



**ERIE COUNTY MEDICAL CENTER  
CORPORATION**

**Department of Volunteer Services  
716-898-3266**

Dear Prospective Volunteer:

Thank you for expressing an interest in becoming a volunteer at the Erie County Medical Center Corporation. Enclosed is an application for you to fill out and a form to be completed by your physician including an up-to-date immunization record.

When you are ready to submit these materials, please call to schedule an interview by calling (716) 898-3266. At the interview, we will discuss what you hope to gain from your volunteer experience and what volunteer opportunities are available.

Please be aware that you will be expected to consent to and pass a criminal background check and drug and alcohol screening tests if you are offered a position as a volunteer. You will need to provide **picture ID and a social security number** in order to have these checks completed.

I look forward to working with you to better serve the patients and families at ECMCC.

Sincerely,

Kathi Mitri  
Volunteer Coordinator



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Health Assessment \_\_\_\_\_  
Orientation \_\_\_\_\_  
Start Date \_\_\_\_\_  
Location \_\_\_\_\_

Date: \_\_\_\_\_

Application for :       Volunteer       Student Intern       Community Service

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

**In case of emergency, please notify:**

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

**Are you 18 years old or older?**      **If no, what is your birth date?**      **Are you a US citizen?**

Yes  No  Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_      Yes  No

**Please answer the following questions:**

Why are you interested in volunteering at ECMCC? \_\_\_\_\_  
\_\_\_\_\_

If you are interested in a particular area or assignment, please indicate your preferences: \_\_\_\_\_  
\_\_\_\_\_

Are there any physical limitations that might affect your volunteer work? \_\_\_\_\_  
\_\_\_\_\_

Please list all previous volunteer experience: \_\_\_\_\_  
\_\_\_\_\_

Do you have any special interests or talents? \_\_\_\_\_  
\_\_\_\_\_

**EDUCATION:**

Are you currently in school? Yes  School: \_\_\_\_\_ Major: \_\_\_\_\_  
No

Are you volunteering to fulfill a school requirement? Yes  No   
If yes, number of hours needed \_\_\_\_\_  
Name of contact school person: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMPLOYMENT:**

Are you currently employed? Yes  If yes, your title: \_\_\_\_\_  
No  Employer: \_\_\_\_\_  
Address: \_\_\_\_\_

**REFERENCES:**

**Please list one employment or educational reference:**

Company Name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/Town/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Your title or Position: \_\_\_\_\_ Years employed: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

**Please list one personal reference (not a relative):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Town/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Signature:		Date:	
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Please return to:

Erie County Medical Center Corporation  
Department of Volunteer Services  
462 Grider St.  
Buffalo, NY 14215

Director:

Kathi Mitri  
Volunteer Coordinator  
716-898-5337  
kmitri@ecmc.edu



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Dear Health Care Provider:

As a requirement for volunteering in a health care facility in New York State, each prospective volunteer must meet pre-employment health standards. Kindly complete this form for your patient who is seeking such an opportunity at the Erie County Medical Center Corporation. Thank you.

Sincerely,

Kathi Mitri, Volunteer Coordinator

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Is this person in general good health and free from communicable disease?  
Yes  No  (Please comment on reverse side)

2. Date of last exam: \_\_\_\_\_

3. Rubella immunization Date: \_\_\_\_\_

or

Rubella antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

4. For those born after December 31, 1956:

Rubeola (measles) immunization dates: 1<sup>st</sup>: \_\_\_\_\_ 2<sup>nd</sup>: \_\_\_\_\_

or

Rubeola (measles) antibody test results: \_\_\_\_\_ Date: \_\_\_\_\_

5. TB skin test (PPD):

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Results: \_\_\_\_\_

or

Known prior positive test; PPD skin test not performed.

6. Diptheria/tetanus Date: \_\_\_\_\_

7. OPTIONAL

Hepatitis B vaccine Dates: 1<sup>st</sup>: \_\_\_\_\_ 2<sup>nd</sup>: \_\_\_\_\_ 3<sup>rd</sup>: \_\_\_\_\_

Other (Specify): \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Examining Provider:** \_\_\_\_\_

Print or Stamp Name: \_\_\_\_\_ Date: \_\_\_\_\_