

# VOLUNTEER APPLICATION

Year \_\_\_\_\_ Name \_\_\_\_\_

Proof ☐ PPD shot      \*\* Orientation \_\_\_\_\_

☐ Covid Vaccination      Notes: \_\_\_\_\_

☐ Booster \_\_\_\_\_

☐ Flu shot \_\_\_\_\_

Initials/entered \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ date



Livingston County Center for  
Nursing and Rehabilitation  
11 Murray Hill Dr.  
Mt. Morris, NY 14510  
Peter Donlon, Leisure Time Activities Director  
(585) 243-7222  
pdonlon@co.livingston.ny.us

## Volunteer Requirements

Here is what you need to do to become a volunteer:

- Complete an annual personal and confidential health screening with our nurse, including a tuberculosis skin test (PPD)
- Fill out this Volunteer application complete, and return it.
- Once your application is received, the activity director or designee will contact you to schedule an interview.
- You will have to attend an orientation
- You need to be at least 14 years old with parental consent form up until 16 years old. (See last page)



## **Volunteer Application**

Name \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell # \_\_\_\_\_

### **EMERGENCY CONTACT**

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell # \_\_\_\_\_

#### **Day(s) and time preference(s):**

Morning: \_\_\_\_\_ Afternoon: \_\_\_\_\_ Evenings: \_\_\_\_\_  
Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_  
Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

### **Areas of Opportunities:**

- \_\_\_\_ Friendly visitor / 1:1 resident visits
- \_\_\_\_ Assisting Activity staff with programs
- \_\_\_\_ Playing cards/ board games
- \_\_\_\_ Assisting residents with simple computer tasks (email, skype)
- \_\_\_\_ Transporting residents to activity programs, special events, Religious programs and/or in-house appointments
- \_\_\_\_ Gardening, tending & watering flower pots throughout center
- \_\_\_\_ Assist residents during scheduled shopping trips
- \_\_\_\_ Taking residents for walks or push wheelchair
- \_\_\_\_ Assist with volunteer clerical support
- \_\_\_\_ Conduct a resident class in painting, ceramics, crafts, reading group.
- \_\_\_\_ Resident Craft Club (Sunday Afternoons)
- \_\_\_\_ Other \_\_\_\_\_



## Health Screen for Volunteers

### **COVID 19 Vaccination**

(Please provide a copy of your card)

1<sup>st</sup> date \_\_\_\_\_ 2<sup>nd</sup> date \_\_\_\_\_

Booster \_\_\_\_\_ Brand: \_\_\_\_\_

Name \_\_\_\_\_

**This volunteer had a Mantoux/PPD on \_\_\_\_\_ at the Livingston County Center for Nursing and Rehabilitation. Mantoux/PPD site \_\_\_\_\_ done by \_\_\_\_\_**

**Please read and record results and sign.**

**Results \_\_\_\_\_ Signature \_\_\_\_\_**

Have you ever been treated for or had an indication of any of the following since your last health assessment? Please indicate YES or NO—if yes please explain.

- A. Food or drug allergies Yes or No \_\_\_\_\_
  - B. Heart trouble, chest pain, high blood pressure or abnormal pulse Yes or No \_\_\_\_\_
  - C. Nervous or mental disorder, severe headaches Yes or No \_\_\_\_\_
  - D. Pleurisy, Chronic cough, spitting of blood Yes or No \_\_\_\_\_
  - E. Diabetes, sugar in Urine Yes or No \_\_\_\_\_
  - F. Arthritis, Rheumatism, Back or Spine disorder Yes or No \_\_\_\_\_
  - G. Hernia Yes or No \_\_\_\_\_
  - H. Impaired vision or hearing Yes or No \_\_\_\_\_
  - I. Have you had surgery? Yes or No \_\_\_\_\_
  - J. Have you used sedatives or narcotics habitually or had treatment for a drug habit or alcoholism? Yes or No \_\_\_\_\_
  - K. Have you recently had a close association with anyone having TB and/or other infectious diseases? Yes or No \_\_\_\_\_
  - L. Do you take medications routinely? Yes or No \_\_\_\_\_
  - M. Have you ever had an abnormal x-ray or electrocardiogram Yes or No \_\_\_\_\_
  - N. Rash or other skin conditions? Yes or No \_\_\_\_\_
  - O. Do you have any reason to believe you are not in excellent health? Yes or No \_\_\_\_\_
- Further explanation(s) \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The forgoing report is an accurate summary of my health assessment to the best of my knowledge

Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_



## **Volunteer Confidentiality Agreement**

I understand that Federal Law requires the Center to protect health information and the personal privacy of its' Residents. The Health Insurance Portability and Accountability Act (HIPAA) provides these protections.

I understand that any and all information I may acquire as a volunteer concerning Residents, Center and Personnel must be held in strict confidence.

As represented by my signature below, I agree to comply with HIPAA requirements. I understand that I will be removed from the volunteer program if I am found to have violated these requirements.

Name \_\_\_\_\_ Date \_\_\_\_\_  
Signature \_\_\_\_\_



**ACTIVITIES**  
**CONSENT FORM FOR MINOR VOLUNTEER**

I, \_\_\_\_\_, Parent/ Guardian of \_\_\_\_\_

Hereby give my consent for my son/daughter to participate in the **Livingston County Center for Nursing and Rehabilitation** volunteer program.

I understand my son/daughter will provide (    ) hours of service per week and will participate only in the following activities:

- \_\_\_ Friendly visitor / 1:1 resident visits
- \_\_\_ Assisting Activity staff with programs
- \_\_\_ Playing cards/ board games
- \_\_\_ Assisting residents with simple computer tasks (email, skype)
- \_\_\_ Transporting residents to activity programs, special events, Religious programs and/or in-house appointments
- \_\_\_ Gardening, tending & watering flower pots throughout center
- \_\_\_ Assist residents during scheduled shopping trips
- \_\_\_ Taking residents for walks or push wheelchair
- \_\_\_ Assist with volunteer clerical support
- \_\_\_ Conduct a resident class in painting, ceramics, crafts, reading group
- \_\_\_ Other \_\_\_\_\_

In case of an Emergency please contact:  
(PLEASE PRINT)

1) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (    ) \_\_\_\_\_

2) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(    ) \_\_\_\_\_

3) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(    ) \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian      Date \_\_\_\_\_

