

# ROME

MEMORIAL HOSPITAL

*Total commitment. Total care.*

Dear Volunteer Applicant:

Thank you for your interest in volunteer work at Rome Memorial Hospital. We have need for volunteers in both clinical and non-clinical areas. Some volunteer job titles are included in the next page.

The New York State Department of Health requires that we have the following health information on file for all volunteers. You are required to provide this to us:

1. Your immunization record showing that you have had two (2) shots for Measles, Mumps, Rubella (MMR), or if you were born before 1956, proof of immunity to Rubella.

\*\* If you can not find proof of your MMR, PLEASE contact the Volunteer Office first before ANY tests are done.

2. A copy of a Medical Health Physical done within one (1) year.
3. A Mantoux (TB) test done within one year.
4. A copy of your working papers if you are under the age of 18.

I have also enclosed a copy of our volunteer application. When you have all the above information together, or if you have questions, please call me at (315) 338-7134 to set up an appointment for an interview.

**\* Please be aware that Rome Memorial Hospital is a tobacco-free campus. Smoking is prohibited in all areas owned, leased and operated by Rome Memorial Hospital, including parking lots.**

Sincerely,

Juliana H. Chrysler, M Ed.  
Volunteer Coordinator

Encl.

# Volunteer Application

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Email address: \_\_\_\_\_

Cellphone # \_\_\_\_\_

Person to notify in case of an emergency

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone # \_\_\_\_\_

Type of work you are volunteering for? Adult \_\_\_\_\_ Student \_\_\_\_\_

- Patient care (visiting, delivering meals, transporting by wheelchair / stretcher)
- Assisting in the Residential Health Care Facility (RHCF)
- Student volunteer hours (specify below , IE Gov't class, PHP, New Ventures, BOCES)
- Other \_\_\_\_\_

Special skills or interest you have (e.g. clerical, patient care, computer, crafts etc.):

\_\_\_\_\_  
\_\_\_\_\_

Do you have a preference as to the department / area of assignment Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give preference(s): \_\_\_\_\_

**Please circle** the days you wish to volunteer: Mon Tues Wed Thurs Fri Sat Sun

Hours of the day you wish to volunteer: \_\_\_\_\_

Why do you want to volunteer at Rome Memorial Hospital ? \_\_\_\_\_

\_\_\_\_\_

Have you volunteered before? YES NO If yes, where? \_\_\_\_\_

Have you ever been convicted of a felony? \_\_\_\_\_

Were you referred to us? By Individual? \_\_\_\_\_ Agency? \_\_\_\_\_

Do you have any special needs we should be aware of in order to accommodate you in your volunteer status?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Please list 2 people to be contacted as a reference, i.e. Teacher, employer, friend, co-worker, an adult other than a parent or spouse.

**References:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Rome Memorial Hospital

Physical Examination Report for Volunteers

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Ht. \_\_\_\_\_ Wt: \_\_\_\_\_ B/P: \_\_\_\_\_

Vision: \_\_\_\_\_ Left: \_\_\_\_\_ Right: \_\_\_\_\_

Immunizations: MMR: 1 \_\_\_\_\_ 2 \_\_\_\_\_

\_\_\_\_\_ Mantoux \_\_\_\_\_ Results \_\_\_\_\_

Influenza Vaccine date: \_\_\_\_\_ H1N1 vaccine date: \_\_\_\_\_

Review of Systems:

Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_

Teeth/Gums \_\_\_\_\_ Cardiac \_\_\_\_\_ Lungs \_\_\_\_\_

GI \_\_\_\_\_ GU \_\_\_\_\_ Skin \_\_\_\_\_

Musculoskeletal \_\_\_\_\_ Nutrition \_\_\_\_\_ Nervous System \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

Limitations: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Summary: I have examined the patient and found him/her \_\_\_able \_\_\_unable to participate in volunteer activities at Rome Memorial Hospital. He/she is free of communicable diseases and addictions to drugs/alcohol.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date