Special Placement Volunteer (SPV) On-boarding process

Patient Contact

Steps:

- **Request to Appoint a Special Placement Volunteer Form** is completed and submitted to Office of Volunteer Services (OVP)

- OVP sends **Application link** via email to SPV applicant

- **Criminal Background check** submitted online (link sent with application)

- **Medical Clearance:**

  1. **Certificate of Health Statement form (Section I only with proof of Immunizations)**

  2. **Immunization records (you may obtain these records from your school's health office)**

     Please note: If you do not have proof of your Immunizations, you will need to have your Physician complete Section II of the Certificate of Health

Upstate Employee Health Office: is located on the 4th floor of Jacobsen Hall Ph#315-464-4260, please call to schedule an appointment for your initial medical clearance. You will need to bring all completed health forms

- **Training and Orientation:** Applicant completes all requirements below

  Follow this link: http://www.upstate.edu/hr/new_staff/orientation/non_employee_orientation.php

  ONLY COMPLETE

  ☐ #1 – Non-Employee Orientation Guide and Completion Certificate

  ☐ #2 - HIPAA Privacy Rule Education and Completion certificate

Print completion certificates and bring with you to the Office of Volunteer Programs (OVP)

- **CITI TRAINING:** Please check with your requestor to see what course(s) are required for your type of research.

- **Payroll for ID badge:** you will be issued a Special Placement Volunteer ID Badge after you have completed medical clearance. Please report to **Payroll Services the 1st floor of Jacobsen hall** to obtain your Upstate Volunteer SPV ID Badge.

ONCE YOU HAVE COMPLETED ALL STEPS

Please contact Lauren Saldo to set up an appointment to come in to OVP to sign paperwork
Email: saldol@upstate.edu or **Ph# 315-464-5177**

Office of Volunteer Programs is located on the 1st **floor of the main hospital, ROOM 1401** You can stop at the information desk in the main lobby to ask for directions back to the office

Downtown Campus
Employee/Student Health
Office 175 Elizabeth Blackwell
St. Syracuse, NY 13210 315-464-4260 (telephone)
315-464-5471 (fax)
eshealth@upstate.edu

UPSTATE
MEDICAL UNIVERSITY

Certificate of Health Statement

For Special Placement Volunteer
Non-Employee Medical Clearance

Community Campus
Employee Health Office
4900 Broad Road
Syracuse, NY 13215 315-492-5624 (telephone)
315-492-5117 (fax)
eshealth@upstate.edu

Name: ______________________ DOB: ____________ Today's Date: ____________

Phone Number: ______________ Email: ______________ SS#: xxx-xx- ________ *(last four digits)*

Upstate Dept: ______________ Contact Person and Phone #: ______________

Upstate Job Title or Activity: ______________ **Begins:** ________ **Ends:** ________

Is patient contact expected? Yes / No *(circle one)* Your school/organization: ______________

(CONFIDENTIAL)

Section I: In the past year have you had or currently have: *(explain all YES responses)*

1. Any medical or surgical illness? No / Yes ______________
2. Contagious illness? No / Yes ______________
3. Mental health disorder? No / Yes ______________
4. Habitual use of alcohol or illicit drugs? No / Yes ______________
5. Skin infection or open (non-healing) wounds? No / Yes ______________
6. Recent weight loss, cough, fever, fatigue, loss of appetite and/or night sweats? No / Yes ______________
7. Medications? *(list)* ______________ Allergies? ______________
8. Disability/Limitations? ______________

I certify that the above information is true and complete: ______________ Date: ________
(signature)

You must provide Proof of Immunizations OR have this Section II completed by your Physician

Section II:

1. Tuberculin Skin Test *(Mantoux)* (must be within 12 months):
   Date Placed: ________
   Date Read: ________ Reaction (mm): ________ *(10mm or greater is considered Positive; Chest X-ray required)*
   If Positive TST: Chest X Ray required *: Date: ________ Result: ________ *(must be within 12 months)*
2. MMR Vaccination Date(s): 1.________ 2.________
   or titer Rubella IgG Antibody (date/result) ______________
   (include immunization record or lab reports) Rubeola IgG Antibody ________
   Mumps IgG Antibody ________
3. Varicella Vaccination Date(s): 1. ________ 2.________
   or titer Varicella IgG Antibody (date/result) ______________
4. Flu vaccination date (current seasonal) (Aug 1st - April 1st)______________

Provider Name (print): ______________ Signature: ______________ Date: ________

Address: ______________ Phone: ________

ESH USE ONLY: ________

Contact Employee Health with any questions about completion of this form.

Reviewed by OVP 4/2018 F82034 Rev. 4/2018