

**APPLICATION FOR A VOLUNTEER POSITION
PLEASE PRINT CLEARLY**

NAME: _____ **HOME PHONE:** _____
 Last **First**

ADDRESS: _____ **OTHER PHONE:** _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

E-MAIL _____

SPECIAL SKILLS: Please list the special skills you may have

 ___ **Typing WPM** ___ **Computer**
 ___ **Word Processing** ___ **Other**

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.**

HIGHEST LEVEL OF EDUCATION _____

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 Hospital?

Yes ___ **No** ___

Have you ever been convicted of a crime that has not been annulled, expunged or sealed by a court?

Yes ___ **No** ___

If Yes, please explain: _____

Please read the following carefully before signing this application

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 videotaping.

Signature

Date

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 Hospital 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



AUTHORIZATION

During the application process and at any time during the tenure of my volunteering with Trinitas Hospital, I hereby authorize ChoicePoint Services Inc., on behalf of Trinitas Hospital to procure a consumer report which I understand may include information regarding my character, general reputation, or personal characteristics. This report may be compiled with information from courts record repositories, departments of motor vehicles, past or present employers and educational institutions, governmental occupational licensing or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification; to the extent such investigation includes information bearing on my character, general reputation, or personal characteristics.

Applicant Name and Signature

Date

Social Security Number

Date of Birth

Printed Name _____

Street Address _____

City, State, Zip _____

Phone Number _____

BACKGROUND VERIFICATION DISCLOSURE

This is used to inform you that a consumer report is being obtained from a consumer reporting agency for the purpose of evaluating you for employment, volunteer service or a contracted position, including retention as an employee, volunteer or independent contractor.

This report may contain information bearing on your character, general reputation, and personal characteristics from public or private record sources.

DO NOT WRITE ON THIS PAGE

TO BE COMPLETED BY VOLUNTEER OFFICE:

Interview Date: _____

Orientation Date: _____

Start Date: _____ **Preceptor:** _____

Volunteer Assignment: _____

Day: _____ **Time:** _____

Training Sessions: _____

Physical Limitations: _____

Remarks: _____

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