Jersey City Medical Center | RWJBarnabas HEALTH

Dear Prospective Student Volunteer:

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

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

Upon receipt of your application we will contact your reference 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. 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.

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 7PM.

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

30 Regent St, Jersey City, NJ 07302 PH: (201) 309-2739 FX: (201) 516-2032 Email: Joshua.Remland@rwjbh.org

Jersey City Medical Center | RWJBarnabas HEALTH

Department of Volunteer Services

Student Application

(14 – 17 years of age)

APPLICANT INFORMATION

First Name:	Last Name:	
Current Address:		Apt#:
City:	State:	Zip:
Date of Birth (Month and Day):	Phone:	
Email:	Cell:	

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

Personal or Professional Reference – An Adult, Non Family		
Name:		Relationship:
Company:		
Address:		Apt #:
City:	State:	Zip:
Providing an Accurate Address Will Allow For Speedy Processing		

Office Use Only	
Mailed	Received
Reference:	
Guidance:	

EXTRA CURRICULAR ACTIVITIES

Volunteer Experience:
Organizational Affiliations:
School Activities:

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 7PM)
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
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:

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:

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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 permission to volunteer at Jersey City Medical Center.

_____ _____

Signature of Parent/Guardian Date

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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: _____

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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:
_____
_____

Signature: _____ Date: _____

Print Name & Title: _____

Please return to: Jersey City Medical Center – Volunteer Services Department
30 Regent Street, Jersey City, NJ 07302