TRINITAS
Regional Medical Center

Thank you for your interest in volunteering at Trinitas Regional Medical Center.

Please be advised that each participant in the Trinitas Regional Medical Center Volunteer program must complete the following requirements:

- Produce immunization record indicating immunization to Measles and Rubella if born 1/1/57 or later
- Submit to criminal background check subject to a fee
- ID badge is required (supplied by Trinitas RMC)
  Subject to a returnable deposit
- Volunteer Jacket is required (supplied by Trinitas RMC)
  Subject to a returnable deposit

Please print out the application and return it along with your immunization record.
If you have any questions, please feel free to contact me at lliss@trinitas.org or 908-994-5164.

Yours truly,
Lisa E. Liss

Lisa E. Liss
Director, Volunteer Services
Trinitas Regional Medical Center
225 Williamson Street
Elizabeth, NJ 07207
908-994-5164 – office

4/22/2016

TRINITAS
Regional Medical Center

APPLICATION FOR A VOLUNTEER POSITION

PLEASE PRINT CLEARLY

NAME: _____ _____
Last **First**

HOME PHONE: _____

ADDRESS:_____ **CELL PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E-MAIL: _____

SPECIAL SKILLS: Please list any special skills you may have:

_____

_____

PLEASE INDICATE PREVIOUS VOLUNTEER EXPERIENCES (past or current)

_____

_____

Assignment Preferred: _____

AVAILABILITY: _____**Weekday Hours** ___**am to** ___**pm**
_____ **Evening Hours** ___ **pm to**___**pm**
_____ **Weekend Hours** ___**am to** ___**pm**

REFERENCES: **1.**_____
Name **Relationship to you** **Phone no.**
2._____
Name **Relationship to you** **Phone no.**

- over-

4/22/2016

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HIGHEST LEVEL OF EDUCATION: _____

ARE YOU PRESENTLY ATTENDING SCHOOL? IF SO, WHICH SCHOOL? ANTICIPATED GRADUTION DATE?_____

_____

REFERRED BY: _____

WHY DO YOU WANT TO VOLUNTEER OR WHAT DO YOU HOPE TO GAIN FROM THIS VOLUNTEER EXPERIENCE?

_____

_____

_____

_____

INTERESTS, SKILLS, HOBBIES: _____

PERSON TO BE CONTACTED IN AN EMERGENCY:

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **PHONE:** _____

Have you ever been employed or are currently employed by Trinitas Regional Medical Center or any of its affiliated organizations before? If so, please to list your former position and dates of employment.

Yes _____ **No** _____ **If Yes, please list the department and dates below**

Department	**From**	**To**
_____	_____	_____
_____	_____	_____

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Please read the following carefully before signing this application

I understand that this is an application for and not a commitment or promise of volunteer opportunity.

I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with Trinitas Regional Medical Center that is true, correct and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for a volunteer position with Trinitas Regional Medical Center or my termination as a volunteer. I give Trinitas Regional Medical Center ("TRMC"), Elizabeth, NJ, my consent to photograph, record, or film/videotape me/my child ("photograph"), or to interview me/my child. I also give TRMC my consent to use those photographs or interviews and other information about me/my child in any publication or advertising materials (printed or electronic) or for any lawful purpose. I understand and agree that TRMC may distribute my/my child's photograph and/or interview information to other organizations for use in promoting volunteer services. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or name or my child's photograph and/or name.

I understand that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Volunteer Services Department at Trinitas Regional Medical Center, 225 Williamson Street, Elizabeth, NJ 07207. I understand that my revocation will not apply to information that has already been released in response to this authorization. I further understand that this consent is expressly intended to release all personnel of Trinitas Regional Medical Center, as well as the attending physician and consultants, from any claim arising out of the use of such interviews, photographs and/or videotape

_____ _____

Signature **Date**

DO NOT WRITE BELOW THIS LINE

TO BE COMPLETED BY VOLUNTEER OFFICE:

Interview Date: _____

Orientation Date: _____

Start Date: _____ **Preceptor:** _____

Volunteer Assignment: _____

Day: _____ **Time:** _____

Training Sessions: _____

Physical Limitations: _____

4/22/2016

Remarks: _____

TRINITAS
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IF ACCEPTED AS A HOSPITAL VOLUNTEER, I AGREE THAT:

1. **I shall at all times uphold the mission, vision and values of the hospital.**

2. **I shall make my best effort to fulfill my commitment of a minimum 50 hours to the hospital by completing all assignments that I accept.**

3. **I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.**

4. **I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, physicians or staff, and not seek to obtain confidential information from a patient.**

5. **I shall attempt to resolve any problems related to my volunteer activities with my supervisor, and or, Director of Volunteer Services.**

6. **I shall not sell or attempt to sell goods or services, request contributions, or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Director of Volunteer Services to engage in these activities.**

7. **I agree to sign a release of medical information form so that my doctor(s) may furnish Trinitas Regional Medical Center information concerning my health.**

8. **I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of: (a) failure to comply with Hospital policies, rules and regulations; (b) absences without notifications; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the Director of Volunteer Services, would make my continued service as a volunteer contrary to the best interests of the hospital.**

I have read each of the above conditions and I agree to be bound by them.

_____ _____

Volunteer Signature **Date**

VOLUNTEER SERVICES DEPARTMENT

THIS HEALTH CERTIFICATE MUST BE COMPLETED BY A PHYSICIAN BEFORE APPLICANT MAY VOLUNTEER AT TRINITAS REGIONAL MEDICAL CENTER.

VOLUNTEER APPLICANT: _____

ADDRESS: _____

1. TO MY KNOWLEDGE THIS APPLICANT:

IS FREE FROM CONTAGIOUS DISEASE AND CAPABLE OF PERFORMING VOLUNTEER ASSIGNMENTS AT TRINITAS REGIONAL MEDICAL CENTER.

YES _____ NO _____

2. HAS THE FOLLOWING PHYSICAL AND/OR EMOTIONAL CONDITION REQUIRING RESTRICTIONS AND/OR PRECAUTIONS TO BE OBSERVED:

PLEASE NOTE RESTRICTIONS AND/OR PRECAUTION:

_____

_____

_____

HAS NO RESTRICTIONS:

_____ _____

PHYSICIAN'S NAME (PLEASE PRINT) **PHYSICIAN'S SIGNATURE**

_____ _____

PHYSICIAN'S ADDRESS **DATE**

PLEASE RETURN COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.

4/22/2016