



EPISCOPAL HEALTH SERVICES INC.

VOLUNTEER/INTERN/STUDENT APPLICATION PACKET



Office Hours

Monday – Thursday

9:30am – 3:00pm

Tel: (718) 869-7870

By Appointment Only

Episcopal Health Services Inc., St. John's Episcopal Hospital

Volunteer Services Office

First Floor

327 Beach 19th Street

Far Rockaway, NY 11691

Tel: (718) 869-7870

Email: Volunteer@ehs.org

Lisa Sampson, Manager, Guest Relations Department/Volunteer Services Office



EPISCOPAL HEALTH SERVICES INC.

Service Covenant

Welcome to the Episcopal Health Services, Inc. (EHS) family.

We are delighted by your interest in serving at EHS. Our patients and their loved ones, staff and board members are grateful for the gift of your time and talent.

Please find attached the information needed to get started to volunteering at St. John’s Episcopal Hospital:

1. Onboarding Checklist
2. Volunteer Application
3. Reference Forms
4. Youth Volunteer Career Builder Worksheet (if applicable)

Individuals who are accepted will be trained, serve side by side with hospital staff, will receive a certificate of service upon completion. In return, the hospital requires a minimum of 100 hours of service within 9 months of onboarding. This is equal to approximately 3 hours of weekly service. EHS requires all volunteers, student and interns to comply with all EHS policies and with policies of agencies or entities that regulate our services.

In some cases, failure to complete 100 hours means EHS will not supply you with a certificate of service, which is normally necessary for potential employers or education institutions.

Failure to comply with EHS policies may result in action up to and including dismissal from the program. Reckless or egregious conduct which violates EHS’s Code of Conduct may result in immediate significant action.

For more information, please contact the Volunteer Services Office at (718) 869-7870 or via email at Volunteer@ehs.org.

Your signature below acknowledges your receipt and understanding of the Service Covenant.

Printed Name _____ Date _____

Signature _____ Date _____

Parents/Guardians for Youth Volunteers Only (under 18):

Printed Name _____ Date _____

Signature _____ Date _____



Onboarding Process

Phase 1

- Individuals complete and submit an application to the Volunteer Services Office either in-person or via e-mail at Volunteer@ehs.org, via fax (718) 869-7754 or via mail at, St. John's Episcopal Hospital, c/o Volunteer Services Office, 327 Beach 19th Street, First Floor, Far Rockaway, NY 11691.

Important: EHS employees or staff who wish to pursue an internship at EHS must secure written authorization to do so from their Department Director. This authorization will be vetted by Human Resources Dept. Additionally, with limited exception, hours for any internship cannot be completed during working hours at EHS.

- A completed application includes a resume and two (2) references (using the forms provided).

Important: Youth Volunteers (under 18) only are encouraged to use the Career Building Form if they do not have a resume. Youth Volunteers must also complete the parent/guardian permission section and the application must be notarized.

- Once complete, contact the Volunteer Services Office to schedule a meeting to learn more about the on-boarding process and discuss placement options (718) 869-7870.

Important: Interns/Students Only: please bring summary course/program information, a list of preceptor responsibilities, a list of intern/student responsibilities along with any other forms that will need to be completed by EHS or your preceptor. If applicable, provide proof of insurance, licensing and certificates of competency as well.

- Shortly after this meeting with the Volunteer Services Office, you will receive a letter confirming your status, placement and other details.

Phase 2

- A Human Resources team member will call to set an appointment for onboarding. Be sure to schedule your appointment for a date and time that work for you. Please bring photo identification (e.g., valid driver's license, passport, NYC ID Card, etc.) and student ID card (where applicable) to this appointment.

Important: Individuals will receive Health Assessment packet. Take this to your medical practitioner (MD, DO or NP) to complete. Please make sure they fully complete all the forms. Acceptance is contingent upon successful completion of a health assessment.

Important Health Assessment Reminders:

- Make sure your practitioner draws blood to test for immunity & attach lab results;
- Make sure your practitioner completes, signs, and provides license number;
- Include proof PPD test and immunization record;
- Return the medical / health assessment forms to Human Resources Department; and
- Receive a lab slip and directory of laboratories for drug testing (Please note this test **must** be completed within 48 hours of receiving the slip!)



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- Ensure you receive, among other things the Worker's Compensation Acknowledgement Form, NYS Justice Center's Code of Conduct Form and EHS's New Personnel Confidentiality Acknowledgement.
- Complete the Consumer Authorization Form to initiate a background check; Human Resources initiates the background investigations. A third party under contract by EHS conducts investigations. Investigations may include obtaining reports from several agencies

Phase 3

- A member of the Human Resources Department registers cleared applicants for the mandatory two (2) day Orientation.
- During Orientation, a Human Resources team member will issue your EHS ID and enroll you into the timekeeping system (where applicable).
- On the second day of Orientation, visit the Volunteer Services Office (located on the 9th floor of the hospital) to confirm department placement and finalize schedules. Further, where applicable, issue meal cards and arrange computer access (for those whose placement it is required).

Phase 4

- Turn in copies of completed attendance records, journal of duties, etc. to the Volunteer Services Office weekly.
- Communicate changes in schedules to the Volunteer Services Office immediately.
- Complete Volunteer Services Office service evaluation form annually or prior to completion of internship.
- Where applicable, make sure preceptor provides copies of documents submitted to the school to the Volunteer Services Office.
- Comply with all EHS policies and procedures.
- Understand that your schedule maybe suspended during visits by regulatory agencies or the hospital/department is unable to fulfill the schools requirements for your internship.
- Bring all concerns, questions or complaints to the Volunteer Services Office.



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VOLUNTEER/INTERN/STUDENT APPLICATION

All information contained in this application is strictly confidential and will become part of your volunteer/intern/student record at EHS. EHS prohibits any and all discrimination against applicants on the basis of the following, without limitation; race, veteran status, color, religion, sex, age, marital status, gender, gender identity, citizenship status, handicap or disability, socio-economic status, national origin, sexual orientation or affectional preference.

CATEGORY		
Status: <input type="checkbox"/> Volunteer <input type="checkbox"/> Youth Volunteer (under 18) <input type="checkbox"/> Intern <input type="checkbox"/> Student <input type="checkbox"/> Other:		
Desired Department: <input type="checkbox"/> Surgery <input type="checkbox"/> Medicine <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pediatrics <input type="checkbox"/> Family Medicine <input type="checkbox"/> OB/GYN <input type="checkbox"/> Dietary/Nutrition <input type="checkbox"/> Social Work/Behavioral Health <input type="checkbox"/> Facilities/Engineering <input type="checkbox"/> Other:		
DEMOGRAPHIC INFORMATION		
Name (Last, First, M.I.):		
Name in School (if different):		
Maiden Name (if applicable):		
DOB: / /	AGE:	SSN#:
Sex at Birth:	<input type="checkbox"/> M <input type="checkbox"/> F	
Home Address:		
Telephone #: <input type="checkbox"/> Cell <input type="checkbox"/> Home () - Email:		
Preferred Contact:	<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Portal <input type="checkbox"/> Email	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Citizenship Status:	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Work Visa <input type="checkbox"/> Student Visa	
Languages Spoken Fluently:	<input type="checkbox"/> English <input type="checkbox"/> Other/s:	
Languages Spoken Fluently:		
Briefly describe your interest in volunteering/interning at EHS:		

EDUCATION/PROGRAM/INSTITUTION INFORMATION	
Name of School/Program Currently Attending (if applicable):	
Address:	
Graduated/Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Graduated:
Advisor Name:	
Advisor Phone & Email:	
Days/Times Available (Select all that apply): <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday <input type="checkbox"/> Daytime <input type="checkbox"/> Evening	
Earliest Start Date Available:	



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Emergency Contact Name:	
Address:	
Phone:	Relationship:
Comments:	

SIGNATURES	
Applicant Name (Printed):	
Applicant Name (Signature):	Date:
EHS Representative Name (Printed):	Recommendation/Approval: <input type="checkbox"/> Yes <input type="checkbox"/> No
EHS Representative Name (Signature):	Date:

YOUTH VOLUNTEERS (UNDER 18) ONLY	
I am the parent and/or legal guardian of the above named applicant and I hereby grant permission for them to volunteer at Episcopal Health Services Inc., St. John's Episcopal Hospital. Further, in the event of my absence or unavailability, I understand that emergency medical treatment for an acute illness or injury incurred by them will be provided, if deemed necessary by an examining physician.	
Parent/Guardian Name (Printed):	
Parent/Guardian Name (Signature):	Date:

Notary Information	
State of New York, County of _____	
On the ____ day of _____ in the year _____	

PLEASE HAVE TWO (2) LETTERS OF REFERENCE COMPLETED AND SENT TO THE VOLUNTEER OFFICE THE LETTERS SHOULD BE FROM THOSE WHO YOU HAVE TRAINED, WORED WITH OR HAVE OTHER REGULAR KNOWLEDGE OF YOU DURING THE PAST SIX (6) MONTHS.

**THANK YOU FOR COMPLETING THE APPLICATION.
PLEASE ENSURE THE PROMPT RETURN OF THE APPLICATION ALONG WITH ANY REQUIRED OR NECESSARY DOCUMENTAITON.**



EPISCOPAL HEALTH SERVICES INC.

CONFIDENTIAL REFERENCE FORM

Applicants Name: _____

The individual named above is completing an application for volunteer or internship at Episcopal Health Services Inc., St. John’s Episcopal Hospital and has listed you as a reference. Please complete and return this form to:

St. John’s Episcopal Hospital, Attn: Volunteer Services Office, 9TH Floor, 327 Beach 19th Street, Far Rockaway, NY 11691 or by email at Volunteer@ehs.org.

Your cooperation is greatly appreciated. Thank you in advance.

Please evaluate the applicant on the following **SJEH Core Values:**

Innovation: Generating new ideas and methods to further the mission of excellence in the provision of high quality care. Above Expectation At Expectation Below Expectation

Compassion: Demonstrating kindness and concern in the care of patients, care of families, care of colleagues, care of self and care of community.
 Above Expectation At Expectation Below Expectation

Accountability: Accepting responsibility for the work we do, the actions we take and the words we use.
 Above Expectation At Expectation Below Expectation

Respect: Projecting genuine concern for diversity and the attributes, qualities and achievements of others
 Above Expectation At Expectation Below Expectation

Empathy: Seeking to understand the feelings of others.
 Above Expectation At Expectation Below Expectation

Do you recommend this applicant as a qualified individual to accept internship responsibility in a hospital?
 Yes No

Why/Why not? _____

How long have you known the applicant? _____

What is your relationship to the applicant? _____

Reference Name: _____

Reference Contact Information
(Phone & Email): _____

Signature _____ Date _____

The information contained herein is confidential and is intended only for the use by Episcopal Health Services Inc., and will not be shared with applicant named above.



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Do you recommend this applicant as a qualified individual to accept internship responsibility in a hospital?
 Yes No

Why/Why not? _____

How long have you known the applicant? _____

What is your relationship to the applicant? _____

Reference Name: _____

Reference Contact Information
(Phone & Email): _____

Signature _____ Date _____

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Youth Volunteer Career Builder Worksheet

Name: _____

Phone: _____ Email: _____

Address: _____

1. What Do You Aspire to Be and Why?

2. What Are Your Interests?
