Dear Adult Applicant:

We are pleased to learn of your interest in the Volunteer Program at Community Medical Center. Please fill out the attached application and return it to the Volunteer Resource Center at your earliest convenience.

We will be contacting you to schedule a personal interview. This will provide an opportunity for us to identify your interests, your skills and your available schedule. We will then discuss the areas of the hospital in which you may be assigned and together we will select a position that will meet with your approval.

All new volunteers are required to attend a general orientation program, submit to a criminal background check and medical screening prior to beginning their volunteer assignment.

Volunteers are very special people and we appreciate your desire to serve Community Medical Center in such a special way. Again, we thank you for your interest and we look forward to meeting you.

Sincerely,

Gladys Zakar, CAVS
Volunteer Resource Center
732-557-8000 ext. 11256

COMMUNITY MEDICAL CENTER

an affiliate of the Saint Barnabas Health Care Center

ADULT VOLUNTEER APPLICATION

Date of Application: ________________________

We would appreciate you filling in and returning this form to the Volunteer Office. We will contact you to arrange an interview.

PERSONAL INFORMATION (please print)

Mr.
Mrs.
Miss ____

Last Name *First* *MI*

Marital Status: ☐ Single ☐ Married ☐ Widowed

____

Nickname *Spouse Name*

Address ____

Street

Home Phone ________________________

____

City *State* *Zip*

____

E-mail address

Birth Date _______________ Social Security No. __________-_____-__________

Personal Physician ____

Name *Phone*

____

Address

Have you ever committed, been convicted of, pled guilty to or pled nolo contendo to a felony or a misdemeanor? (Note: Conviction of a crime is not necessarily grounds for disqualification)
Yes _____________ No _______________

If yes, please explain ____

Please give us the name, address and telephone number of someone who can be notified in case of emergency

____

Name *Address* *Relationship*

____

Home Phone *Business Phone*

VOLUNTEER EXPERIENCE

Have you ever volunteered before? Yes _______ No ________ If yes, please list the last two organization (s)

____ From:_________ To: _________

name/address/phone

____ From:_________ To: _________

name/address/phone

How were you referred to Community Medical Center to volunteer? ___________________________

BACKGROUND

☐ Currently Employed ☐ Currently unemployed ☐ Retired

Employer ____ Work Phone __________________

Occupation ____

Education ____

COMMITMENT

Volunteer work preferred:

☐ Patient Contact ☐ Delivery Services ☐ Clerical/Reception
☐ Silver Spoon Patient Feeders ☐ Cashier/Sales

Are you available year round? Yes______ No ______ If no, when?__________________________

Time (s) and Day (s) available for volunteer service. Please specify hours that you can volunteer.

	Sun	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
Morning							
Afternoon							
Evening							

I have completed this application to the best of my knowledge, and verify its contents. I hereby authorize Community Medical Center to investigate all statements. I am also authorizing Community Medical Center to contact employers and/or volunteer organizations listed to verify statements or provide information.

Applicant signature ______________________________________ Date:______________________

FOR VOLUNTEER RESOURCE CENTER USE ONLY

Date application received ____________________________

COMMUNITY MEDICAL CENTER

VOLUNTEER RESOURCE CENTER

REFERENCE RELEASE

Please list the names, addresses and phone number of three references.

Please sign and date this release:

I authorize Community Medical Center Volunteer Office to contact my former employer(s), schools, companies corporations, law enforcement agencies and other persons who can verify or provide information on my volunteer application. Further, I release from liability such former employer (s), schools, companies, law enforcement agencies, and other persons contacted by and providing information to Community Medical Center. A copy of this authorization shall be as valid and binding as the original.

____ _________________________

Signature Date

ADULT VOLUNTEER HEALTH HISTORY

NAME: ___________________________________PHONE:__________________________

DATE OF BIRTH:___________________________SS#:_____________________________

PHYSICIAN'S NAME:________________________PHONE#___________________________

PERSONAL MEDICAL HISTORY

If you have or have had any of the following, please indicate with a check by that illness.

___Allergies
___Anemia
___Arthritis
___Asthma
___Back Injury
___Cancer
___Chicken Pox
___Dermatitis
___Dizziness
___Diabetes
___Drug or Alcohol
___Emotional Disorder
___Epilepsy
___Fainting

___German Measles
___Hay Fever
___Headaches
___Hearing Loss
___Heart Disease
___Hepatitis A
___Hepatitis B
___Hernia
___Herpes
___High Blood Pressure
___Intestinal Disorder
___Kidney Disease
___Liver Disease
___Low Blood Pressure

___Mumps
___Mononucleosis
___Measles
___Nervous Disorders
___Phlebitis
___Pleurisy
___Pneumonia
___Polio
___Rheumatic Fever
___Scarlet Fever
___Shortness of Breath
___Stroke
___Tuberculosis
___Typhoid

Do you have any physical limitations?____

____

Please list any medications you may take on a regular basis ___________________________

____

Are you allergic to any medications? _______ Yes _____No

Have you had any of the following inoculations?

TB Screening (Mantoux/PPD) _______ Yes _____No If yes, date ________________
(Please provide documentation)

Rubeolla (Measles) _______ Yes _____No If yes, date ________________
(Please provide documentation)

Rubella (German measles) _______ Yes _____No If yes, date ________________
(Please provide documentation)

(OVER)

CERTIFICATION OF TRUTH AND COMPLETENESS

I certify that all information given by me, in this history is true and complete and that I have not knowingly withheld any pertinent facts. I understand that giving any false information or omitting and pertinent data, may be cause for my release by the hospital.

Volunteer Signature____

Date ____________________________________