Jersey City Medical Center
Barnabas Health

Dear Prospective Student Volunteer:

Thank you for your interest in our Student Volunteer Program. Please complete the following forms and return them to the Volunteer Services Department at Jersey City Medical Center:

- Volunteer Application
- Student Agreement/Parental Permission
- Consent for Emergency Treatment
- School Guidance Counselor Evaluation

Upon receipt of your application we will process your references and contact you to schedule a personal interview. During the interview, we will discuss current volunteer opportunities and your availability.

If, at the time of interview, a volunteer assignment is mutually agreed upon, you will then be asked to complete a medical process through our Employee Health Department. This clearance includes completion of our medical release form by your physician and two Tuberculin Skin Tests. You will be provided with more information on this process during your personal interview.

Upon completion of all necessary paperwork, volunteers will be invited for an individual placement interview. Once accepted to the program, volunteers will be asked to purchase a uniform shirt from the hospital at a cost of $20.00.

The Student Volunteer Program requires a commitment of 50 hours of service within the first six months. Volunteers are generally scheduled for one three-hour shift per week (same day and time) and are not permitted to volunteer past 7 PM.

If you should have any questions, please contact us at 201-309-2739. Again, thank you for your interest in our program. We look forward to having you join our fine group of volunteers.

Sincerely,
Renee Giliberti

Renee Giliberti
Coordinator, Volunteer Services

Jersey City Medical Center
Barnabas Health

Department of Volunteer Services

Student Application

(14 – 17 years of age)

Applicant Information		
Name:		
Current Address:		Apt #:
City:	State:	ZIP:
Date of Birth:	SSN:	Phone:
Email:		Cell or Work Phone:

School Information		
Name:		
Address:		Phone:
City:	State:	Zip:
Current Grade:		Expected Graduation Date:
Guidance Counselor's Name:		

Employment Information		
Current or Most Recent Employer:		
Employer Address:		Dates employed:
City:	State:	ZIP:
Phone:	Fax :	Email :

Emergency Contact		
Name of Guardian:		Relationship:
Address:		
City:	State:	ZIP:
Phone:	Alternate Phone:	

Physician Information		
Name:		
Address:		
City:	State:	ZIP:
Phone:	Fax :	Email:

Reference

We will contact the Guidance Counselor you listed above for a reference. In addition, please provide the contact information for an adult willing to serve as a reference. Please do not include friends or relatives.

Name:	Relationship:		Office Use Only
Address Line 1:			Mailed / Rec'd
Address Line 2:			
City:	State:	Zip:	

Extra Curricular Activities
Volunteer Experience:
Organizational Affiliations:
School Activities:

Jersey City Medical Center
Barnabas Health

Department of Volunteer Services

Student Application

(14 – 17 years of age)

Skills	
Special Skills:	
Languages Spoken (fluently):	
Would you be willing to provide NON-MEDICAL translation services to patients/families/visitors?	
Preferences/Interests	
Type of Volunteer Work Desired (if known)	
Are you comfortable interacting with patients? Yes No Unsure	
Is there work you are unable or unwilling to perform?	
Availability	
Please circle all that apply Monday Tuesday Wednesday Thursday Friday Saturday Sunday	
Time Availability Morning Afternoon Evening (until 7 PM)	
Specify Hours Desired:	Available to Start:
Are you available throughout the year?	If no, when are you NOT available?
Is volunteer work a requirement for school credit or religious classes?	
If so, number of hours required?	Date by which hours must be completed:
Referrals	
How did you learn of volunteer opportunities at Jersey City Medical Center? Brochure Newspaper Website Bulletin Board Community Presentation School Other Please specify:	
If referred by Barnabas Health employee or volunteer, please specify name, location and relationship:	
Applicant's Authorization	
I certify that the above information is true and complete and I authorize Barnabas Health and/or its entities to investigate any and all statements that I have made. I understand any false statement on this application may be considered cause for rejection of this application or immediate termination if my volunteer assignment has begun. I understand that completion of this application and/or interview/screening process is not a promise of an offer of assignment.	
Signature of Applicant:	Date:
Guardian Consent	
I hereby give permission for this applicant to perform volunteer service at Jersey City Medical Center. I understand the responsibilities involved and will support my son/daughter in their volunteer efforts.	
Print Name:	
Signature:	Date:

ONCE WE RECEIVE YOUR APPLICATION WE WILL REACH OUT WITH THE NEXT STEPS. THANK YOU.

Jersey City Medical Center
Barnabas Health

Student Volunteer Agreement

I understand that my commitment to Jersey City Medical Center as a Student Volunteer is to contribute a minimum of FIFTY HOURS. Evaluations or written references will not be provided by the Volunteer Services Department until such hours have been completed. All requests for evaluations and references will be made to the Director of Volunteer Services.

_____ _____

Signature of Volunteer Date

Parental Permission

Your child has expressed interest in a volunteer opportunity at Jersey City Medical Center. If this meets with your approval, he/she will be considered for a Student Volunteer position.

We give much consideration and welcome all inquiries. However, due to the nature of hospital regulations and patient safety issues, there are a few things you should consider.

Your child must be at least 14 years of age and attending high school. Students are permitted to volunteer three hours per day and no later than 7 PM during the academic school year. Additional hours may be arranged during the summer and other school vacations.

Jersey City Medical Center's primary responsibility is to provide a safe environment for our patients. Volunteering is a responsibility that should be taken seriously. Student volunteers will be expected to follow hospital procedures while conducting themselves professionally. Volunteers who are unable to meet their commitment or adhere to hospital policies will be dismissed from the program.

My son/daughter _____ is 14 years or older and has my permission to volunteer at Jersey City Medical Center.

_____ _____

Signature of Parent/Guardian Date

Jersey City Medical Center
Barnabas Health

CONSENT FOR EMERGENCY MEDICAL TREATMENT

VOLUNTEER:_____ DATE OF BIRTH:_____

Any person under the age of 18 cannot authorize treatment for himself/herself or someone else. If your child is in need of medical treatment while volunteering his/her services at Jersey City Medical Center, every attempt will be made to contact you or your designated responsible adult in order to obtain consent for medical treatment.

By your statements and signature below, it is understood that you are granting consent for emergency medical treatment to be rendered to the above minor volunteer.

In the event that medical treatment is required, please contact one of the following:

Parent/Guardian_____
Address:_____
_____
Telephone:_____

Parent/Guardian:_____
Address:_____
_____
Telephone:_____

Designee:_____
Address:_____
_____
Telephone:_____

Family Physician:_____
Address:_____
_____
Telephone:_____

In the event that none of the above can be contacted, I hereby give my consent for medical treatment to be rendered to_____(Volunteer Name) in the Jersey City Medical Center Emergency Room.

Parent/Guardian Signature_____Date:_____

Relationship:_____

Jersey City Medical Center
Barnabas Health

GUIDANCE COUNSELOR
CONFIDENTIAL EVALUATION

Student's Name: _____

School Name: _____Grade: _____

CONSENT TO RELEASE SCHOOL RECORDS

I authorize a representative of the fore mentioned school to complete the School Guidance Counselor Evaluation Form in connection with the above student's application to participate in the Student Volunteer Program at Jersey City Medical Center. I understand the purpose of this form is to aid Jersey City Medical Center in selecting qualified student volunteers.

All information provided by the school will remain confidential.

Signature of Parent or Legal Guardian: _____Date: _____

DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY GUIDANCE COUNSELOR

I would rate this student as follows:

1. Requires (less, more, about the same) amount of instruction as most students.
2. Requires (minimal, occasional, considerable) amount of supervision or direction.
3. (Does , Does not) follow through on assignments.
4. Gets along (well, very well, not well) with peers.
5. Gets along (well, very well, not well) with older adults.
6. (Has, Does not have) adequate emotional stability to work with hospital patients.
7. (Is, Is not) regular in school attendance. If not, what is cause of absence or tardiness? _____

_____ I recommend this candidate to be accepted as a Student Volunteer at Jersey City Medical Center.

_____ I do not recommend this candidate to be accepted as a Student Volunteer at Jersey City Medical Center.

Comments:

_____

_____

Signed: _____Date: _____

Print Name & Title: _____

Please return to: Jersey City Medical Center
Volunteer Services Department
355 Grand Street
Jersey City, NJ 07302