this form in person to:
Employee/Student Health Services
440 Lenox Road, Suite #1S Brooklyn, NY 11203.
to receive your Medical Clearance Form.

SECTION 1: Profile Information

Soc Sec # - -

Last Name First Name

Birthdate Gender

Address Apt #

City State Zip Code

Home Phone#

SECTION 2: Contact Information

Emergency Name Emergency Phone #

Personal Physician Physician Phone #

SECTION 3: Medical History

Please describe any acute or chronic medical conditions and list all medication medications being taken

Do you have or have you had:

History of Mental Disorder	Y	N
Allergies to medications	Y	N
Allergies to foods or other substances	Y	N
History of/or present use of illegal drugs or alcohol	Y	N

Measles History	Y	N	<input type="checkbox"/> Disease	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Other	_____
If Vaccine please give date of dose(s)			DOSE 1 _____	DOSE 2 _____		
Mumps History	Y	N	<input type="checkbox"/> Disease	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Other	_____
If Vaccine please give date of dose(s)			DOSE 1 _____	DOSE 2 _____		
German Measles/Rubella History	Y	N	<input type="checkbox"/> Disease	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Other	_____
If Vaccine please give date of dose(s)			DOSE 1 _____	DOSE 2 _____		
Chicken Pox/Varicella History	Y	N	<input type="checkbox"/> Disease	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Other	_____
If Vaccine please give date of dose(s)			DOSE 1 _____	DOSE 2 _____		
Hepatitis B History	Y	N	<input type="checkbox"/> Disease	<input type="checkbox"/> Vaccine	<input type="checkbox"/> Other	_____
If Vaccine please give date of dose(s)			DOSE 1 _____	DOSE 2 _____	DOSE 3 _____	

SECTION 4: Physician's Statement

I have reviewed the medical history and examined the above named individual on date: _____
I certify that he/she is free of contagious disease and has no problem that might interfere with his or her ability to perform volunteer activities in a hospital setting. If there is a history of Positive PPD, I have performed a chest X-RAY within the last year and submitted the written report with this health form.

_____ Name of Physician (please print)	_____ Address	_____ State and License Number
_____ Signature of Physician	_____ Phone #	_____ Date



MOBILE DEVICE UNDERSTANDING FORM

I have read and understand the Downstate Health Sciences University Mobile Device Policy and its requirements, which include but not limited to:

1. Using responsible and appropriate safeguards at all times, including whether on-site or off -site, to protect the confidentiality and to prevent unauthorized access of Downstate Health Sciences University related data on mobile devices.
2. Using a least a four-digit password on my cell phone/smart phone if it is used in any way for Downstate Health Sciences University business.
3. Using USB drives and portable devices only for temporary on-site storage or sharing of ePHI between authorized users and deleting the information as soon as the business purpose has been accomplished. Patient images taken with a mobile device will be immediately uploaded to Downstate Health Sciences University network and the images will be deleted from the device before going off-site.
4. Not removing USB drives and portable devices containing ePHI from Downstate Health Sciences University premises unless the data is encrypted in accordance with Downstate Health Sciences University encryption standards.
5. Not transmitting ePHI over the Internet unless the data is encrypted in accordance with Downstate Health Sciences University encryption standards.
6. Not using USB drives and portable devices for long term or permanent storage of ePHI unless the drives and devices meet Downstate Health Sciences University encryption standards.
7. Keeping up to-date with security patches and updates for Mobile devices.
8. Properly disposing mobile devices when they are retired from use, including following Downstate Health Sciences University procedures for Downstate Health Sciences University issued devices.
9. Immediately reporting lost or stolen mobile devices that have been used for Downstate Health Sciences business in any way.
10. Immediately reporting a breach or potential breach of any mobile device that has been used for Downstate Health Sciences University business in any way, including unauthorized access to ePHI contained on the mobile device.

**** Reports should be made to the IT Service Delivery & Customer Support Center at extension 4357(HELP), to Downstate Health Sciences University Compliance Line at 1-877-349 SUNY or by making a web report by clicking the link "Compliance Line" on the bottom of Downstate Health Sciences University Webpage.**

I also understand that if I choose to use my personal mobile device to access Downstate Health Sciences University business purposes, all of the data on the mobile device (business and personal) may be deleted when deemed necessary by Downstate Health Sciences University management.

Workforce Member Name

Workforce Member Signature

Date