Dear Prospective Volunteer,

Thank you for your interest in volunteering for Kaleida Health. In joining our team, you will perform a vital service by helping our staff provide the best care to our patients.

All of Kaleida Health’s volunteer activities are coordinated through our Volunteer Services offices located at:

**Buffalo General Medical Center**  
100 High Street, Buffalo, NY 14203  
Fr. Richard Augustyn, 859-2603, 859-1625 (fax)  
email: raugustyn@kaleidahealth.org

**DeGraff Memorial Hospital**  
445 Tremont Street, North Tonawanda, NY 14120  
Jessica Krol, 568-3820, 690-2187 (fax)  
email: jkrol@kaleidahealth.org

**Millard Fillmore Suburban Hospital**  
1540 Maple Road, Williamsville, NY 14221  
Jessica Krol, 568-3820, 568-3832 (fax)  
email: jkrol@kaleidahealth.org

**Women & Children’s Hospital of Buffalo**  
219 Bryant Street, Buffalo, NY 14222  
McKenzie Mattison, 878-7241, 878-7653 (fax) email: mmattison@kaleidahealth.org

If you would like to be considered for a volunteer position at Kaleida Health, please complete the attached forms (checklist provided below) and contact the volunteer office of the site in which you are interested.

- Application
- Volunteer Availability Form
- Recommendation Form (APPLICANTS UNDER 18 ONLY)
- High School students must also supply Working Papers (APPLICANTS UNDER 18 ONLY)
- Background Check Disclosure & Consent Form (APPLICANTS 18+ ONLY)
- Physical Exam Form (Health Screening must be completed by personal physician with documentation of MMR and two-step PPD – must have been performed within the last year)

After completing the required paperwork, you may be considered for assignment at one of our sites. We will make every effort to match your volunteer assignment with your skills, your interests, and your schedule. If considered, we will contact you for a personal interview, and once a final decision is made, you must complete a required physical from your personal physician (including documentation of MMR and two-step PPD). Once this requirement is completed, you will attend a mandatory orientation at your site. On-the-job training is also provided under the supervision of department staff or an experienced volunteer.

Thank you for your interest in volunteering for Kaleida Health. We hope to hear from you soon!

Sincerely,

The Volunteer Managers of Kaleida Health
Volunteer Application
(Please print clearly)

Check one: □ Buffalo General Medical Center □ DeGraff Memorial Hospital □ Millard Fillmore Suburban Hospital □ Women & Children’s Hospital of Buffalo

Mr./Mrs.
Miss/Ms.

__________________________________________________________________________
Last Name First Name Middle Initial

Address
__________________________________________________________________________
Number & Street
City State Zip
Telephone, Home

E-mail
__________________________________________________________________________
Telephone, Cell

What is the best way to reach you? □ Home □ Work □ Cell □ E-mail

Name of Employer
__________________________________________________________________________
Telephone, Work

Business Address


Work Experience

Volunteer Experience

Education/Special Training/ Certifications

Hobbies/Interests/Skills


Have you ever been convicted of a crime? □ Yes □ No If “Yes,” explain when, where, and disposition of case.

__________________________________________________________________________

***It is your responsibility to self-report any future infractions to your immediate supervisor as soon as they occur.***

Why did you decide to volunteer at Kaleida Health?

__________________________________________________________________________

How did you learn about our program?

__________________________________________________________________________

Is volunteer work a requirement for school credit? □ Yes □ No If so, what number of hours are required?

School Name
__________________________________________________________________________
Grade

Physical and Medical Background

Do you have any physical condition or medical problem which may limit your ability to perform the work of a volunteer? □ Yes □ No

If “YES” please explain.

__________________________________________________________________________
In case of an emergency, please notify:

Name: ____________________________________________________________
Relationship: ______________________________________________________
Phone, Home: __________________________ Work: __________________________ Cell: __________________________

• The Volunteer Service Department is not obligated to provide a placement, nor are you obligated to accept the placement offered. Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.

• Your Volunteer Services Manager reserves the right to terminate your volunteer status if expectations are not met.

• I agree that the above information is correct as of the date it has been filed. I also agree to the rules, regulations, and policies of the Volunteer Department of Kaleida Health.

Signature of Applicant: ____________________________________________ Date: __________________________

Parental Consent for Program Participation (required if applicant is under 18)

I give consent to my child's participation in the Kaleida Health Student Volunteer Program. I authorize Kaleida Health to give emergency medical treatment to my son/daughter. I understand that I am also consenting to the administration of a intradermal tuberculin skin test (if needed) as required by NYS Dept. of Health (PPD). I agree that the above information is correct as of the date it has been filed.

Signature of Parent/Guardian: ______________________________________ Date: __________________________

*** For Office Use Only ***

Date Received: __________________________ Volunteer Number: __________________________

Training: __________________________ Interview Date and Time: __________________________

Department: __________________________ Day/Time: __________________________

TB Test Taken: __________________________

Picture Taken: __________________________
Volunteer Availability Form
(Please print clearly)

Name: .................................................................................................................................

Address: .............................................................................................................................

Home Phone: ................................................................. Cell Phone: ................................

Work Phone: ............................................................... Email Address: ................................

STUDENTS: Please discuss this schedule with your parents and consider your transportation needs and work schedule BEFORE completing this form.

Please provide 3 instances of availability by placing check marks (✓) in the calendar below.
(Shift times may vary by site.)

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<td>8:00 a.m. - 12:00 p.m.</td>
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<td>12:00 p.m. - 4:00 p.m.</td>
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<tr>
<td>4:00 p.m. - 8:00 p.m.</td>
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</table>

Please check your areas of interest:

☐ Book Cart (WCHOB only)  ☐ Long-Term Care Support (HighPointe & DeGraff only)
☐ Office Support  ☐ Patient Interaction
☐ Errands/Escort  ☐ Pharmacy Support
☐ Greeter  ☐ Spiritual/Pastoral Care
☐ Information/Waiting Area  ☐ Other .................................................................
☐ Women’s Board/Auxiliary

Kaleida Health
Thank you for your invaluable help in selecting suitable candidates for this community hospital program. Please mail this form directly to the hospital in the envelope provided by the applicant. Please be certain to sign this form and list your telephone number should we wish to contact you.

1. Name of applicant: ____________________________

2. How long have you known this applicant? ____________________________

3. Does the applicant have the willingness to learn and then follow through and do a job thoroughly? □ Yes □ No

4. Is he/she apt to drop out of the program before its completion? □ Yes □ No

5. Is the applicant responsible and dependable? □ Yes □ No

6. Can he/she work independently? □ Yes □ No

7. Does he/she have a good attitude toward the community which will be reflected within the hospital? □ Yes □ No

8. Do you think this applicant will be an asset to the Student Volunteer Program, offering his/her service to help others while learning about hospital careers? □ Yes □ No

Additional comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature ____________________________ Telephone No. ____________________________

Relationship to Applicant ____________________________ Date ____________________________
Disclosure Form:

KALEIDA HEALTH May Procure Consumer Reports
(Applicants 18+ Only)

I acknowledge that I have been provided with a document called "Disclosure Concerning Consumer Reports". The disclosure states that KALEIDA HEALTH may obtain consumer reports pertaining to me, for employment purposes now or in the future. It is contained in a separate document that consists solely of the disclosure. The disclosure (reduced in size) is reproduced below.

I acknowledge that I have read the "Disclosure Concerning Consumer Reports", that I understand it, and that I have been asked to keep it for my future reference.

I hereby authorize KALEIDA HEALTH to obtain consumer reports pertaining to me, as explained in the "Disclosure Concerning Consumer Reports".

Date: ___________________________ Signature: _________________________________

Printed Name: _________________________________

DISCLOSURE CONCERNING CONSUMER REPORTS

This is to inform you KALEIDA HEALTH may obtain a "consumer report" pertaining to you as part of its consideration of your application for employment. KALEIDA HEALTH may also obtain additional "consumer reports" pertaining to you from time to time in the future, in the event that you are hired as an employee.

The “consumer report” refers to information about you, including information bearing on your character, general reputation, personal characteristics or mode of living, which may be used in whole or in part as a factor in making employment decisions. KALEIDA HEALTH may request this information from one or more agencies or persons who regularly assemble or evaluate information of this kind.

If KALEIDA HEALTH decides to take adverse employment action against you based in whole or in part on a “consumer report,” we will first provide you with a copy of the report as well as a statement of your rights as prescribed by the Federal Trade Commission. Your rights would include the ability to contact the agency that provided the “consumer report” to us, and the right to advise them of any dispute that you may have regarding the accuracy of information contained in their files.

KALEIDA HEALTH will not obtain any “consumer report” pertaining to you unless you sign an authorization permitting this. However, you will not be considered for employment unless you sign an authorization.

Please make a copy of this Disclosure for your future reference.
Volunteer Consent Form
CF-012914

Disclosure: In relation to your application for employment, volunteer status or your current employment, your prospective employer or present employer may obtain a consumer report and/or an investigative consumer report. Such reports may include information as to your character, general reputation, personal characteristics, and/or mode of living. Also, subsequent reports may be requested to update, renew or extend employment. This disclosure is given to you in compliance with the Federal Fair Credit Reporting Act and applicable state law. You have the right to request additional disclosures as to the nature and scope of the investigation from your prospective or present employer. Such request must be made in writing.

The following information is for the sole purpose of conducting a volunteer position background investigation:

Current Name
First Name
Maiden First Name
Alias/Other First Name

Middle Name

Maiden Last Name
Alias/Other Last Name

Date of Birth – Month/Day/Year

Social Security Number

Driver’s License Number
State of Issue

Current ZIP Code
Daytime Phone Number

Male
Female

List Current and all Counties and States you have lived in for the past 7 Years

County
State
ZIP Code
From Month Year
To Month Year

Have you ever been convicted of crime? Yes □ No □ Misdemeanor □ Felony □ Any pending criminal charges? Yes □ No □

If yes, give location of Court: City ____________ County ____________ State ____________

Type of Offense ____________ Date of Offense ____________ Case Number ____________

Explain

*** (IF YOU HAVE MORE THAN ONE CONVICTION OR NEED ADDITIONAL SPACE, LIST ALL INFORMATION ON A SEPARATE SHEET OF PAPER) ***

Authorization Release: I certify receipt of this notice and give permission to my prospective employer and/or current employer and its agents to verify the information submitted by me and to conduct a background search on me. I understand this search may include social security number verification and address history, criminal history, driving history, education history, license/certification verification, past employment information, and/or reference checks. Such verification shall not constitute a violation of my right to privacy in any manner and I hereby release them from all liability whatsoever for actions related to this information. I understand that the sole purpose for obtaining this information is for employment/volunteer purposes.

Print Name of Applicant/Employee __________________________ Signature of Applicant __________________________ Date __________

Company Name __________________________ Requested By __________________________ (PRINT NAME CLEARLY) Date __________

*** For Employer Use Only ***
A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness and privacy of information in the files of every “consumer reporting agency” (CRA). Most CRAs are credit bureaus that gather and sell information about you – such as if you pay your bills on time or have filed bankruptcy – to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission’s web site (http://www.ftc.gov). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

• You must be told if information in your file has been used against you. Anyone who uses information from a CRA to take action against you – such as denying an application of credit insurance, or employment – must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.

• You can find out what is in your file. At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve month upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.

• You can dispute inaccurate information with the CRA. If you tell a CRA that you file contains inaccurate information, the CRA must investigate the items (usually with 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source must also advise national CRAs – to which it has provided the data – of any error). The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA’s investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.

• Inaccurate information must be corrected or deleted. A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, The CRA cannot reinsert into your file a disputed item and must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.

• You can dispute inaccurate items with the source of the information. If you tell anyone such as a creditor who reports to a CRA that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you’ve notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.

• Outdated information may not be reported. In most cases, a CRA may not report negative information which is more than seven years old; ten years for bankruptcies.

• Access to your file is limited. A CRA may provide information about you only to people with a need recognized by the FCRA – usually to consider an application with a creditor, insurer, employer, landlord, or other business.

• Your consent is required for reports that are provided to employers, or reports that contain medical information. A CRA may not give out information about you to your employer, or your prospective employer without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.

• You may choose to exclude you name from CRA lists for unsolicited credit and insurance offers. Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.

• You may seek damages from violators. If a CRA, user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

<table>
<thead>
<tr>
<th>FOR QUESTIONS OR CONCERNS REGARDING:</th>
<th>PLEASE CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRA’s creditors and others not listed below</td>
<td>Federal Trade Commission Consumer Response Center – FCRA Washington, DC 20580 202-326-3761</td>
</tr>
<tr>
<td>National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name).</td>
<td>Office of the comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743</td>
</tr>
<tr>
<td>Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks).</td>
<td>Federal Reserve Board Division of Consumer &amp; Community Affairs Washington, DC 20551 202-452-3693</td>
</tr>
<tr>
<td>Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appears in federal institution’s name).</td>
<td>Office of Thrift Supervision Consumer Programs Washington, DC 20552 800-842-6269</td>
</tr>
<tr>
<td>Federal credit unions (words “Federal Credit Union” appear in institution’s name).</td>
<td>National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-8360</td>
</tr>
<tr>
<td>State-chartered banks that are not members of the Federal Reserve System</td>
<td>Federal Deposit Insurance Corporation Division of Compliance &amp; Consumer Affairs Washington, DC 20429 800-934-FDIC</td>
</tr>
<tr>
<td>Air, surface or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission</td>
<td>Department of Transportation Office of Financial Management Washington, DC 20590 202-3661306</td>
</tr>
<tr>
<td>Activities subject to the Packers and Stockyards Act, 1921</td>
<td>Department of Agriculture Office of Deputy Administrator – GIPSA Washington, DC 20250 202-720-7051</td>
</tr>
</tbody>
</table>
Employee Health Department Volunteer Physical Examination Form

New York State Department of Health requires the following to medically clear you to volunteer at a hospital: **Physical, 2 step PPD, proof of immunization/immunity to Rubella, Rubeola, Mumps and Varicella.**

Last Name: ______________________  First Name: _____________________  SS#: _____________________  Sex: □ M  □ F  DOB: ____________

Address: ________________________________________________________  Phone #: _____________________

<table>
<thead>
<tr>
<th>INFECTIOUS DISEASE HISTORY</th>
<th>IMMUNIZATION HISTORY (VACCINES)</th>
<th>ATTACH IMMUNIZATION RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of any of the following :</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Measles</td>
<td>Tdap: ___________ Td:</td>
<td>Flu vaccine:</td>
</tr>
<tr>
<td>German Measles</td>
<td>Hepatitis B Vaccine: yes / no #1:</td>
<td>#2: #3</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>Rubella &amp; Mumps /2 MMR vaccines (or positive titer) (2 Doses required) #1:</td>
<td>#2</td>
</tr>
<tr>
<td>Mumps</td>
<td>Rubella/ MMR vaccine (or positive titer) (1 Dose required) #1:</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Varicella Vaccine (or positive titer) #1:</td>
<td>#2:</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>PPD/ TB Skin Test (2 PPD’s administered in the past 12 months.</td>
<td></td>
</tr>
<tr>
<td>Yellow Jaundice</td>
<td>PPD #1 Date Placed:</td>
<td>Date Read:</td>
</tr>
<tr>
<td>Polio</td>
<td>PPD #2 Date Placed:</td>
<td>Date Read:</td>
</tr>
<tr>
<td>Herpes Simplex (oral or hand)</td>
<td>If known history of positive PPD, provide date of conversion and last chest x-ray:</td>
<td>Positive PPD Date:</td>
</tr>
<tr>
<td>□ Normal Chest X-Ray</td>
<td>□ Abnormal Chest X-Ray</td>
<td></td>
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</tbody>
</table>

List any medications (over the counter or prescribed by a physician: □ Asymptomatic-denies all symptoms □ Symptomatic-fatigue, Anorexia, Weight loss, Low grade fever, Productive cough (circle any that pertain)

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<tr>
<th>REVIEW OF SYSTEMS</th>
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<tr>
<td>For the following items, check the appropriate column:</td>
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<table>
<thead>
<tr>
<th>ALLERGIES (Latex, Medications, etc)</th>
<th>CHRONIC COUGH (more than 3 weeks)</th>
<th>ASTHMA</th>
<th>HEART TROUBLE (chest pain, heart attack, etc)</th>
<th>HERNIA</th>
<th>NECK/BACK INJURY OR PAIN</th>
<th>ARTHRITIS</th>
<th>WEAKENED IMMUNE SYSTEM (such as leukemia, HIV, chronic steroid use, chemotherapy)</th>
<th>Fainting Spells</th>
<th>SEIZURES</th>
<th>SKIN PROBLEMS</th>
<th>DIABETES</th>
<th>SHORTNESS OF BREATH</th>
<th>CHEST PAIN</th>
<th>HEARING PROBLEMS</th>
<th>VISION PROBLEMS</th>
<th>ILLICIT DRUG USE</th>
<th>MAJOR ILLNESSES/HOSPITALIZATIONS</th>
<th>MENTAL HEALTH CONDITIONS</th>
<th>DO YOU DRINK ALCOHOL?</th>
<th>DO YOU SMOKE?</th>
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<tbody>
<tr>
<td>Now</td>
<td>Past</td>
<td>Never</td>
<td>Comments filled in by Provider</td>
<td></td>
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<tr>
<th>SKIN</th>
<th>Normal</th>
<th>Abnormal</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Provider: please comment on abnormalities</td>
</tr>
<tr>
<td>EYES</td>
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<tr>
<td>EARS</td>
<td></td>
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<td>NOSE</td>
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<tr>
<td>MOUTH/THROAT</td>
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<td>NECK, THYROID</td>
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<tr>
<td>LYMPH NODES</td>
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<td>CHEST</td>
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<td>HEART</td>
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<td>ABDOMEN</td>
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<td>BACK</td>
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<tr>
<td>NEURO</td>
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<tr>
<td>EXTREMITIES</td>
<td></td>
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<tr>
<td>HERNIA</td>
<td>□ None</td>
<td>□ Present</td>
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<thead>
<tr>
<th>Vision</th>
<th>Distance</th>
<th>Near</th>
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<tbody>
<tr>
<td>Uncorrected 20/</td>
<td></td>
<td></td>
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<tr>
<td>Corrected 20/</td>
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<td>Blood Pressure</td>
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<tr>
<td>Pulse</td>
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<tr>
<td>Height:</td>
<td>Weight:</td>
<td></td>
</tr>
<tr>
<td>General Appearance:</td>
<td>□ Good</td>
<td>□ Fair</td>
</tr>
</tbody>
</table>

PLEASE OUTLINE ANY LIMITATIONS: ________________________  MEDICALLY RELEASED TO BEGIN VOLUNTEERING ON: / /

MD/DO/NP/PA SIGNATURE: ________________________  DATE: ____________

Provider’s Address & Phone number ______________________________________________________________________  16-05/30/2017