Department of Volunteer Services
PH: 716-898-3266
FAX: 716-898-4358

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 medical form to be completed by your health care provider including an up-to-date immunization record. This medical form must be completed **in full and signed by your health care provider.**

When you are ready to submit these materials, please call to schedule an interview by calling (716) 898-3266. You will bring all your paper work to your interview. 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 government issued **picture ID and a social security card or 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

Health Assessment_____
Orientation_____
Start Date_____
Location_____

Volunteer Services

716-898-3266

Date: _____

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?

Yes ☐ No ☐

If no, what is your birth date?

Month_____ Day_____ Year_____

Are you a US citizen?

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:	

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

716-898-3266

Department of Volunteer Services

Fax# 716-898-4358

Department of Volunteer Services
716-898-3266
Fax# 716-898-4358

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 and sign this form for your patient. Thank you, 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. Rubeola (measles) immunization dates: 1st:_____ 2nd:_____
   or

   Rubeola (measles) antibody test results:_____ Date:_____
5. Mumps immunization Date:_____2nd_____
   or
   Mumps antibody test results:_____ Date:_____
6. Varicella immunization Date:_____2nd_____
   or
   Varicella antibody test results:_____ Date:_____
7. TB skin test (PPD):

   Date:_____ Type:_____ Results:_____
   or
   ☐ Known prior positive test; PPD skin test not performed. Chest X-ray WNL. No signs and symptoms of active TB.
8. Diphtheria/tetanus Date:_____
9. Influenza Vaccine Date: _____ Lot #_____ Expiration Date:_____

10. OPTIONAL

Hepatitis B vaccine Dates: 1st:_____ 2nd:_____ 3rd_____
Other (Specify):_____ Date:_____

Signature of Examining Provider:_____

Print or Stamp Name:_____ Date:_____