NYC HEALTH + HOSPITALS | Woodhull

WELCOME TO VOLUNTEER SERVICES

Thank you for considering Woodhull for your "One of a Kind Volunteer Experience".
The Volunteer Services team is dedicated to discovering the right volunteer opportunity for you.
The following information will guide both potential volunteers/interns through our application process.

Required Documentation
Completed Volunteer Services application packet
Photo ID (Driver's License or State ID), Birth Certificate, Passport or Visa
2 Personal Letters of Reference (recently signed, dated and should not be from a family member)
Degree, Diploma, GED or Official Transcript (if applicable)
Resume

The Application Process

- The submitted application packet and required documentation will be reviewed for process readiness.
- On the same day, the applicant will be scheduled for a health assessment and drug/alcohol screening.
- The applicant will be subjected to a placement interview, conducted by a Volunteer Services rep.
- The applicant's status will not be determined until the results from the background checks, health assessment, and drug/alcohol screening have been received.
- Should the applicant be accepted, he/she will be notified via email. The email will contain vital information such as:
  - Information regarding the applicant's status.
  - If accepted, the official start date in the Host department.
  - If accepted, the dates for the required hospital orientation.

Note: The application process and pending clearances can take anywhere from two to six weeks to be completed.

Again, thank you for choosing Woodhull.

Gwendolyn D. Murph – Director

Volunteer Services Department

NYC Health + Hospital /Woodhull
760 Broadway, room 10-200B
Brooklyn, NY 11206
Office: (718)963-8077
Hours of Operation: Monday – Friday; 9:00am – 5:00pm
In-Take Hours: 10:00 am to 1:00 pm and 2:00 to 4:00pm

NYC HEALTH+ HOSPITALS

Volunteer / Unpaid Student Intern Application

At which Facility/Business Unit do you wish to volunteer? Woodhull

Applicant Information

Full Name: _____ **Date:** ___/___/___
Last *First* *Middle*

Name(s) previously used _____

Current Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

If you have resided at your present address listed above for less than three years, indicate your previous address(es) below:

Date of Birth: _____ **Social Security #:** _____

Phone Number: _____ **Email Address:** _____

Emergency Contact: Name, Relationship and Contact Information: _____

Employment Information

(Please submit a copy of your resume with your prior work and/or volunteer experience)

If currently or previously employed with NYC Health + Hospitals, please provide your:

Current or Former Title:

EMPID Number: ***Username:***

Are you related in any way to an officer(s) or employee(s) of NYC Health + Hospitals? YES ☐ NO ☐

If yes, please provide the name, relationship, facility, department and title:

Present or Last Employer/Volunteer Position

Name of Employer: **Title:** **Dates of Employment:**

Address of Employer:

Name and Title of Supervisor: **Reason for Leaving:**

Brief Description of Duties and Responsibilities:

Education

Highest Degree Received/In Process High School ☐ Bachelor's ☐ Master's ☐ Doctorate or Above ☐

Name of School: _____

NYC HEALTH+ HOSPITALS

Volunteer / Unpaid Student Intern Application

Special Skills/Languages

(Please list the name(s) of the computer programs/software you are comfortable using (e.g., MS Excel, PowerPoint, Outlook) and the languages you speak, other than English. Please rate your level of proficiency as beginner, intermediate or advanced.

Name(s) of Computer Programs	Level of Proficiency	Language	Level of Proficiency

Excluded Provider List Certification

1. **Have you ever or do you currently appear on the:**

U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals or Entities (LEIE)?
☐ YES ☐ NO If yes, please explain:

NYS Office of Medicaid Inspector General (OMIG) List of Restricted, Terminated or Excluded Individuals or Entities?
☐ YES ☐ NO If yes, please explain.

U.S. General Services Administration (GSA) System for Award Management (SAM) Excluded Parties List?
☐ YES ☐ NO If yes, please explain:

Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons List (SDN) or any other sanction list in the US Treasury Department's Consolidated Sanctions List?
☐ YES ☐ NO If yes, please explain:

2. **Have you ever, or do you currently appear on a Medicaid List of excluded individuals or entities in any state or U.S. territory?**
☐ YES ☐ NO If yes, please explain:

Certification and Signature

I understand and attest that:

If I am offered a Volunteer or Unpaid Student Intern position **with** NYC Health + Hospitals there is absolutely no expectation that I will receive compensation of any kind for my services or that my position will lead to paid employment with the System.

If I am offered a Volunteer or Unpaid Student Intern position, I agree to comply with the policies, rules, regulation and procedures of NYC Health + Hospitals.

I hereby certify that all facts set forth above are true, complete, and correct to the best of my knowledge. I understand that if I am offered a Volunteer or Unpaid Student Internship position all information may be subject to investigation and that false information will be grounds for denying or ending my assignment with NYC Health + Hospitals.

Signature: **Date:**

If you are under 18 years of age, your parent or legal guardian must sign your application in order for it to be considered complete.

Name of Parent/ Legal Guardian: **Signature:** **Date:**

Assignment Information (Completed by Human Resources)

Work Location: **Work Number:** ( ) -

Supervisor: **Start Date:**

EMPID: **H+H Email:**

ID Received On: **Expires On:**

NYC HEALTH+ HOSPITALS

TERMS AND CONDITIONS OF VOLUNTEER and UNPAID STUDENT INTERN ASSIGNMENTS

Name: _____ **Title:** _____ **Facility:** _____

Start Date: ____/____/____ **Department:** _____ **Tour:** _____

I, the above named individual, hereby accept an assignment to a Volunteer or Unpaid Student Intern position subject to the following terms and conditions:

1. I understand that my assignment as a Volunteer or Unpaid Student Intern is subject to my being cleared for employment by NYC Health + Hospitals, which will include a background investigation and a medical assessment that may include screening for the presence of drugs or alcohol. I may also be obligated to take a physical test or other qualifying tests, if required for the position. I shall willingly undergo such examinations.

2. I hereby authorize NYC Health + Hospitals to commence its clearance procedure by making any investigation of my background deemed necessary. I understand I will be subject to a criminal background check and give NYC Health + Hospitals permission to secure all necessary personal data from sources governmental and private. I further agree to co-operate in all phases of the clearance procedure.

3. I understand that any misrepresentation of material fact on my Volunteer or Unpaid Student Intern application or any other documents submitted in connection with my assignment may result in my dismissal. I hereby declare that I answered all questions truthfully.

4. I hereby agree to hold NYC Health + Hospitals and the City of New York, its agencies, employees, and agents, harmless with respect to any personal claims for damages, expenses, or injuries that may arise should the above-mentioned procedure not be completed satisfactorily and my Volunteer or Unpaid Student Intern services be terminated.

5. If my assignment requires completion of a training program (whether at the time of my initial assignment or thereafter), I must successfully complete that training program and any required periodic training.

6. If my assignment requires a valid license, certification or permit, I must obtain and maintain such credential(s) on my own time.

7. I understand that my attendance at the Volunteer Orientation program is required.

8. I understand that I serve at the pleasure of the appointing officer and acquire no tenure or rights to a paid position with NYC Health + Hospitals. I understand that I may be terminated at any time with or without cause.

9. I understand and agree that in the performance of my duties as a Volunteer or Unpaid Student Intern, I must hold medical information and other information regarding a patient and/or employee in confidence, regardless of the form the information is presented in. Accessing confidential data is to be undertaken solely in the performance of authorized assignments as specified and directed by my supervisor. I also understand the use of this data for other than facility business is expressly prohibited and will result in disciplinary action up to and including termination of my volunteer services.

10. I understand that I am required to complete mandatory training and education provided by the Office of Corporate Compliance, including Compliance and HIPAA Privacy & Security Training within 30 days after my start date. Training must be completed prior to me being granted access to any computer, electronic or any other information or records systems that creates, maintains, processes or transmits patient protected health information or other sensitive and confidential information, or before being granted access to any records which contain protected health information or other sensitive and confidential information. I understand that failure to complete this mandatory training or any additional training assigned to me by the Office of Corporate Compliance, may result in disciplinary action, including and not limited to the termination of my volunteer or student intern services.

11. I understand that if my assignment requires that I sign the NYS Justice Center Code of Conduct, I must sign a new Code of Conduct annually or as otherwise required by the NYS Justice Center.

12. I agree to notify NYC Health + Hospitals Office of Corporate Compliance (OCC) in writing (e-mail:compliance@nychhc.org) within five (5) business days if I have been excluded from participating in any Federal health care program including, but not limited to, Medicare and Medicaid, or if I am subject to any investigation which could lead to such exclusion. I also agree to notify the OCC within five (5) business days if I become aware that my name is present on the Office of Foreign Assets Control ("OFAC") list, the Designated Nationals Sanction List, the Social Security Administration's Death Master File ("SSDMF"), or any other sanction list in the U.S. Treasury Department's Consolidated Sanctions List, or have an inactive National Provider Identifier ("NPI") listed on the Center for Medicare and Medicaid Services' National Plan and Provider Enumeration System ("NPPES").

    I understand that I cannot volunteer, continue to volunteer, or hold a position as an unpaid student intern with NYC Health + Hospitals if I am excluded from participating in any Federal health care program or if I appear on any of the above identified lists.

Additional Terms and Conditions on Next Page

TERMS AND CONDITIONS OF VOLUNTEER and UNPAID STUDENT INTERN ASSIGNMENTS

13. I understand that in the event that I am ever arrested, or convicted after my Volunteer or Student Intern assignment begins, I am required to report the arrest or conviction to Human Resources at my assigned facility/business unit within 24 hours.

14. I understand that, as a condition of my assignment, I must adhere to the NYC Health + Hospitals *Principles of Professional Conduct* ("POPC") and am subject to Operating Procedure 50-1, Corporate Compliance and Ethics Program, at all times while volunteering with NYC Health + Hospitals.

15. I understand that if appointed to a volunteer position with Correctional Health Services (CHS), my continued assignment with CHS is contingent upon repeated full background screenings, Department of Correction (DOC) clearance (if applicable to my position) and Medical clearance (if applicable to my position). At any time, unsuccessful background screenings and/or revocation of DOC clearance may result in immediate separation.

    CHS will not continue a volunteer assignment with anyone who will have direct contact with patients who has engaged in, been convicted of, or been civilly or administratively adjudicated for engaging in sexual abuse in confinement settings.

    I fully understand CHS has the right to end my assignment at any time due to unsuccessful background screenings and/or revocation of DOC clearance or Medical clearance.

16. I acknowledge that I have received, the NYC Health + Hospitals *Information Technology Resources Acceptable Use Policy* and my signature below certifies that I have read and fully understand the contents. In addition, I understand that this policy applies to all IT resource access, current and future, that is issued to me by NYC Health + Hospitals. Finally, I understand that violation of any of the policy statements set forth in this policy may result in disciplinary action up to and including termination from my assignment.

17. I understand that failure to fulfill any of the above conditions may result in the revocation of my Volunteer or Student Internship assignment.

VOLUNTEER (SIGNATURE) _____ DATE _____

IF APPLICANT IS UNDER 18 YEARS THEIR YOUR PARENT/LEGAL GUARDIAN MUST SIGN THIS DOCUMENT

PARENT/GUARDIAN (PRINT NAME) _____ PARENT/GUARDIAN (SIGNATURE) _____ DATE _____

HUMAN RESOURCES WITNESS

(PRINT NAME) _____ (SIGNATURE) _____ DATE _____

NYC
HEALTH+
HOSPITALS

VOLUNTEER / UNPAID STUDENT INTERN AUTHORIZATION FOR RELEASE OF INFORMATION AND WAIVER OF PRIVILEGE OF CONFIDENTIALITY

I, _____, am being considered for a position as a Volunteer or
(PRINT NAME)
Unpaid Student Intern with NYC Health + Hospitals and as a condition of my assignment, consent to a background investigation conducted by NYC Health + Hospitals.

In furtherance of the background investigation, I consent to and authorize the disclosure of all information NYC Health + Hospitals deems relevant to the evaluation of my eligibility to hold a position of public trust. I, therefore, authorize the disclosure of such information to NYC Health + Hospitals, including but not limited to, files and records maintained by former and current employers, hospitals, clinics and the U.S. Veterans Administration, by educational institutions, governmental bodies, professional associations, and by investigative, disciplinary, judicial or grievance bodies.

Furthermore, as may be required under the Privacy Act of 1974, 5 United States Code Section 552a, and the Freedom of Information Act, 5 United States Code Section 552, I hereby give my consent to inquiries concerning me by NYC Health + Hospitals to any Federal agency or public or private entity, and to the disclosure to NYC Health + Hospitals by such Federal agency or public or private entity of any information the agency or entity may have pertaining to me, with the exception of any material which is specifically exempt from disclosure by a Federal statute other than the Privacy Act of 1974 or the Freedom of Information Act.

I waive any privilege of confidentiality with respect to the release of any such information to the NYC Health + Hospitals.

A photocopy of this authorization shall be considered effective and valid, as the original, which shall remain on file at the facility/business unit of the NYC Health + Hospitals, for this and any future reports or updates that may be requested.

Further information may be made available upon written request within a reasonable period of time.

_____ _____
APPLICANT SIGNATURE *DATE*

IF APPLICANT IS UNDER 18 YEARS OF AGE:

_____ _____ _____
PARENT/GUARDIAN (PRINT NAME) *PARENT/GUARDIAN (SIGNATURE)* *DATE*

NYC HEALTH+ HOSPITALS

CONVICTION RECORD – VOLUNTEERS/UNPAID STUDENT INTERNS

Please answer Questions 1 and 2 below to disclose any convictions, pending charges or reportable arrests. **If arrested or convicted after your volunteer assignment begins, you are required to report the arrest or conviction to your facility Human Resources Department within 24 hours.**

1. **Have you been convicted of a misdemeanor or felony? Answer "NO" if: (a) you have never been convicted of a misdemeanor or felony; (b) the misdemeanor or felony was sealed, expunged, or reversed on appeal; (c) was for a violation, infraction, or other petty offense such as "disorderly conduct;" (d) resulted in a youthful offender or juvenile delinquency finding; or (e) if you withdrew your plea after completing a court program and were not convicted of a misdemeanor or felony.** ☐ **YES** ☐ **NO**

   If "YES", explain each conviction setting forth the date, charge, court and action taken in the boxes below. If you need additional space, use the back of this form. Please attach a copy of the final disposition for each conviction. If you are currently on probation or parole, you will need to provide documentation regarding the condition of your probation/parole.

Date of Arrest	Date of Conviction	Conviction Charge(s) & Sentence/Penalty	Court of Conviction (County, City, etc.)

2. **Have you been summoned, arrested or indicted in connection with any criminal matter which is still pending in court?** ☐ **YES** ☐ **NO**

   If yes, explain each pending matter setting forth the date, charge, court and action taken in the boxes below. If you need additional space, please use the back of this form.

Date of Arrest or Indictment	Charges	Court and Location (County, City, etc.)

CERTIFICATION

I hereby certify that all of the facts set forth above are true, complete and correct to the best of my knowledge and belief. I understand that all information shall be subject to investigation and that false information and/or misrepresentation will be grounds for withdrawal of an assignment or separation from my Volunteer or Unpaid Student Intern assignment.

Signature:	**Date:**
Print Name:	**Last 4 digits of SSN:**

This information and any documents received by NYC Health + Hospitals as part of the background criminal record investigation are strictly confidential and shall not be available for copying after inspection, except as expressively provided by law.

HR USE ONLY – all dispositions provided? YES NO Initials: _____

LDSS-3370 (Rev. 04/2011) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
379	20028166	N/A		(718)963 - 8077

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: WOODHULL MEDICAL & MENTAL HEALTH CENTER

AGENCY LIAISON: Kenneth Grey

STREET ADDRESS 760 BROADWAY, RM 10-200B

CITY: BROOKLYN **STATE:** NY **ZIP CODE:** 11206

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE

APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE

SIGNATURE	DATE

Reviewed 2/2013

LDSS-3370 (Rev. 04/2011)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

Reviewed 2/2013