



Weill Cornell Medicine

Human Resources

Volunteer Application

Weill Cornell Medicine or the Weill Cornell Graduate School of Medical Sciences (WCGSMS) may accept the unsalaried services performed by a volunteer on behalf of Weill Cornell Medicine or WCGSMS. Any services provided by the designated volunteer are subject to the prior approval of Weill Cornell Medicine or WCGSMS, and are subject to the oversight of a designated Cornell employee.

Weill Cornell Medicine strives to minimize risks and provide a safe work environment. **However, a volunteer is not eligible for any employee benefits or for Workers' Compensation. In addition, Weill Cornell Medicine bears no responsibility in case of an accident or health problem encountered in connection with performance of volunteer activity. A volunteer is financially responsible for all medical or other expenses related to any injury or illness suffered as a result of volunteer activities.**

A volunteer is subject to Cornell University, Weill Cornell Medicine and WCGSMS rules and policies, as well as the laws of the United States, New York City and State and any applicable regulations. If a volunteer violates any of these rules and policies, or if Weill Cornell wishes to dismiss a volunteer for any reason in its sole discretion, Weill Cornell retains the right to immediately dismiss them without prior notice.

All Weill Cornell volunteers must be at least 15 years of age.

Application Process

- 1. Application and medical clearance documentation.** Prospective volunteers must complete an *Application for Volunteer Service* and *Volunteer Request and Release Form* and submit it to the department in which they wish to volunteer. All volunteers must also comply with the medical clearance guidelines outlined on page 2. The department must then complete Part B of the *Application for Volunteer Service* to document the time period of voluntary service, duties to be performed, and volunteer location.
- 2. Department approval.** All completed documents must be approved by the relevant Department Chair, Vice Provost, Associate Provost, Associate Dean, or Designee.
- 3. Review by Human Resources.** The department must submit all completed documents and relevant medical clearance documentation to Human Resources for review and approval.

Volunteers cannot begin service until their application materials have been reviewed and approved by Human Resources. Upon approval, HR will send an email notification to the department with instructions on how to request a CWID for the volunteer, obtain an identification badge, and complete required training courses, including HIPAA and Fire Safety. If needed based on the volunteer's length of service, HR will also assist in scheduling a medical clearance appointment at Workforce Health and Safety.

Medical Clearance Guidelines

Medical clearance is based on a volunteer's length of service.

Volunteer with an assignment less than four weeks (30 days or less): Departments must submit an *Immune Assessment Form*, completed by the volunteer's primary care provider, along with the *Application for Volunteer Service*. No fee is required.

Volunteer with an assignment between four weeks and three months (31 to 90 days): Departments can submit the appropriate medical attestation form listed below along with the *Application for Volunteer Service*. If the volunteer cannot provide a medical attestation form, the volunteer may be cleared through Workforce Health & Safety (WHS) for a \$200 fee. This fee must be paid by the department via payment requisition to HR, or by the volunteer via personal check or money order. A check or money order may be delivered in person or mailed to Weill Cornell Medicine Human Resources, 575 Lexington Avenue, Suite 670, New York, NY 10022.

- Non-Physician volunteers: Submit a *Non-Physician Visitor Attestation of Medical Fitness Form*, completed and signed by the volunteer's primary care provider. WHS will charge a \$25.00 fee to review the attestation form. (Note that WH&S will not accept any substitute medical documentation.)
- Physician volunteers: Submit a *Physician Attestation of Medical Fitness to Provide/Observe Patient Care Form*, which allows visiting physician observers who will not have direct patient care or prescribe medications at WCM to complete and sign the attestation form. WH&S will charge a \$15.00 fee for reviewing each attestation form.

Volunteer with an assignment longer than three months (91+ days): The volunteer must be medically cleared by WHS for a \$200 fee. The department may submit a payment requisition to Human Resources for this amount, or the volunteer may cover the cost by submitting a personal check to HR via mail or in person at Weill Cornell Medicine Human Resources, 575 Lexington Avenue, Suite 670, New York, NY 10022 prior to their start date. Note that the timing of this clearance depends on where the volunteer will be located:

- Volunteers in Joint Commission or Article 28 Space must be medically cleared by WHS before they can begin volunteer services.
- Volunteers who are not in Joint Commission or Article 28 Space will be scheduled for a health assessment with WHS after their start date.

Volunteer requiring animal clearance who will serve for any length of time: The volunteer must be medically cleared by WHS for a \$200 fee before they can begin service. The department may submit a payment requisition to Human Resources for this amount, or the volunteer may cover the cost by submitting a personal check to HR via mail or in person at Weill Cornell Medicine Human Resources, 575 Lexington Avenue, Suite 670, New York, NY 10022

Application for Volunteer Service

| | | | |
|---|-----------------------------------|-----------|------------------------|
| Name (Last, First, Middle Initial): | | | Date of Birth: |
| Local Address (Street, Apt Number): | City, State: | Zip Code: | Home or Mobile Number: |
| Permanent Address (Street, Apt Number): | City, State (or foreign country): | Zip Code: | E-mail Address: |

Volunteer Interests (please document):

WCM/WCGSMS Supervisor/Advisor: _____

Department/Division: _____ Room #: _____ Telephone Extension: _____

Are you a student? YES NO

If YES:

(a) Please indicate your academic affiliation: _____

- (b) Status: Undergraduate --- (**please select one**):
- FRESHMAN JUNIOR
 SOPHOMORE SENIOR
 Graduate

(c) Are your volunteer activities part of a formal program? YES NO

(d) If YES, please provide program name: _____

Education Information (please check highest attained)

- | | |
|--|---|
| <input type="checkbox"/> Grade School/ High School Highest Year _____ <input type="checkbox"/> High School Diploma <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Master's Degree <input type="checkbox"/> Other Non-Medical Degree (Please specify): _____ | <input type="checkbox"/> Ph.D.* <input type="checkbox"/> D.V.M.* <input type="checkbox"/> M.D.* <input type="checkbox"/> D.D.S. or D.M.D.* <input type="checkbox"/> D.O.* <input type="checkbox"/> M.D./Ph.D.* |
|--|---|

***Please indicate school/hospital affiliation for degree(s) with *** _____

Volunteer Request and Release Form

Part A - To be completed by all volunteers:

1. Rules governing activities of volunteers:

a. You agree that your participation is entirely voluntary.

b. You, on behalf of yourself, your agents, your heirs, representatives, executors or administrators, hereby release, indemnify and hold harmless Cornell University, Weill Cornell Medicine, WCGSMS, its officers, agents and employees from any and all liability, damages, claims of any nature whatsoever arising out of or in any way related to your volunteer duties. Cornell University bears no responsibility in case of an accident or health problem which you may encounter as a result of activities carried out in connection with your volunteer activity or otherwise.

c. You understand that Cornell University, Weill Cornell Medicine, and WCGSMS do not provide any Accident or Medical Insurance and that you are required to provide your own Accident and Medical Insurance. You hereby agree that you are financially responsible for all such expenses. You are not covered by **any** employee benefit plans or by Workers' Compensation.

d. You understand that all volunteers are subject to Cornell University, Weill Cornell Medicine and WCGSMS rules and policies as well as the laws of the United States, New York City and State, and any applicable regulations. In the event of a violation of any of these, or for any behavior which is considered to be detrimental to students, patients, or any Cornell personnel, or to the department, the University, Weill Cornell Medicine, WCGSMS, or the Medical Center, or for any reason in its sole discretion, Cornell retains the right to immediately dismiss you as a volunteer without prior notice. You do not have a formal appointment to any Cornell department.

e. The duties outlined by the Department Chair, Vice Provost, Associate Dean or Designee of the Department in which you will be performing voluntary activities shall be a part of this agreement and release. Cornell's Indemnification Policy, which provides indemnification for claims brought by third parties, provides coverage for "volunteers, but only while acting at the specific prior request of an authorized official of the University to perform unsalaried services on behalf of the University."

2. Disclosure of Risks and Safety Requirements

Volunteering in a laboratory or in a medical environment may involve significant risks. These risks include the possibility of exposure to toxic chemicals, the possibility of exposure to radioactive materials or radiation, the possibility of exposure to infectious agents and the possibility of exposure to human blood or other bodily fluids which might contain infectious agents including HIV, the virus which causes AIDS. The nature of research also involves study of unknown or poorly understood conditions and unanticipated risks may exist.

As long as you are volunteering at Weill Cornell Medicine, you are required to strictly adhere to all safety regulations. If you have any questions regarding safety, you should promptly contact the Office of Environmental Health and Safety at 646-962-7233.

If you cannot provide acceptable evidence to the NewYork-Presbyterian Hospital Workforce Health and Safety Clinic of immunity to or immunization against designated communicable diseases (i.e., measles, mumps, rubella, varicella), you will be required to receive immunizations appropriate for your assignment prior to beginning your volunteer service. If you refuse immunizations for measles or rubella, you will be unable to perform any activities in a clinical setting. If your volunteer duties involve exposure to human blood or other body fluids then immunization against hepatitis B is required. If you decline to receive hepatitis B vaccination, you will be required to sign a statement to that effect.

Weill Cornell Medicine and the NewYork-Presbyterian Hospital will not be responsible for any injury or exposure to toxic, hazardous or infectious materials which you may sustain while volunteering here. If you are injured or exposed to dangerous materials while volunteering at the Weill Cornell Medicine you will be offered emergency medical care but you will receive no compensation for your injuries and will be responsible for all medical care cost.

Please indicate your awareness and acceptance of these terms and conditions by completing and signing this Form and returning it to your Weill Cornell Medicine or WCGSMS supervisor before beginning any volunteer duties.

| | |
|-----------------------------------|-------|
| Name of Volunteer (please print): | |
| Volunteer Signature: | Date: |

| Emergency Contact | | | |
|-------------------------------|--------------|---------------|------------------------|
| Name: | | Relationship: | |
| Address (Street, Apt Number): | City, State: | Zip Code: | Home or Mobile Number: |

If the volunteer is under 18 years of age, this document must be co-signed by a parent or legal guardian:

| | | | |
|---|--------------|-----------|------------------------|
| Name of Parent or Legal Guardian (please print): | | | |
| Address of Parent or Legal Guardian (Street, Apt Number): | City, State: | Zip Code: | Home or Mobile Number: |
| Parent or Legal Guardian Signature: | | | Date: |

Part B. - To be completed by Supervisor and Department Chairman or Associate Dean:

Volunteer Name: _____ Work Location: _____

Period of volunteer service from ____ / ____ / ____ to ____ / ____ / ____

PLEASE INDICATE VOLUNTEER'S PROPOSED SCHEDULE WHILE ON WCM PREMISES:

SAMPLE

| <i>Monday</i> | <i>Tuesday</i> | <i>Wednesday</i> | <i>Thursday</i> | <i>Friday</i> |
|------------------|----------------|-------------------|-----------------|-------------------|
| 9:00am to 5:00pm | Off | 12:00pm to 4:30pm | Off | 12:00pm to 4:30pm |

VOLUNTEER'S SCHEDULE: (PLEASE COMPLETE)

| <i>Monday</i> | <i>Tuesday</i> | <i>Wednesday</i> | <i>Thursday</i> | <i>Friday</i> |
|---------------|----------------|------------------|-----------------|---------------|
| | | | | |

Check off all activities to be performed by the volunteer and provide a detailed description for each activity on the following page:

| | |
|--------------------------|--|
| <input type="checkbox"/> | Clerical/ Computer Data Entry/ Data Compilation & Analyses |
| <input type="checkbox"/> | Library Research/ Medical Record Research/ Record |
| <input type="checkbox"/> | Patient Contact - In-person/ Over the phone |
| <input type="checkbox"/> | Observing Laboratory Work/ Conducting Laboratory Work |
| <input type="checkbox"/> | Observing Patient Care |
| <input type="checkbox"/> | Attendance in Meeting |
| <input type="checkbox"/> | Counseling |

| | YES | NO |
|--|--------------------------|--------------------------|
| Will the volunteer have patient contact in person? | <input type="checkbox"/> | <input type="checkbox"/> |
| Will the volunteer be physically located in New York Presbyterian Hospital space subject to Joint Commission regulation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Will the volunteer be physically located in a clinical laboratory setting? | <input type="checkbox"/> | <input type="checkbox"/> |
| Will the volunteer be physically located in a research laboratory setting? | <input type="checkbox"/> | <input type="checkbox"/> |
| Will the volunteer be physically located in a patient care setting (not subject to Joint Commission requirements)? | <input type="checkbox"/> | <input type="checkbox"/> |

Weill Cornell Medicine employee/faculty member supervising volunteer:

Name (please print) _____ Signature _____ Date _____

Department/Division/Office of _____ Phone Number _____

Department Chair, Vice Provost, Associate Dean, or Designee:

Name (please print) _____ Signature _____ Date: _____

Description of Activities, Part B. - Continued

Volunteer Name: _____ Work Location: _____

Please provide a detailed description for each activity the volunteer is expected to perform:

Clerical/ Computer Data Entry/ Data Compilation & Analyses:

Library Research/ Medical Record Research/ Record Research/ Writing, Editing

Patient Contact - In-person/ Over the phone

Observing Laboratory Work/ Conducting Laboratory Work (Please specify, if working with Animals, DNA, Blood or Cells.)

Observing Patient Care

Attendance in Meeting

Counseling