NYC HEALTH+ HOSPITALS | Queens

Department of Volunteer Services
82-68 164th Street
N-Bldg.
Jamaica, NY 11432
(718) 883-2280

Date: _____

Volunteer Applicant
Name_____

Please note the required tasks listed below must be completed no later than one month from the date listed above.

Required Documents to be submitted to the Department of Volunteer Services

✓	Signed Application with Personal Contact Information and In Case of an Emergency Person's Contact Information
✓	Copy of Government ID with Picture and Date of Birth
✓	Copy of Working Paper, If Under 18
✓	Two Current Signed Reference Letters with Contact Information
✓	Accreditation & Certification(unofficial transcript or resume)
✓	Up to Date Medical Clearance
✓	**COVID19** Vaccination Card & Booster **Flu Vaccine** is required during flu season
	Once You Have Obtained All the Required Documents Checked Above, Please Contact the Department of Volunteer Services to schedule Your Orientation at (718) 883-2280.
	Hospital Orientation

NYC HEALTH+ HOSPITALS

Volunteer / Unpaid Student Intern Application

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

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.

TERMS AND CONDITIONS OF VOLUNTEER and UNPAID STUDENT INTERN ASSIGNMENTS

Additional Terms and Conditions on Next Page

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

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.

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*

NEW YORK CORRECTION LAW - ARTICLE 23-A

LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

§750. Definitions.

For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§751. Applicability.

The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.

No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) The issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§754. Written statement upon denial of license or employment.

At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

**Effective February 1, 2009, employers must post a copy of the Correction Law relating to the use of prior convictions.*

HEALTH+ HOSPITALS | Queens

VOLUNTEER PROGRAM DRESS CODE

Volunteers are required to dress appropriately and to follow the established dress code for all Queens Hospital staff.

1. Please wear clothing that is clean, neat and professional. Remember you are working with the public. A business-like appearance presents a positive image to the patients and visitors.

2. You must wear dress slacks/pants. Jeans, shorts, and Capri pants are NOT acceptable. Slacks can be at the ankle or full length. Please do not wear sweatpants, leggings and other spandex pants, or baggy pants.

3. Shirts, knit tops, turtlenecks, sweater, and jackets are acceptable. Do not wear "skimpy" tops, sleeveless tops, tank tops, sport jerseys, or sweatshirts. If wearing something sleeveless, please wear a jacket or sweater over it. Avoid wearing any t-shirt with offensive words, pictures, logos, or slogans – a plain t-shirt only.

4. Dresses and skirts with a comfortable and appropriate length are permitted. Please no visible undergarments.

5. Please wear comfortable shoes like loafers, clogs, boots (below the knee), flats, and dress heals. You can wear open toed shoes and dress sandals. Flip-flops are NEVER acceptable. Solid color sneakers are permitted.

6. Excessive jewelry is not necessary. Fingernails must be neatly manicured and at a reasonable length. Minimal use of perfume/cologne is recommended.

7. Please do not wear caps/hats at your assignment. Wearing sunglasses inside the hospital is not permitted. Walkman, any MP3 player, Bluetooth device, or cell phone may not be used while you are working. There are no personal calls at your assignment.

8. Wear your ID above the waist at all times.

You must follow these guidelines and any other department specific guidelines that may be required at your assignment. We are required to enforce the dress code. You will be sent home for the first violation. Any further violations may require other disciplinary action, including dismissal from the program.

Please practice good customer service skills at all times. You represent our office throughout the hospital. Please show that you care about your appearance, your work, and our patients.

Requirements for Occupational Health Services Clearance

ADULTS (18 yrs. and older)

- Current Physical Examination
- TB screening via QuantiFERON within 30 days
- If QuantiFERON positive, copy of written CXR report, with documentation of any treatment for LTBI
- Forensic drug screening within 30 days of assessment by OHS (10 Panel)
- Serologies for following:

  Measles IgG

  Rubella IgG

  Mumps IgG

  Varicella IgG

  Hepatitis B surface Ab.

  Hepatitis B Surface Ag.

  Measles and Mumps not required for individuals born before January 1957.

- Influenza (Flu Vaccine)
- Covid Vaccination
- Copies of all test + results.

Name:

DO NOT WRITE BELOW - PROVIDER USE ONLY
IMMUNIZATIONS/ TITERS / PHYSICAL EXAM

Height: _____ Weight: _____ BMI: _____ B/P: _____ Pulse: _____ Temp._____ Resp. _____

PHYSICAL EXAM (Please check & explain if abnormal findings)

	Normal	Abnormal	Explain Abnormality
Skin			
HEENT/ Neck			
Cardiac			
Respiratory			
Abdomen			
Musculoskeletal			
Neuro			

TB Testing - TST / PPD (two step required) OR QuantiFERON (within 3 months). Attach copy of original Lab Reports showing name of Laboratory and Laboratory Director and chest X-Ray report if TB test is positive.

TEST	DATE	NEGATIVE	POSITIVE	INDETERMINATE
QuantiFERON/IGRA	_____	_____	_____	_____
PPD / TST #1	_____	_____(mm)	_____(mm)	CXR: _____
PPD / TST #2	_____	_____(mm)	_____(mm)	LTBI Rx _____

*Most recent PPD from past 3 months & previous PPD from past 12 months of most recent PPD

VACCINE TITERS / LABS (Attach copy of original Lab Reports showing name of Laboratory and Lab Director)

TEST	DATE	IMMUNE	SUSCEPTIBLE	INDETERMINATE
Measles IgG				
Mumps IgG				
Rubella IgG				
Varicella IgG				
HBsAb (AntiHBsAg)				
HBsAG		[ ] Negative	[ ] Positive	

VACCINES (Proof of Vaccination Required)

MMR (Two doses/minimum 4 weeks apart)	1.	2.	
Varicella (Two doses/minimum 4 weeks apart)	1.	2.	
Hepatitis B Series	1.	2.	3.
[ ] TD [ ] Tdap			
Influenza			

OTHER TESTS

Color Vision Screening [ ] Normal [ ] Deficient [ ] Color blind

Visual Acuity [ ] WITH or [ ] WITHOUT corrective lenses _____ / 20

Forensic Urine Toxicology -10 Panel (within 30 days) Date: _____ [ ]PASS [ ]FAIL (Must attach Lab Results)

Fit Testing result (N95): [ ] PASS [ ] FAIL [ ] N/A (Please attach the documentation. See next page)

MEDICAL CLEARANCE CERTIFICATION (PROVIDER USE ONLY)

PLAN: [ ] Drug Toxicology [ ]MMRV IgG [ ]HBsAg/Ab [ ]Td/Tdap [ ]QFT [ ]PPD [ ]CXR [ ]Flu Vaccine

Based on this evaluation, can this individual be granted medical clearance? [ ] Yes [ ] No

Provider/ Designee Name: _____ *License Number:* _____

Provider/ Designee Signature: _____ *Date:* _____

Facility: **NYC Health+Hospital/Queens**

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Chart No.

Name

Unit

(Patient Imprint Card)

GENERAL CONSENT FOR TREATMENT

FORM A

For patients seeking in-patient, out-patient and/or emergency room services.

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care, including vaccination. I understand that these services will be provided to me by physicians, dentists, nurse practitioners, midwives, physician assistants and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive.

2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.

3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures.

_____ _____ and _____ am pm
Signature of Patient or Parent/Legal Guardian of Minor Patient **Date** **Time**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____ and _____ am pm
Signature of Health Care Agent/Legal Guardian **Date** **Time**
(Place a copy of the authorizing document in the medical record)

_____ _____ and _____ am pm
Signature and Relation of Surrogate **Date** **Time**

WITNESS:

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ _____ and _____ am pm
Signature and Title of Witness **Date** **Time**

INTERPRETER/TRANSLATOR: (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ _____ and _____ am pm
Signature of Interpreter/Translator **Date** **Time**

HEALTH+ HOSPITALS | Queens

Queens Hospital Center

OHS Registration Information Form

PLEASE PRINT

Name: _____ _____
Last First

Date of Birth: _____

Maiden Name: _____

Address: _____

Apartment #: _____ _____ _____ _____
City State Zip code

Telephone Number: _____

Race: _____ Sex: ( ) F ( ) M

Title: _____

Marital Status: _____

Father's Name: _____

Mother's Name: _____

Mother's Maiden name: _____

Place of birth: _____ _____
How long in US

Religion: _____

Insurance Information

Name of insurance Company: _____

Identification Number: _____

Authorization: _____

Referral: _____

NYC HEALTH+ HOSPITALS | Queens

COVID-19 Assessment Form

Staff's Contact information

Name: _____ Sex: _____

Date of Birth: _____ TKID: _____

Contact phone number: _____

Personal Email: _____

Tile: _____

Department: _____ Facility: _____

Full Address: _____

Any signs and symptoms of following WITHIN THE LAST 14 DAYS?

Fever (subjective or > 100 F)	☐ YES	☐ NO
Use of antipyretic medication	☐ YES	☐ NO
Cough	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO
Muscle pain	☐ YES	☐ NO
Sore throat	☐ YES	☐ NO
Loss of taste or smell	☐ YES	☐ NO

Other: _____

Travel history WITHIN THE LAST 14 DAYS

Travel within the last 14 days ☐ YES ☐ NO

If YES, which country did you travel? : _____

Date of arrival to JFK: _____

Direct Contact with suspected or confirmed COVID 19 WITHIN THE LAST 14 DAYS

☐ YES ☐ NO

If yes, please answer following questions

Brief contact (< 1- 2 mins) ☐ YES ☐ NO

Close contact ☐ YES ☐ NO

- Within 6 feet = 2 meters for a prolong period of time
- Caring for, visiting, or sitting within 6 feet in a health care waiting Area or room
- Unprotected direct contact with infectious secretions (e.g., Being coughed on, touched used tissues with a bare hand)

Staff Signature _____ Staff Name _____ Date _____