

■ ■ SAINT BARNABAS
■ ■ HEALTH CARE SYSTEM
Monmouth Medical Center

RONALD J. DEL MAURO
President and Chief Executive Officer
Saint Barnabas Health Care System

FRANK J. VOZOS, MD, FACS
Executive Director
Monmouth Medical Center
(732) 222-5200

Dear Potential Volunteer;

Thank you for your interest in volunteering at Monmouth Medical Center. Please download the volunteer application and complete every page. **Incomplete applications will not be accepted and that may delay the entire application process.**

After your application is completed, and your references and Doctors' release form have been collected; you may contact my office to make an appointment for an interview. **You will bring your completed application with you at that time.**

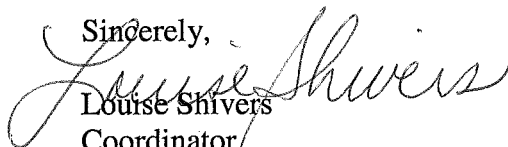
During the interview, we will talk about various topics including schedules, available and appropriate assignments, your interests and our needs. If a match is made, you will be invited to the next monthly New Volunteer Orientation. A criminal background check will be completed on anyone 18 years and older.

Every new volunteer is required to attend a New Volunteer Orientation. It is a four hour educational session covering such topics as safety, infection control and patient confidentiality. After completing an orientation, a start date is selected and you will be an official Monmouth Medical Center Volunteer.

If you have any questions about the volunteer application process, please contact me at 732-923-6670 or via e-mail at lshivers@sbhcs.com.

Thank you for your interest and I hope to hear from you soon.

Sincerely,


Louise Shivers
Coordinator
Office of Volunteer Services



Volunteer Application

Today's Date _____

Name

Last	First	MI	Nickname
------	-------	----	----------

Address _____

City	State	Zip
------	-------	-----

Home phone _____ Work phone _____ Other _____

E-mail address _____ Volunteer type _____
(teen 14 – 18) (adult over 18)

Birth date _____ Gender _____
Month/Day/Year female male

In case of an emergency, notify _____

Phone numbers #1 _____ #2 _____ Relationship _____

T			
E	Father's Name _____	Address _____	Phone _____
E			
N	Employer _____		Phone _____
S			
	Mother's Name _____	Address _____	Phone _____
O			
N	Employer _____		Phone _____
L			
Y			

Who referred you or how did you hear about volunteering at Monmouth Medical Center?

MMC Employee _____

MMC Volunteer _____

Newspaper article or advertisement from what paper and date _____

Your school _____ Other _____

Work experience:

Name of employer _____

Business address _____ Phone _____

Academic background:

High School _____ years completed _____

College _____ years completed _____

Other educational experiences _____

Extra activities, hobbies and skills:

Sports _____

Clubs _____

Hobbies _____

Skills _____

Foreign language(s) spoken _____

Have you had any previous volunteer experience: Yes _____ No _____

If yes, where and what were your duties? _____

Are you interested in a health career? Yes ____ No ____ If yes, which one? _____

In what area(s) are you interested in volunteering? #1 _____ #2 _____

What day(s) and hours are you available to volunteer?

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Why did you decide to volunteer at Monmouth Medical Center? _____

Personal references: Even though you have given the attached Personal Reference Check forms to your two references to complete, please write their names, addresses and phone numbers below in case more information is needed. References can not be immediate family members. Teens must have a school reference – teacher, guidance councilor, coach, etc. – as one of their two references.

Your application is not complete if any reference information is omitted.

1. _____
Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. _____
Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you ever been convicted of a crime? Yes ____ No _____. If yes, please explain the nature of the crime, when and where it occurred, and the outcome.

The information provided is accurate and correct to the best of my knowledge. My signature indicates that I give my approval and permission for Monmouth Medical Center to check my references; that I understand I will not be compensated for my services; and that I understand that the Office of Volunteer Services is not obligated to provide a placement, nor am I obligated to accept the position offered; and my signature indicates that if an assignment is accepted, I agree to abide by all Monmouth Medical Center rules and regulations as they will be outlined in the New Volunteer Orientation.

Signature _____ Date _____

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Interviewer _____ Date _____ Time _____

Assignment _____ Day(s) _____ Time(s) _____

Doctor's Release Form

PLEASE NOTE: THIS FORM MUST BE COMPLETED BY YOUR PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL AND PRESENTED WITH YOUR APPLICATION AT YOUR INTERVIEW. YOU WILL NOT BE ALLOWED TO BECOME A MONMOUTH MEDICAL CENTER VOLUNTEER WITHOUT THIS FORM.

Please PRINT patient's name

I VERIFY, PATIENT HAS NO MENTAL, PHYSICAL OR OTHER HEALTH PROBLEMS; OR COMMUNICABLE DISEASES THAT WOULD PRECLUDE HIM/HER FROM VOLUNTEERING. (Please initial) _____

OR... THE FOLLOWING LIMITATIONS OR PRECAUTIONS SHOULD BE TAKEN WHILE VOLUNTEERING:

WHAT IS THE DATE OF YOUR LAST PHYSICAL EXAMINATION? _____

WHAT IS THE DATE AND RESULTS OF THE LAST PPD/MANTOUX? _____ MM

IS THERE A HISTORY OF POSITIVE PPD? YES _____ NO _____

IF YES, WHAT IS THE DATE AND RESULTS OF LAST CHEST X-RAY? _____

HAVE YOU HAD A SEASONAL FLU SHOT? _____ If yes, when _____

HAVE YOU HAD THE H1N1 (SWINE FLU) SHOT? _____ If yes, when _____

TEENS: All vaccinations must be up-to-date. Please have your physician complete the following information or attach a copy of your shot record.

DATES OF MMR VACCINE _____

DATES OF HEPATITIS B VACCINE _____

DATES OF TETANUS _____

HAS PATIENT HAD CHICKEN POX? YES / NO IF NO, DATE OF THE VARICELLA VACCINE _____

PHYSICIAN'S NAME _____

PHYSICIAN'S SIGNATURE _____

ADDRESS _____ PHONE _____

DATE _____

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Dear Parent:

Your son/daughter has inquired about becoming a Teen Volunteer in the Volunteer Program at Monmouth Medical Center. We are happy to introduce him/her to the volunteer experience at our hospital; however, it is the policy of this institution that minors who wish to volunteer must complete an application and have parental consent.

If you agree to allow your son/daughter to be considered to become a volunteer, please sign the attached consent form and note that there are other forms must be completed by appropriate persons as well. The attached personal reference forms must be given to two people to complete. One must be a school reference such as a guidance councilor, coach or teacher and the other can be anyone else except an immediate family member. You will also find a Doctor's Release form. It must be completed by your child's physician. Please be assured that all information will be kept in strict confidence.

Once your child has filled in all the information and has collected all of the other forms, then the application is complete. The next step is for you or your child to contact my office to schedule an interview. I can be reached at 732-923-6670 or via e-mail at lshivers@sbhcs.com.

Parents are encouraged to become involved with the Volunteer Program at Monmouth Medical Center as well. If you should have any questions regarding your child's participation in the program or would like information on becoming a volunteer yourself, please do not hesitate to contact my office.

Sincerely,



Louise Shivers
Coordinator
Office of Volunteer Services



Dear Parent or Guardian:

This form assures that you understand and agree to the following:

1. Your son/daughter meets the age requirement of 14 years of age
 2. He/she volunteers with your approval
 3. Both you and he/she realize that volunteering at Monmouth Medical Center is a very important commitment. Your child must follow all rules and regulations established by the Office of Volunteer Services and Monmouth Medical Center, especially as it relates to attendance at volunteer orientation and maintaining patient confidentiality at all times.
 4. He/she must be regular in attendance and in the proper uniform.
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Parental Permission

It is the policy of Monmouth Medical Center that any minor volunteering should have a parent's consent for any emergency treatment needed while volunteering. I hereby give permission for my child to perform volunteer services at Monmouth Medical Center. I realize the need for him to be dependable, courteous and uphold the hospital code of ethics. I will be glad to cooperate with him/her in complying with the rules and regulations set up for both the volunteer's and hospital's protection. I will not hold Monmouth Medical Center responsible for any illness or injury incurred by my son/daughter, which is related to a previously existing medical condition/disability. I understand that it is my responsibility to inform the Office of Volunteer Services of any such pre-existing condition/disability prior to my child's receiving his/her assignment.

Signature of Parent or Guardian: _____ Date: _____

References

I give permission to the provided references to release information on my child as requested on the reference form by the Office of Volunteer Services at Monmouth Medical Center. It is my understanding that all information will be kept in strict confidence.

Signature of Parent or Guardian: _____ Date: _____

Department of Volunteer Services
Personal Reference Check

I, _____, have applied for a position as a volunteer with Monmouth Medical Center. Please take a moment to complete this form or write a letter of recommendation on my behalf. Upon completion, please return it to me in a sealed envelope. You may be contacted by the Department of Volunteer Services for more information or to verify authenticity.

1. What is your relationship to this applicant? _____
2. How long have you known him/her? _____
3. How would you describe his/her general attitude? _____
4. Is he/she dependable? _____ Responsible? _____
5. How would you describe his/her interpersonal skills? _____
6. What is his/her greatest attribute? _____
7. Any additional comments that you would like to make regarding this candidate? _____

Print name: _____ Signature: _____

Date: _____

If you have any questions, please contact Louise Shivers, Coordinator, Department of Volunteer Services at 732-923-6670.

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Date: _____

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