Thank you for your interest in Trinitas Regional Medical Center

WINTER Collegiate Medical Mentor Program 1/2/19-1/11/19

Please be advised that each participant in the Collegiate Medical Mentor Program must complete the following requirements:

- Submit to criminal background check subject to a fee once accepted
- Include a copy of your immunization record indicating immunity to Measles and Rubella if born 1/1/57 or later
- Include a brief essay describing why you want to be a part of this program and what you hope to gain. Please limit your essay to one page, double spaced.
- Include a copy of your resume and copy of transcript.

APPLICATION DEADLINE: NOVEMBER 26, 2018

Please print out the application and return it along with the necessary documents to the following address:

TCMM
Trinitas Regional Medical Center
225 Williamson Street
Elizabeth, NJ 07207
Attn: Lisa Liss

If you have any questions, please send an email to: tcmm@trinitas.org.

NOTE: INCOMPLETE OR LATE APPICATIONS *WILL NOT* BE CONSIDERED

TRINITAS
Regional Medical Center

APPLICATION FOR WINTER COLLEGIATE MEDICAL MENTOR PROGRAM

1/2/19-1/11/19

PLEASE PRINT CLEARLY

NAME: _____ _____
Last **First**

HOME PHONE: _____

ADDRESS:_____ **CELL PHONE:** _____

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

E-MAIL: _____

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

LEVEL OF EDUCATION January 2019: _____

DECLARED MAJOR: _____

Have you participated in the TRMC Collegiate Medical Mentor program before: _____Y _____N

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**
_____	_____	_____
_____	_____	_____

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: _____

TRINITAS
Regional Medical Center

IF ACCEPTED INTO THE COLLEGIATE MEDICAL MENTOR PROGRAM I AGREE THAT:

1. **I shall at all times uphold the mission, vision and values of Trinitas Regional Medical Center.**

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

3. **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.**

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

5. **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.**

6. **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 status as a result of: (a) failure to comply with Medical Center 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 contrary to the best interests of the Medical Center.**

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

_____ _____

Student Signature **Date**

VOLUNTEER SERVICES DEPARTMENT

THIS HEALTH CERTIFICATE MUST BE COMPLETED BY A PHYSICIAN BEFORE APPLICANT MAY PARTICIPATE IN ANY PROGRAM 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.