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 cannot 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.

I have also enclosed a copy of our volunteer application. When you have all the above information together, please forward to me by fax or mail. My contact information is below. If you have questions, please call me at (315) 338-7134 to set up an appointment for an interview.

Sincerely,

Juliana H. Chrysler, M Ed.
Volunteer Coordinator
Rome Memorial Hospital
1500 N. James Street
Rome, NY 13440

Phone #:315-338-7134
Fax #: 315-338-7526

Encl.

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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?

☐ 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, spouse or other relative.

References:

Name_____

Address _____

Telephone_____

Name_____

Address _____

Telephone_____

_____ _____
Signature Date

*** 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.**

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: _____

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**