NEW VOLUNTEER INFORMATION PACKET

Thank you for your interest in the volunteer program at Niagara Falls Memorial Medical Center. Enclosed are all the materials you will need to get started.

1. Complete the APPLICATION & CONSENT AND DISCLOSURE FORMS. Return these completed forms to the Volunteer Office at Niagara Falls Memorial Medical Center. Make sure you have read and signed the agreements. You can use the List of Volunteer Services Opportunities to help you select your area of preference.

2. Give your doctor the VOLUNTEER HEALTH FORM to complete and return.

3. Call the Volunteer Service Department at 278-4440 to make an appointment for an interview after the application, health form and consent/disclosure form have been completed.

4. If an appropriate assignment is available, you will be given an orientation and issued a volunteer uniform.

FOR MORE INFORMATION, PLEASE CALL:
JUDY VILLANI, DIRECTOR OF VOLUNTEER SERVICES @ 278-4440
EMAIL: Judy.Villani@nfmmc.org

Niagara Falls Memorial Medical Center
621 Tenth Street, Box 708
Niagara Falls NY 14302
Volunteer Service Application

Name: __________________________ Telephone: ___________ D.O.B. ___________

Address: _______________________________________________________________

City: __________________________ State: ______ Zip: __________

E-Mail Address: _________________________________________________________

In Case of Emergency Notify:

_________________________________ Relationship: ______ Telephone: ___________

Background:

How did you become interested in our volunteer program? ________________________________

Do you have previous volunteer experience? Yes No
If yes, where? ________________________________

What type of work experience have you had? ___________________________________________

Do you have any special skills or hobbies? Yes No
If yes, What? ________________________________

Do you speak a foreign language? Yes No
If Yes, What language? __________________________________________________________

Education:

Are you currently enrolled in school? Yes No If yes, give name of school ________________

Is volunteer work a requirement for school credit? Yes No
If yes, how many hours are needed for credit? _______________________________________

Medical History:

Do you have any physical limitations which should be considered in your volunteer assignment? Yes No
Please explain: _______________________________________________________________________

Family Doctor: __________________________ Telephone: _____________________________

Pagemaker/volapplication.08/05.pnt5
Placement Information:

What day(s) would you be available to volunteer? Please Circle Day(s):

SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

Would you be willing to work more than one day a week? Yes No

What time do you prefer to work? MORNING AFTERNOON EVENING

What type of placement interests you? (Please see attached list.)

First Choice ___________________________________________

Second Choice _________________________________________

Third Choice _________________________________________

How long do you plan to volunteer with us? ____________________________

Reference: Please list two persons who could recommend you to the volunteer program. (Current volunteers, your doctor, employer, your clergyman, etc.).

Name: ______________________________________ Phone: __________________________

__________________________________________ ________________________________

Employment History
Give past employment record as completely as possible. Start with the more recent employer.

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<th>Name of Employer</th>
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<th>Dates</th>
<th>Phone # of Employer</th>
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Have you ever been convicted of a crime? Yes No If yes: Date: __________________________

Where convicted:
Nature of Charge:
Disposition:

Release: I hereby declare that all the above statements are true and correct to the best of my knowledge, and authorize the Niagara Falls Memorial Medical Center to inquire into all matters contained in this volunteer application. I understand that I may be rejected as a volunteer and may be discharged for falsifying information contained in this volunteer application.

Signature: ___________________________ Date: ___________________________
Volunteer Health Form

DOCTOR OR HEALTH SERVICES NURSE SECTION

Dear Doctor or Health Services Nurse:

The New York State Health Department and Niagara Falls Memorial Medical Center (NFMMC) policy require that we have the following medical history recorded for each volunteer before he/she becomes an active volunteer. As an active volunteer, he/she may be assigned to work directly with patients and could be performing a variety of tasks. These tasks may include pushing patients in wheelchairs & carts, lifting moderate loads, running errands, standing or driving a van.

This section must be completely filled out by the applicant's doctor or nurse to ensure that the volunteer (applicant) is free of communicable diseases, and that the applicant is physically able to perform the tasks outlined. All information is required to volunteer at NFMMC.

Applicant's Full Name: ____________________________, Date of Birth: ________________

The applicant is in general good health and is free from communicable disease? __ Yes ___ No
If no, please explain:______________________________________________________________

List any restrictions:______________________________________________________________

Two MMR Injections are required for anyone born since January 1, 1957. If two MMR Injections were not given, please provide other proof of immunity:

Date of first MMR: ____________________________ (after 12 months of age)
Date of second MMR: ____________________________
Other proof of immunity: __________________________________________________________

Date of last Diphtheria-Tetanus (must be within last 10 years): ____________________________

Applicant has had CHICKENPOX? ___ Yes ___ No ___ Unknown

Doctor or Health Services Nurse Signature: ____________________________

Print name of person completing the form: ____________________________________________
Address:______________________________________________________________________
City/State/Zip: ________________________________________________________________
Phone:______________________________________________________________________

Do not write in the section below: NFMMC Employee Health Nurse Only

An annual PPD test is required for all volunteers at NFMMC. The PPD test will be administered by the Employee Health Nurse without charge to the volunteer each year.

Emp. Health Nurse: ____________________________ Previous Positive: ___ Yes ___ No
Lot Number: ____________________________, Expiration Date: ____________________________ Manufacturer: ____________________________
Date of PPD Test: ____________________________, Result: ____________________________, Date PPD Test Read: ____________________________

Please return to: Director of Volunteer Services
Niagara Falls Memorial Medical Center
621 Tenth Street, Niagara Falls, NY 14302 FAX: 278-4614
BACKGROUND INVESTIGATION AUTHORIZATION

In connection with my employment, application for employment, or promotion with Niagara Falls Memorial Medical Center, I understand that background inquiries may be requested by you, or on your behalf, that will seek information as to my character, work habits, including oral assessments of my job performance, experiences and abilities, along with reasons for termination of past employment. Further, I understand and agree that you may request information from various federal, state, and other agencies, including public and private sources which maintain records concerning my past activities relating to my driving record, criminal record, credit history, civil matters, previous employment, education background, professional licensing, as well as other experiences.

I acknowledge that a telephone facsimile or copy of this release shall be as valid as the original. This authorization is valid for any consumer report requested at any time during the tenure of my employment. This release is valid for all federal, state, county and local agencies and school authorities. I understand that I have the right to make a written request within a reasonable period of time for complete and accurate disclosure of information concerning the nature and scope of this investigation. I also voluntarily release my date of birth for my own benefit and fully understand that age is not a consideration on assessing my qualifications for employment.

Print Name

DOB ________________________________ Soc. Sec. No. ________________________________

Drivers license # (if applicable) ________________________________ State ________________

Current Address ________________________________ City ________________________________ State ________________ Zip ________________

List Previous addresses and names (Maiden and/or aliases) used during the past 7 years
Name (if applicable) ________________________________ Address ________________________________ City, State, Zip ________________ County ________________

Notice to NEW YORK Applicants: Under Article 25 Section 380-g of the New York General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

Please initial here to acknowledge receipt of Article 23-A of the New York Correction Law.

Applicant Signature ________________________________ Date ________________