



2020

Dear Applicant,

Thank you for your interest in the Trinitas Regional Medical Center Nurse Camp Program 2020.

We have an exciting program designed to introduce you to Health Professions.

As you requested, you will find attached an application to participate in this wonderful program.

Please note the following:

- The application must be complete and received in its entirety by MAY 1, 2020 (PROGRAM MAY FILL EARLIER)
- Open to FIRST TIME ATTENDEES ONLY
- Applications must include a \$50 non- refundable processing fee if accepted. This does not guarantee acceptance. ***This fee will be returned if NOT ACCEPTED.***

Please make fee made payable to:

Trinitas Regional Medical Center

Please mail your application and deposit to:

Volunteer Services
Trinitas Regional Medical Center
225 Williamson Street
Elizabeth, NJ 07207

Email and Faxed applications will NOT BE ACCEPTED.

Space is limited and is available on a first come, first serve basis.

Please remember this is a VERY POPULAR program which usually fills before March 31.

Sincerely,
Lisa E. Liss

Lisa E. Liss
Director – Volunteer Services



TRINITAS REGIONAL MEDICAL CENTER 2020 NURSE CAMP CHECKLIST

I have enclosed:

- Completed Application
- Immunization Record
- Documentation of a NEGATIVE PPD Test performed within the past year (if available)
- Guidance Counselor Recommendation
- Parental Permission form
- \$50 PROCESSING FEE (REFUNDED IF NOT ACCEPTED - NO CASH)

Make certain each page is signed with appropriate signatures.


TRINITAS
Regional Medical Center
225 Williamson Street
Elizabeth, NJ 07207



APPLICATION FOR NURSE CAMP 2020

Name: Last _____ First _____ Date: _____

Home Address: _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth: _____ **Home Phone:** _____ **Are you Male or Female?** (circle one)

Cell Phone: _____ **E-mail** _____

Parent or Guardian's Name: _____ **cell phone#** _____

Address: _____

Name of School: _____

Address of School: _____

Grade in September 2020: _____

Have you attended Nurse Camp before: ____Y ____N

Are you a resident of Union County: ____Y ____N

Please circle size for scrubs:

Tops: circle one XS S M L XL Other

Bottoms: circle one XS S M L XL Other

(Note: scrubs are unisex and run large- please choose carefully)

Please check the box next to the week you would like to be considered for: (please indicate first, second, third...choice)

Week A 7/6-7/10 Week B 7/20-7/24 Week C 7/27-7/31

Week D 8/10-8/14 Week E 8/17-8/21 Week F 8/24-8/28



PERSON TO BE CONTACTED IN AN EMERGENCY:

Name: _____ **Relationship:** _____

Address: _____ **City & State** _____ **Phone #** _____

Career Planned: _____

Why do you want to participate in Nurse Camp?

References:

1.	_____	_____	_____
	Name	Relationship to you	Phone No.
2.	_____	_____	_____
	Name	Relationship to you	Phone No.

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 hereby authorize that I may be interviewed, photographed or videotaped by a photographer or videographer authorized by Trinitas Regional Medical Center. I understand that such interview, photograph or video may be used in print and electronic communications. 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 of Parent or Guardian

Date

PLEASE NOTE: Application is not complete and will not be considered if not returned in its entirety by May 1, 2020. This program is very popular and usually fills early. Priority will be given to residents of Union County.

COMPLETION OF APPLICATION DOES NOT INDICATE ACCEPTANCE INTO THE PROGRAM.

TO GUIDANCE COUNSELOR

Mr./Miss _____ has expressed an interest in becoming a participant in Nurse Camp, part of the Teen Volunteer Program at Trinitas Regional Medical Center.

In order to insure the selection of the most eligible applicants, we would appreciate your cooperation by completing the following questionnaire. If you have any questions, please feel free to contact Lisa Liss, Director of Volunteer Services at (908) 994-5164.

Thank you for your assistance.

1. Scholastically, the applicant is considered:

Excellent _____ Good _____ Fair _____

2. The applicant is cooperative and accepting of authority:

Excellent _____ Good _____ Fair _____

3. The applicant is conscientious:

Excellent _____ Good _____ Fair _____

4. The applicant is willing and able to follow directions:

Excellent _____ Good _____ Fair _____

5. The applicant's attendance and tardy record is:


Excellent _____ Good _____ Fair _____

6. The applicant is in good health:

Excellent _____ Good _____ Fair _____

I recommend the applicant for Trinitas Regional Medical Center Nurse Camp:

With enthusiasm _____ I would not recommend _____

 Please check here if student receives free or reduced lunch.

Signature

Date

School

Dear Parent or Guardian:

Your permission is necessary for _____ to have a Mantoux Test for TB once accepted by Trinitas Employee Health Department. **If the Mantoux Test for TB is positive, it will be necessary to have a chest x-ray performed. If the Mantoux Test for TB is positive, a urine test for pregnancy will be required for all females.** Please sign below to indicate your approval.

1. Please indicate if your child has a history of allergies. Please be as specific as possible.

My child _____ is free from allergies.

(name – please print)

My child _____ has the following allergies: i.e food, latex, etc.

(name – please print)

2. My child _____ has the following physical and/or emotional condition requiring restrictions and/or precautions to be observed:

(name – please print)

PLEASE SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORD ALONG WITH THIS APPLICATION. THIS CAN BE OBTAINED FROM YOUR CHILD'S PHYSICIAN OR SCHOOL NURSE.

Sincerely,
Lisa E. Liss

Lisa E. Liss
Director - Volunteer Services

I give permission to the staff of Trinitas Regional Medical Center to complete all Medical Center requirements for pre-placement tests.

Parent or Guardian Signature

Date

Relationship

If you prefer to have the TB test done by your private physician, it must be completed by and documentation received by June 1 or your place will be forfeited.



Dear Parent or Guardian:

PLEASE READ THE FOLLOWING CAREFULLY

Your son/daughter has expressed an interest in participating in Nurse Camp at Trinitas Regional Medical Center. We would appreciate if you would sign the consent form below and have your son/daughter return it to us as soon as possible since it becomes part of their permanent record.

The form assures Trinitas Regional Medical Center that:

1. Your son/daughter is entering 11th or 12th grade in September 2020.
2. He/she attends Nurse Camp with your approval.
3. Both you and he/she realize that attendance is now his/her responsibility and should be taken very seriously. He/she agrees to complete a week of instruction, from 7:30am to 3:00pm. He/she must follow all rules and regulations established and be regular in attendance. Should an attendee be negligent of his/her duties, it may be cause for dismissal from the program.
4. He/she is not to be at the Medical Center on any other days or times than those assigned except when visiting a patient.
5. He/she is at the Medical Center as part of our Nurse Camp Program. Excessive socializing on the premises may result in termination.
6. It is the duty of the parent/guardian to assume responsibility for transportation to and from the Medical Center.
7. Unless there is an emergency, campers may not make or receive phone calls. Please arrange transportation ahead of time.
8. Uniforms are required. A uniform will be provided on the first day for your child. Uniforms must be worn at all times and it is the responsibility of the camper to keep their uniform neat and clean.
9. Students MAY NOT leave TRMC campus for any reason.
10. Signature below does not indicate acceptance to Nurse Camp.

Director - Volunteer Services
Trinitas Regional Medical Center

TO: DIRECTOR OF VOLUNTEER SERVICES

My son/daughter _____ is entering 11th or 12th grade in September 2020 and has my consent to become a participant in NURSE CAMP at Trinitas Regional Medical Center on the day/days for which he/she is scheduled and to adhere to the rules and regulations of the Volunteer Program.

Signature Date

Please check one: Parent _____ Guardian _____



PLEASE READ THIS PAGE VERY CAREFULLY:

You must commit to attend Nurse Camp for five full days from 7:30am-3:30pm.

If you are absent (even one day), you will forfeit your deposit and a certificate of attendance will not be given.

If you leave early (you have to be at work, your ride home has arrived early, etc.), you will forfeit your deposit and a certificate of attendance will not be given.

Females: Artificial nails, wraps, extenders, gels, or acrylic overlays are prohibited. Natural nail length must be limited to ¼ inch beyond the end of the finger. Finger polish is permitted but should be free of cracks & chips.

Please sign indicating that you have read this page and agree to it.

Student **Date**

Parent or Guardian **Date**