VOLUNTEER APPLICATION

Livingston County Center for
Nursing and Rehabilitation
11 Murray Hill Dr.
Mt. Morris, NY 14510
Kim Kavanagh, Leisure Time Activities Director
(585) 243-7222

Volunteer Application

Name____
Address_____________________________ Phone #_______________________
City______________ State____ Zip______ Home or Cell

EMERGENCY CONTACT

Name_________________________ Relation ___________________
Address_____________________________ Phone #_______________________
City______________ State____ Zip______ Home or 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.
___ Other:____
____

Health Screen for Volunteers

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______________________