



Dear Prospective Volunteer:

Thank you for your interest in becoming a volunteer at Jersey City Medical Center. Per your request, I am enclosing an application form.

Please complete the application, making certain to respond to each area as instructed. Be sure to include the names and **complete** mailing addresses of **two** personal or professional references [no relatives please]. Applications with missing addresses can not be processed.

Please return the completed application form to Volunteer Services at the address listed below. Upon receipt of your application we will contact your two references by mail and schedule you for our monthly prospective volunteer information and orientation session. During this session, we will explore our volunteer options and volunteer education materials.

Volunteer applicants will also complete a medical process and a criminal background check. You will be provided with more information on this process at the information session.

Upon completion of all necessary paperwork, volunteers will be invited for an individual placement interview. Once accepted to the program, volunteers will be provided a uniform shirt and hospital ID badge.

If you should have any questions, please contact Volunteer Services at 201-309-2739. Again, thank you for your interest in joining our fine group of volunteers. I know that you will find the experience rewarding.

Sincerely,

Joshua Remland

Coordinator, Volunteer Services





Department of Volunteer Services Adult Application

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	APPLICANT INFORMA	ATION	
First Name:	Last Name	e:	
Current Address:		Apt#:	
City:	State:	Zip:	
Date of Birth (Month and Day):		Phone:	
Email:		Cell:	
	EMPLOYMENT INFORM	MATION	
Current or Most Recent Employer:			
Employer Address:		Dates Employed:	
City:	State:	Zip:	
Phone:	Fax:	Email:	
	EDUCATION INFORMA	ATION	
Current or Last School Attended:			
City:	State:		
Course of Study/Degree Earned:			
Other Education/Special Training:			
Are you applying to volunteer as part			
	EMERGENCY CONT.		
Name:	Relationship:		
Address:			
City:	State:	Zip:	
Phone:	Alternate Phone:		
T	PHYSICIAN INFORMA	ATION	
Name:			
Address:			
City:	State:	Zip:	
Phone:	Fax:	Email:	
n	REFERENCES	N F 'I	
	onal or Professional Reference		
(1) Name:		Relationship:	
Address:		Apt#:	
City:	State: Zip:		
(2) Name:		Relationship:	
Address:		Apt#:	
City:	State:	Zip	
Providing Ac	ccurate Addresses Will Allow	For Speedy Processing	

	Office Use Only	
	Mailed	Received
Reference (1)):	
Reference (2)):	

EXTRA CURRICULAR ACTIVITIES			
Volunteer Experience:			
Organizational Affiliations:			
Have you previously volunteered or been employed at any RWJBarnabas Health facility?			
If so, where and when?			
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			
Specify Hours Desired: Available to Start:			
Are you available throughout the year? If no, when are you NOT available?			
REFERRALS			
How did you learn of volunteer opportunities at Jersey City Medical Center?			
Brochure Newspaper Website Bulletin Board Community Presentation School Other			
If referred by Barnabas 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 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:			