THE VOLUNTEER SERVICE DEPARTMENT

Wyckoff Heights Medical Center's Volunteer Services Department is designed to assist the Medical Center with its mission of providing quality health care to the patients of the communities served.

Volunteers/Interns are consisting of male and female students, working and retired people of all ages, backgrounds, ethnicity, and academic level. They perform various services within the clerical and nursing floors throughout the entire hospital on a daily basis.

At Wyckoff Heights Medical Center, volunteers/interns provide a welcomed service and get the opportunity to meet new friends, learn new skills, and enjoy helping others.

PROCEDURES

1) The application consists of two letters of recommendation (one personal and one professional) completed by the potential Volunteer/Intern. **Volunteer must be at least 14 years of age. All volunteers under the age of 18 must have current working papers from their school and a signed parental consent.**

2) Call to schedule an interview with the HR/Volunteer Coordinator, **Ms. Larissa Rivera**, at **(718) 963-7110**

3) Complete the Medical Evaluation
- The Urine Drug Screening Test is done at *Wyckoff Heights Medical Center*
- The Medical Physical Form must be completed by your private doctor. If you will deny Flu vaccination, please speak with Larissa Rivera for declination form

4) The Criminal Background Check is conducted by Human Resources Department (18years or older)

5) You must attend a Mandatory Orientation (once a month)

6) Volunteers/Interns will be given a uniform and Identification Badge after making a $10.00 refundable deposit with the hospital's cashier

7) Volunteer/Interns are introduced to the supervisor of their assigned area, who will instruct the volunteer on their duties required

8) Each working day, volunteer/interns must sign in and out in the volunteer book located in the Volunteer Office, and a record of their hours will be kept

9) Volunteers/Interns must commit to 10 hours a week for 10 weeks, volunteers may exceed

GUIDELINES FOR ALL VOLUNTEERS/INTERNS

1. Submit all of the required information, as required by the policy and procedures
2. Once assigned to your department: *you are not allowed to change*
3. Sign the timesheet located in the Volunteer office daily

_____PL

EASE CONTACT THE VOLUNTEER OFFICE AT 718-963-7110, IF YOU ARE UNABLE TO ATTEND WORK.

_____

4. Keep the volunteer jacket clean and tidy
5. Wear I.D Badge and Jacket at all time during work hours
6. If any problems should occur you must discuss it with the volunteer office staff before approaching anyone else
7. Do not stay in the hospital pass 5:00PM, unless given authorize by the volunteer office
8. Free lunch will be provided up to $5.00, if you work 5 hours or more during one day. Otherwise, a thirty minute coffee break will be allowed
9. If you are unsure about your duties ask your supervisor/manager of your respective area or consult with the staff of the Volunteer Department

_____

Volunteers at Wyckoff Heights Medical Center are required to be Professional at all times. Anyone caught not adhering to the hospital Policy and Procedures will be subject to the *three stick rule*:

1) First Incident- Verbal Warning
2) Second Incident – Written warning that will be placed in your permanent file
3) Third Incident – Will result in suspension or permanent termination

All of the above mentioned actions will be construed to mean a lack of interest on your part. This could seriously impair the standing and efficiently of the Volunteer Services Department, and ultimately Wyckoff Heights Medical Center

_____

Print Name: _____

Signature: _____ Date: _____

Wyckoff Heights Medical Center
Dress Code
Attention All Volunteer

The Dress Code is business casual for all volunteers/interns at Wyckoff Heights Medical Center.

Examples of Business Casual attire are:
Business: Slacks, trousers, casual skirts, button down/polo shirts

When volunteering at Wyckoff Heights Medical Center please adhere to the dress code including the following:

1. *No shorts or skirts above your knees*
2. *No jeans, sweatpants or leggings*
3. *No sneakers, flip flops, sandals, or open toed shoes*
4. *No halter tops, tank tops, or shirts with oversized logos*
5. *No caps, hats, or sunglasses*
6. *No skin-tight, body-hugging, or revealing clothing*
7. *No I-Pods, or Phones while volunteering*
8. *No chewing gum*
9. *No smoking*
10. *No extremely long nails (1' from basic cuticle)*
11. *No scrub – unless authorized by the volunteer office*

We appreciate your cooperation
Volunteers/Interns who are not appropriately attired will be sent home.

Your appearance is very important!

Name: _____ Signature: _____

Wyckoff Heights Medical Center
VOLUNTEER APPLICATION

Please print neatly.

Date: _____

Name: _____ _____
Last *First*

Phone Number: ( )_____ Gender: *(circle)* Female or Male

Address: _____ Email Address: _____
_____ Social Security: ____-___-____
_____ Date of Birth: ____/____/_____

Marital Status: _____ Emergency Contact: *(below)*
1. Single___ 3. Married___ A. Name: _____
2. Divorced___4. Separated___ B. Relationship: _____
Spouse Name: _____ C. Phone Number: _____

School Currently Attending: _____
Highest Grade Completed _____ Most Recent GPA _____
Educational/Career Goal _____

Languages Spoken Fluently: _____

Any work experiences: _____
_____
_____
Any volunteer experiences: _____
_____

RESUME MAY BE ATTACHED

Have you ever been employed by or volunteered at WYCKOFF HEIGHTS MEDICAL CENTER? Yes __ No __
If yes please indicate: From ____ to ____ Department: _____
Reason for leaving: _____

Are you related to anyone employed by WYCKOFF HEIGHTS MEDICAL CENTER? Yes __ No __
If YES, please give details: _____

AVAILABILITY

Please indicate the times under the corresponding days you are available to volunteer.

Monday	Tuesday	Wednesday	Thursday	Friday

We realize our volunteers are often motivated by the desire to help others. How do you feel this experience will benefit you? (i.e. skills, preparation for future career goals, experiential learning)

_____
_____
_____
_____
_____
_____
_____

I hereby affirm that all information I have provided on this application is true and may be verified by WHMC.
Signature: _____ Date: _____

****

DEPARTMENT USE ONLY

Date: _____ Interviewer: _____

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Area Assigned _____

Professional Recommendation

To Whom It May Concern:

Miss/Ms./Mr._____ would like to be a volunteer in this hospital and has given your name as a personal reference. Your prompt reply to the following questions will be appreciated and will be confidential. Please return this form to us as soon as possible.

How long have you know the applicant? _____

In what capacity? _____

Do you believe the applicant would be a serious, reliable, and responsible volunteer? Yes/No, if yes please explain:_____
_____
_____
_____

In your opinion, would the applicant work well, and be helpful to the patients and staff?
_____
_____
_____

Additional Comments:
_____
_____
_____

Thank you for your cooperation.

Respectfully,
Larissa Rivera
HR/Volunteer Coordinator

_____ _____
Signature Please Print

Telephone #: _____
Address:
_____

Personal Recommendation

To Whom It May Concern:

Miss/Ms./Mr._____ would like to be a volunteer in this hospital and has given your name as a personal reference. Your prompt reply to the following questions will be appreciated and will be confidential. Please return this form to us as soon as possible.

How long have you know the applicant? _____

In what capacity? _____

Do you believe the applicant would be a serious, reliable, and responsible volunteer? Yes/No, if yes please explain:_____
_____
_____
_____

In your opinion, would the applicant work well, and be helpful to the patients and staff?
_____
_____
_____

Additional Comments:
_____
_____
_____

Thank you for your cooperation.

Respectfully,
Larissa Rivera
HR/Volunteer Coordinator

_____ _____
Signature Please Print

Telephone #: _____

Address:
_____

WYCKOFF HEIGHTS MEDICAL CENTER

HUMAN RESOURCES DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION
VOLUNTEER SERVICES

In connection with my application for Employment at Wyckoff Heights Medical Center, I hereby authorize the Medical Center to investigate any and all information I have provided therein and to contact my past employers and references.

I hereby release from any and all liabilities, all representatives, employees and Board of Trustees of the Wyckoff Heights Medical Center for acts performed in good faith and without malice in connection with evaluating my Application, my credentials and qualifications for employment.

I also hereby release from any and all liabilities, all individuals and organizations that provide information to the Wyckoff Heights Medical Center or it's staff in good faith and without malice, concerning my competence, character and other qualifications. I hereby consent to the release of such information.

_____ _____
(PRINT NAME) **Social Security Number**

_____
Date of Birth

Current Address: _____
_____
_____
_____

_____ _____
Date **(Signature)**

WYCKOFF HEIGHTS MEDICAL CENTER

Confidentiality and Safeguarding of Information

Every attempt must be made to safeguard the confidentiality of patient information. Care must also be taken to guard against invading the privacy of our employees. Access to information regarding individuals should be limited to those persons with a need to know this information. Any employee or agent of the hospital who engages in unauthorized access to or disclosure of information in violation of the privacy rights or our patients may be subject to discipline, up to and including immediate terminations, in addition to possible civil or criminal sanctions. Special confidentiality rules apply to medical information pertaining to mental health, substance abuse and HIV/AIDS. Reading or discussion of a patient or employee record for other than job-related reasons is prohibited.

Hospital business information also must be safeguarded. No employee shall use Hospital business information for his or her own benefit of others during the term of his or her employment or thereafter. This information includes the hospital's methods, processes, techniques, computer software or passwords, copyrights, research data, clinical information in possession of the Hospital which has not been published or disclosed to the general public.

Many of the Hospital's records serve as a basis for treatment decisions for its patients, or as documentation for billing purposes. Consequently, the proper and timely creation of accurate and complete records is a duty of each member of the Hospital community.

The Hospital is required to maintain certain types of medical and business documents for specific periods of time. Employees are expected to comply with the records retention and destruction schedules for their departments.

I acknowledge that I have received and read Wyckoff Heights Medical Center's policy on confidentiality and safeguarding information.

_____ _____

Signature **Date**

_____

Print Name

PLEASE READ CAREFULLY BEFORE SIGNING BELOW

I have read and fully understand the questions asked in this application. I certify that all of the information contained in this application is true, accurate and complete to the best of my knowledge and understand that any false, inaccurate or erroneous answers, omissions or statements made by me on this application, during an interview or in any other required documents shall be grounds for denial and/or discharge from volunteering. I authorize Wyckoff Heights Medical Center to make a thorough investigation including but not limited to my past employment, education, motor vehicle history, military, character, reputation and activities and release from liability all persons, companies or corporations supplying such information. I also agree to indemnify Wyckoff Heights Medical Center against any liability which may result from making such investigation and release all persons from liability for doing so.

If a volunteer/intern relationship is established, I authorize Wyckoff Heights Medical Center to make a thorough investigation including but not limited to my criminal history and release from liability all persons, companies or corporations supplying such information.

If a volunteer/intern relationship is established, I agree to notify Wyckoff Heights Medical Center in writing within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, exclusion from participation in any federal or state health care or procurement programs, any filed and served malpractice suit or arbitration action; any adverse action by a State Licensing Board taken or pending; any adverse action which has resulted in the filing of a report with the State Licensing Board; any revocation of DEA license; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I agree to notify Wyckoff Heights Medical Center in writing within five (5) days of receiving any written or oral notice of investigation that may result in adverse action by any duly authorized regulatory or enforcement agency of the State of New York or Federal Government.

I understand that any offer of volunteering is subject to satisfactory completion of a medical examination, which may include drug and alcohol screening that can be required as a condition of continued volunteering. I further understand that Wyckoff Heights Medical Center is committed to maintaining a “substance abuse free” environment for all of its volunteers and that should the medical evaluation reveal the presence of an illegal drug, misuse or abuse of a controlled substance or other substance which may alter or impair my behavior and/or ability to function, I will not be accepted into the Volunteer Services Department.

I understand that if a volunteer/intern relationship is established, it shall not be for a definite period and my volunteering can be terminated, for any reason or no reason at all, with or without notice, at any time, at the option of either Wyckoff Heights Medical Center or myself. I also agree that in the event of my volunteering with Wyckoff Heights Medical Center, I shall abide by all present and subsequent rules and regulations of Wyckoff Heights Medical Center.

_____ _____

Signature of Applicant Date

ADULT

Department of Volunteer Services
374 Stockholm Street
Brooklyn, NY 11237

PRIVATE PHYSICIAN MEDICAL RELEASE FORM

I authorize the release of the following medical information to the Department of Volunteer Services of Wyckoff Heights Medical Center.

_____ _____ _____
Volunteer's Name Date Volunteer's Signature

MEDICAL INFORMATION
PPD Test #1: (Accepted only if administered less than 1 year ago)
Date planted _____ Date read _____ Results _____

If PPD positive: Please attach a copy of the most recent chest x-ray report
Date of most recent x-ray report _____ Results _____

Rubella Titer: Level _____ Date _____ Immune? Yes No
If no, Rubella Immunization: Date administered _____

Rubeola Titer: Level _____ Date _____ Immune? Yes No
If no, Rubeola Immunization: Date administered _____

Varicella Titer: Level _____ Date _____ Immune? Yes No
If no, Varicella Immunization: Date administered _____

Mumps Titer: Level _____ Date _____ Immune? Yes No
If no, Mumps Immunization: Date administered _____

Hepatitis B Titer: Level _____ Date _____ Immune? Yes No
If no, Hepatitis B Immunization: Date administered _____

Flu Vaccination: Level _____ Date _____ Immune? Yes No

To the best of your knowledge, does this applicant have any physical or emotional disabilities we should consider prior to placement? [ ] Yes [ ] No
If yes, please explain: _____

In compliance with the NYS Health Code, I examined the applicant and found him/her to be free of any health impairments that would pose a potential risk to patients and hospital personnel or which may interfere with his/her responsibilities as a volunteer.

_____ _____
Physician's Name _____
_____

_____ _____ _____
Physician's Signature Date Physician's address & telephone