DOWNSTATE
HEALTH SCIENCES UNIVERSITY

DEPARTMENT OF VOLUNTEER AND COMMUNITY SERVICES
445 LENOX ROAD BROOKLYN NY 11203
Phone Office: (718) 270-2844
Volunteer@downstate.edu

VOLUNTEER APPLICATION INSTRUCTION

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 or Administrator.
   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 in-person from Employee/Student Health Services (440 Lenox Road, Suite #1S Brooklyn, NY 11203) 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.
   A Medical History Form is provided in this packet and must be filled out by your doctor, you must submit the completed form 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 or email the Acknowledgement form.
4. **Final Steps**: Complete the on-line curriculum course: **OCAS Training- Awareness**, and the micro- learning modules each focusing on specific compliance topics**: Compliance & HIPAA Basic**, **Conflicts of interest, Overview, Preventing Sexual Harassment**, NY State. A code will be requested for you once all of the above is submitted. The instructions to complete OCAS Compliance Training will be sent to you via email. 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.

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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 §6522, "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:** __/__/____

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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

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** 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 Health Services
440 Lenox Road, Suite #1S Brooklyn, NY 11203
to receive your Medical Clearance Form

SECTION 1: Profile Information

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 and Requirements

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

Do you have or have you had:

History of Medical 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 ○ ☐ **Disease** ☐ **Vaccine** ☐ **Titer** Date: _____
If vaccine please give date of dose(s) *DOSE 1* _____ *DOSE 2* _____

Mumps History Y ○ N ○ ☐ **Disease** ☐ **Vaccine** ☐ **Titer** Date: _____
If vaccine please give date of dose(s) *DOSE 1* _____ *DOSE 2* _____

Rubella History Y ○ N ○ ☐ **Disease** ☐ **Vaccine** ☐ **Titer** Date: _____
If vaccine please give date of dose(s) *DOSE 1* _____ *DOSE 2* _____

Varicella History Y ○ N ○ ☐ **Disease** ☐ **Vaccine** ☐ **Titer** Date: _____
If vaccine please give date of dose(s) *DOSE 1* _____ *DOSE 2* _____

TB / QuantiFERON Gold Test Y ○ N ○ **Date Placed:** _____ **Date Read:** _____
(Please provide documentation) **Result (Circle one) NEG / POS /** _____ **Induration**

SECTION 4: Physician's Statement

I have reviewed the medical history and examined the above 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

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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