

**SCHNURMACHER CENTER
FOR REHABILITATION AND NURSING**

Dear Volunteer:

We are delighted to have you join the Volunteer Department at The Schnurmacher Nursing Home. You are now part of a highly respected group of enthusiastic and dedicated volunteers who devote their time and services to enhancing the quality of life of the people we serve.

This booklet has been designed to help you become familiar with the goals and standards of our facility as well as to provide you with important information that you will need as a responsible volunteer.

Thank you again for your commitment. We hope that your experience here will be a meaningful one and that you will derive deep satisfaction from your relationships with our residents and staff.

Please remember that the Department of Volunteers is here to assist you in the performance of your duties. If you have any questions or concerns, please do not hesitate to come to me.

Sincerely,

Filomena Cristo
Therapeutic Recreation and Volunteer Supervisor

**SCHNURMACHER CENTER
FOR REHABILITATION AND NURSING
12 Tibbits Avenue,
White Plains, NY 10606
914-287-7210**

VOLUNTEER APPLICATION

Schnurmacher Nursing Home considers applications without regard to race, color, religion, national origin, marital status, sexual orientation, sex, disability or citizenship status.

Date _____ **Social Security #** _____

Name _____ **Date of Birth** _____

Address _____

(Street, Apt #)

(City)

(Zip Code)

Home Phone _____ **Office Phone** _____

Education: List name of school, date of graduation, degree earned

High School _____

College (s) _____

Graduate/ Technical _____

Employment History (List most recent first)

Dates Employed	Employer's Name	Job Title & Responsibilities
_____	_____	_____
_____	_____	_____
_____	_____	_____

Volunteer Experience: _____

Special Training: _____

Referred by: _____

In case of emergency provide name of person to contact

Name _____ **Phone #** _____ **Relationship** _____

Have you ever been convicted of a crime? Yes No

(Applicants will not be rejected based on conviction record alone)

If yes, please explain: _____

Please list two references with full addresses (employer, clergy, physician, friend).

Name _____ **Name** _____

Address _____ **Address** _____

Why are you interested in volunteering: _____

Please make a check mark in front of the areas in which you are interested in working:

- Friendly visiting Clerical work Arts and Crafts
 Holiday celebrations Feeding Computers
 Musical Instruments Rehab Therapy Recreation therapy

Do you have any hobbies (please specify) _____
Foreign language skills _____
Speak _____ Read and write _____

Time Commitment (please indicate times available)

Day	AM 4-Hour Shift	PM 4-Hour Shift	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

I will notify the Volunteer Department if I am unable to keep my volunteer assignment. I agree to abide by the policies and procedures of Schnurmacher Nursing Home. I will be punctual, courteous, dependable and keep in confidence all information I may hear or be told concerning a patient, doctor, employee or volunteer. I confirm to the best of my knowledge that the information in this application is correct and complete.

Signature _____ Date _____

Please return this application to Schnurmacher Nursing Home, Volunteer Department, 12 Tibbits Avenue, White Plains, NY 10606.

-----FOR VOLUNTEER OFFICE USE ONLY-----

Interview Date _____ Start Date _____ I.D Badge Given _____
{PPD _____

Medical Form Complete:{IMM. _____ Permanent Placement _____

Interviewed by _____ Birthday list _____ Date Resigned _____

Comments _____

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VOLUNTEER HEALTH ASSESSMENT

Name _____ Date _____

Address _____ City _____ State _____

Telephone No. _____ Birth date _____ Sex M F

List the names and addresses of all physicians that are currently treating you or HMO Group if applicable.

Please list the name and telephone number of person to contact in case of emergency:

Name _____ Telephone No. _____

MEDICAL INFORMATION

Have you ever been diagnosed with the following conditions?

Diabetes Yes No

Epilepsy Yes No

Heart Disease Yes No

Tuberculosis Yes No

If you answered "Yes" to any of these, please explain. _____

Has a physician limited your physical activity within the past 12 months? If Yes, please explain _____

MEDICATIONS

Please list all prescription drugs that you are currently taking

Medication	Dosage	Frequency	Reason
1. _____			
2. _____			
3. _____			
4. _____			

Do you have any allergies? If so indicate what you are allergic to.

IMMUNIZATIONS

All volunteers must provide a proof of immunization. To do this you must have your doctor complete the section below or have a Rubella Titer blood test to proof that you've been vaccinated.

Measles	Date of illness _____	Immunization date _____
Mumps	Date of illness _____	Immunization date _____
Whooping cough	Date of illness _____	Immunization date _____
Chicken Pox	Date of illness _____	Immunization date _____
Rubella	Date of illness _____	Immunization date _____

Rubella Titer Test Date _____ Results _____

All volunteers must be tested for tuberculosis every 12 months. If you test positive, you must have a chest x-ray.

TB Test Date _____ Results _____

Chest x-ray Date _____ Results _____

Doctor's Signature

Date