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.

CORPORATION

Volunteer Services
PH: 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 (If no, Please comment on revise side)

2. Date of last physical exam: _____/_____/_____ (must be in the last 12 months)

3. Tuberculin Skin Test in previous 12 months

Date of test ____/____/____ Type: _____ Result (circle one) Positive or Negative

Check if known prior positive TST test, treatment dates and latest x-ray date/ result _____

4. Measles/Mumps/Rubella (MMR)

Two doses after 12 months of age…….Dates____/____/____ & Dates____/____/____

OR Measles (Rubeola) – one option must be met:

□ Two immunizations after 12 months of age ……..……Dates___/___/___ & ___/___/___ **OR**

□ Blood titer documenting immunity…….……Date of test___/___/___

AND Mumps – one option must be met:
□ Two Immunization after 12 months of age……Dates ___/___/___ & ___/___/____

OR

□ Blood titer documenting immunity……Date of test ___/___/___

AND Rubella (German Measles) – one option must be met:
□ Immunization after 12 months of age……Date___/___/___ **OR**

□Blood titer documenting immunity……Date of test ___/___/___.

5. Varicella (Chickenpox or Shingles) – one option must be met:

□ Immunizations……Dates___/___/___ & ___/___/___ **OR**

□ Blood titer documenting immunity……Date of test ___/___/___

6. <u>OPTIONAL (not required)</u>: Hepatitis B – one option must be met:

□ Vaccine – Series of three……Dates___/___/___ & ___/___/___ & ___/___/___ **OR**

□ Positive Hepatitis B Antibody Test……..…Date of test___/___/___

7. Tetanus Pertussis-Diphtheria series as a child AND

Tetanus-Diphtheria booster less than 10 years ago…….……Date___/___/___

8. Influenza Vaccination (seasonal)

□ Immunization ……..…Date___/___/___

Signature of Examining Provider: _____ Date: ____/____/____

Print or Stamp Name: _____