



Dear Volunteer Applicant,

Thank you for your interest in volunteering at Monmouth Medical Center. You have chosen to be part of a dynamic team of volunteers who enhance the patient experience at our Medical Center. In an effort to ensure the application review process is timely, please note that incomplete applications will be returned to the applicant. Please ensure that the following sections are complete and make a copy of your application for your records prior to submitting.

Adult Applicants (over the age of 18)

- _____ Application
- _____ 2 Professional References
- _____ Pre-Placement Physical Checklist completed by your physician
- _____ Background Check Form (completed at interview)

Please send completed applications to:

Office of Volunteer Services
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740

Upon receipt of your completed application, you will be contacted to discuss the exciting volunteer opportunities at Monmouth Medical Center and be provided with information to schedule an appointment with our Corporate Care Office to request Medical Clearance. Please be reminded that we ask for a minimum commitment of 150 hours annually with a minimum commitment of one year of service.

Every new volunteer is required to attend a New Volunteer Orientation. It is a five-hour educational session covering such topics as safety, infection control and patient confidentiality.

If you have any questions about the volunteer application process, please feel free to contact the Office of Volunteer Services at 732-923-6671 or e-mail me at laura.siementkowski@rwjbh.org.

Sincerely,

Laura A. Siementkowski
Manager, Office of Volunteer Services

Adult Volunteer Application



Office of Volunteer Services
 300 Second Avenue
 Long Branch, NJ 07740
 Telephone: 732-923-6670 Fax: 732-923-6673
 Adult Volunteer Application

(This application will be kept confidential)

Date _____

Personal Contact Information:		
Last Name: _____	First: _____	MI: _____
Address: _____		
City: _____	State: _____	Zip Code: _____
Home Phone: _____	Work Phone: _____	
Cell Phone: _____	E-mail address: _____	
Birth date _____	Gender _____	_____
Month/Day/Year	female	male

Emergency Contact Information:		
Name: _____	Relationship: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
Home Phone: _____	Work Phone: _____	Cell: _____

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							

We ask for a minimum commitment of 150 hours annually with a minimum commitment of one year of service.

General Information:

How did you learn about our program? _____

Why are you interested in volunteering for Monmouth Medical Center? _____

Work Experience:

Name of Employer: _____ Date(s): _____

Business Address: _____ Phone: _____

Volunteer Experience:

Name of Organization: _____ Date(s): _____

Business Address: _____ Phone: _____

Hobbies, interests, or skills: _____

Languages: English _____ Speak _____ Read _____ Write _____
Spanish/Other _____ Speak _____ Read _____ Write _____

Academic Background:

High School: _____ Years Completed: _____

College: _____ Years Completed: _____

Other Educational Experiences: _____

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

We appreciate your interest in our hospital. A clear understanding of your background and work history will assist us in considering you for the volunteer position that best meets your qualifications and interests.

Interests and Skills (Please indicate with a checkmark)

Clerical Skills:

- | | |
|---|--|
| <input type="checkbox"/> Typing | <input type="checkbox"/> Mailings |
| <input type="checkbox"/> Filing | <input type="checkbox"/> Alphabetizing |
| <input type="checkbox"/> Phone Receptionist | <input type="checkbox"/> Cash Register |
| <input type="checkbox"/> Using Copier | <input type="checkbox"/> Other (specify) _____ |

Patient Care Services:

- | | |
|--|--|
| <input type="checkbox"/> Messenger Services | <input type="checkbox"/> Visiting Patients |
| <input type="checkbox"/> Transporting Patients | <input type="checkbox"/> Feeding Patients |
| <input type="checkbox"/> Pastoral Care | <input type="checkbox"/> Other (specify) _____ |

Personal Skills:

- Arts and Crafts
- Musical Instrument

Additional Skills/Comments: _____

The Monmouth Medical Center Volunteer Program is available to all, without regard to race, color, national origin, disability, gender, political affiliation, or religion.

Professional references: Even though you have given the attached Professional 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 should not be immediate family members. **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 _____

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 outlined in the New Volunteer Orientation.

I am able to volunteer a minimum of 150 hours annually and am committed to volunteering a minimum of one year at Monmouth Medical Center.

Signature _____ Date _____

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Interviewer _____ Date _____ Time _____

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

Department of Volunteer Services
Professional 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: _____ Telephone Number: _____

If you have any questions, please contact Laura Siemientkowski, Manager, Volunteer Services, at 732-923-6670.

Department of Volunteer Services
Professional Reference Check

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 6. What is his/her greatest attribute? _____
 7. Any additional comments that you would like to make regarding this candidate? _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Print name: _____ Signature: _____

Date: _____ Telephone Number: _____

If you have any questions, please contact Laura Siemientkowski, Manager, Volunteer Services, at 732-923-6670.

Volunteer Medical Clearance Process

New Volunteer Pre-Placement Physical Checklist

- To be completed by your physician. This is a requirement for volunteering.

2-Step PPD

- Adults Only: 1 PPD must be completed at MMC Corporate Care Office.

Hepatitis B Vaccine

- All candidates are required to provide documentation of current immunizations or titer testing.
- If you do not have documented immunity to Hepatitis B and choose to opt out of the Hepatitis B Vaccine, you must sign an OSHA Hepatitis B Vaccine Declination Form which is available at Employee Health (Corporate Care) when you submit your completed New Volunteer Pre-Placement Physical Checklist. Teens (14-17) – parent or guardian will be required to sign if you choose to opt out.

Submission of Completed Volunteer Pre-Placement Physical Checklist

- **Completed Pre-Placement Physical Checklist must be reviewed with the volunteer applicant at Employee Health (Corporate Care) in person. You will be required to present a photo ID e.g., driver's license, school ID, passport, etc.**
- **Teens (ages 14-17) must be accompanied by a parent and both present a photo ID.**
- **Applicants will be requested to make an appointment with the Employee Health Office (Corporate Care) by calling 732-923-6745 to present form and schedule drug screening.**

Employee Health (Corporate Care) Location:

- A.K.A. Corporate Care, Occupational Health
Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740
Phone (732) 923-6745 Hours are 8:00 am – 4:00 pm – Monday-Friday.
Please call 732-923-6745 to make an appointment for medical clearance.

TITLE: NEW VOLUNTEER Medical Clearance Policy
EFFECTIVE DATE: 11-13-2018

Corporate Care Policy #6

Attachment #1 **New Volunteer Pre-placement Physical Checklist attestation form**

Name:	Phone Number:
ADULT (18 y/o or older) OR TEEN (17 y/o or younger)	Date of Birth:
Email:	
Department: VOLUNTEER	Social Security #:

1. Physical exam w/in past 12 months, then annually, demonstrating free of communicable disease.

2. Tuberculosis (TB) infection screening with the Tuberculin Skin Test (TST)/PPD, as follows:

- An initial 2-Step PPD/TST process; with an annual PPD subsequently. Please note most recent:

Date PPD#1plant: _____ **Date PPD-read:** _____ **Result:** _____ mm indur.

Date PPD#2plant: _____ **Date PPD-read:** _____ **Result:** _____ mm indur.

NOTE: If a PPD is read Positive or ≥ 10 mm induration, **ALL** the following is required to be provided:

- An evaluation by a Physician (MD/DO) or APN to rule out active Contagious TB infection, and:
- An Interferon Gamma Release Assay (IGRA) blood test (TSPOT® or QFTG®); and if positive (or not negative):
- An initial/baseline chest x-ray that is "Negative" for active/contagious TB; performed w/in past 12 months.

3. Proof of Immunity to all the following viruses:

a. Rubella (German Measles)- a Positive IgG titer or proof of 1 MMR vaccine.

b. Rubeola (Measles) - a Positive IgG titer or proof of 2 MMR vaccines, given at least 4 weeks apart.

c. Mumps- a Positive IgG titer or proof of 2 MMR vaccines, given at least 4 weeks apart.

d. Varicella (Chickenpox)- a Positive IgG titer or 2 VARIVAX vaccines, given at least 4 weeks apart.

e. Hepatitis B- a Positive hepatitis B surface Antibody titer BLOOD TEST for immunity; if negative, then either a Hepatitis B vaccine series started or a signed OSHA Hepatitis B vaccine Declination Form (see OSHA Bloodborne Pathogens Standard 29 CFR 1910.1030).

4. Proof of Vaccination with:

a. **Tdap (Tetanus, diphtheria, acellular pertussis)** adult vaccine (Adacel® or Boostrix®).

(Note: the childhood vaccines called DTAP are NOT acceptable substitutions).

b. **Influenza vaccine** (seasonal, usually between September 1st and March 31st)

DATE Influenza Vaccine: _____ **Was Vaccine given at RWJBH clinic?** YES or NO

(or DATE of RWJBH Influenza Exemption Letter (it must be attached): _____.)

I attest the above named Individual has completed ALL medical requirements listed above, and all medical documentation is retained in my medical office medical records, EXCEPT:

(LIST above only those medical tests or vaccines NOT available in your medical office)

Physician SIGNATURE (conducting exam)

PRINT Name

Date

Physician Address

Telephone Number

License #

After above form COMPLETED, call your RWJBH Corporate Care/Employee Health clinic to schedule an apt. for your Urine Drug Screen and review of this Attestation Form.

Address: 300 Second Avenue, Long Branch, NJ 07740

Hours: M-F, 8a-4p

Telephone: 732-923-6745

FAX: 732-923-6747

Attachment #2 CDC- Recommended Vaccines for Healthcare Workers
<http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines.

Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff.

Vaccines	Recommendations in brief
<u>Hepatitis B</u>	If you don't have documented evidence of a complete hepB vaccine series, or if you don't have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should Get the 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Get anti-HBs serologic tested 1–2 months after dose #3.
<u>Flu (Influenza)</u>	Get 1 dose of influenza vaccine annually.
<u>MMR (Measles, Mumps, & Rubella)</u>	If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles or mumps (i.e., no serologic evidence of immunity or prior vaccination), get 2 doses of MMR (1 dose now and the 2nd dose at least 28 days later). If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to rubella , only 1 dose of MMR is recommended. However, you may end up receiving 2 doses, because the rubella component is in the combination vaccine with measles and mumps. For HCWs born before 1957, see the <u>MMR ACIP vaccine recommendations</u> .
<u>Varicella (Chickenpox)</u>	If you have not had chickenpox (varicella), if you haven't had varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine , 4 weeks apart.
<u>Tdap (Tetanus, Diphtheria, Pertussis)</u>	Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get Td boosters every 10 years thereafter. Pregnant HCWs need to get a dose of Tdap during each pregnancy.
<u>Meningococcal</u>	Those who are routinely exposed to isolates of <i>N. meningitidis</i> should get one dose.

Attachment #3: Excerpts from: **MMWR: Prevention of Measles, Rubella, Congenital Rubella Syndrome, and Mumps, 2013: Summary Recommendations of the Advisory Committee on Immunization Practices (ACIP) Recommendations and Reports June 14, 2013 / 62(RR04);1-34.** Full report found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm>

Summary *This report is a compendium of all current recommendations for the prevention of measles, rubella, congenital rubella syndrome (CRS), and mumps. The report presents the recent revisions adopted by the Advisory Committee on Immunization Practices (ACIP) on October 24, 2012, and also summarizes all existing ACIP recommendations that have been published previously during 1998–2011 (CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices [ACIP]. MMWR 1998;47[No. RR-8]; CDC. Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001;50:1117; CDC. Updated recommendations of the Advisory Committee on Immunization Practices [ACIP] for the control and elimination of mumps. MMWR 2006;55:629–30; and, CDC. Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011;60[No. RR-7]). Currently, ACIP recommends 2 doses of MMR vaccine routinely for children with the first dose administered at age 12 through 15 months and the second dose administered at age 4 through 6 years before school entry. **Two doses are recommended for adults at high risk for exposure and transmission** (e.g., students attending colleges or other post-high school educational institutions, **health-care personnel**, and international travelers) and 1 dose for other adults aged ≥ 18 years. **For prevention of rubella, 1 dose of MMR vaccine is recommended for persons aged ≥ 12 months.** At the October 24, 2012 meeting, ACIP adopted the following revisions, which are published here for the first time. These included:*

For acceptable evidence of immunity, **removing documentation of physician diagnosed disease as an acceptable criterion for evidence of immunity for measles and mumps, and including laboratory confirmation of disease as a criterion for acceptable evidence of immunity for measles, rubella, and mumps.*

Health-Care Personnel Born Before 1957-Although birth before 1957 is considered acceptable evidence of measles, rubella, and mumps immunity, **health-care facilities should consider vaccinating unvaccinated personnel born before 1957 who do not have laboratory evidence of measles, rubella, and mumps immunity; laboratory confirmation of disease; or vaccination with 2 appropriately spaced doses of MMR vaccine for measles and mumps and 1 dose of MMR vaccine for rubella.** Vaccination recommendations during outbreaks differ from routine recommendations for this group (see section titled Recommendations during Outbreaks of Measles, Rubella, or Mumps).

Serologic Testing of Health-Care Personnel- Prevaccination antibody screening before measles, rubella, or mumps vaccination for health-care personnel who do not have adequate presumptive evidence of immunity is not necessary unless the medical facility considers it cost effective. **For health-care personnel who have 2 documented doses of measles- and mumps- containing vaccine and 1 documented dose of rubella-containing vaccine or other acceptable evidence of measles, rubella, and mumps immunity, serologic testing for immunity is not recommended.** If health-care personnel who have 2 documented doses of measles- or mumps-containing vaccine are tested serologically and have negative or equivocal titer results for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine. Such persons should be considered to have acceptable evidence of measles and mumps immunity; retesting is not necessary. Similarly, if health-care personnel (except for women of childbearing age) who have one documented dose of rubella-containing vaccine are tested serologically and have negative or equivocal titer results for rubella, it is not recommended that they receive an additional dose of MMR vaccine. Such persons should be considered to have acceptable evidence of rubella immunity.

TITLE: NEW VOLUNTEER Medical Clearance Policy
EFFECTIVE DATE: 12-19-2017

Corporate Care Policy #6

Attachment #4 **Medical Clearance Form - NEW VOLUNTEER Applicant**
(for Robert Wood Johnson BarnabasHEALTH (RWJBH) Medical facilities)

Name: _____ DOB: _____

_____ Teen Volunteer OR _____ Adult Volunteer

_____ YES, the above named New Volunteer is medically cleared to
VOLUNTEER at RWJBH medical facilities.

_____ YES, the above named New Volunteer is medically cleared to VOLUNTEER at
RWJBH medical facilities with the following Restrictions/Limitations:

_____ NO, the above named New Volunteer is NOT medically cleared to VOLUNTEER at
RWJBH medical facilities.

September 1st through March 31st- INFLUENZA vaccination information:

_____ New Volunteer has medical documentation/attestation showing they received
the Influenza vaccine this season, ELSEWHERE.

_____ New Volunteer had Influenza Vaccine at a RWJBH facility.

RWJBH- Corporate Care/Employee Health Staff Member

Date

Volunteer Director/Representative: _____