Monmouth Medical Center
The Unterberg Children's Hospital
Barnabas Health

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. Please download the volunteer application and ensure that the following sections are complete. In an effort to ensure the application review process is timely, please note that incomplete applications will be returned to the applicant. Please make a copy of your application for your records prior to submitting.

Adult Applicants (over the age of 18)

_____ Application
_____ 2 Professional References
_____ Doctor's Release Form (must be presented to Monmouth Medical Center Corporate Care located at Todd Ground Floor for Medical Clearance). Hours: Monday – Friday 8:00 a.m. – 4:00 p.m. Telephone Number: 732-923-7650
_____ 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

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Upon receipt of your completed application, you will be contacted to discuss the exciting volunteer opportunities at Monmouth Medical Center. Please note that we ask for a minimum commitment of 150 hours annually with a minimum commitment of one year of service.

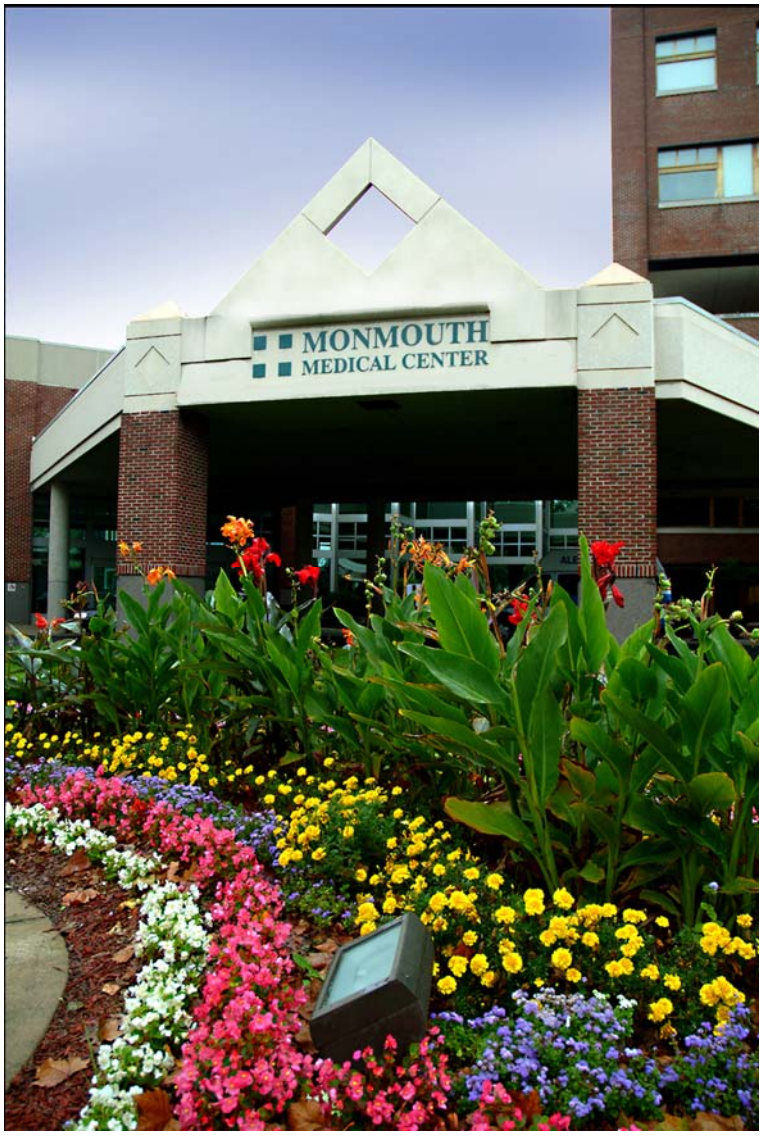
Every new volunteer is required to attend a New Volunteer Orientation. It is a five-hour educational session covering such topics as safety, infection control and patient confidentiality.

If you have any questions about the volunteer application process, please feel free to contact the Office of Volunteer Services at 732-923-6670 or e-mail me at laura.siemientkowski@rwjbh.org.

Sincerely,

Laura A. Siemientkowski
Coordinator, Volunteer Services

Adult Volunteer Application



Monmouth Medical Center
The Unterberg Children's Hospital
Barnabas Health

September 2016

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:

___Typing	___ Mailings
___ Filing	___ Alphabetizing
___ Phone Receptionist	___ Cash Register
___ Using Copier	___ Other (specify) _____

Patient Care Services:

___ Messenger Services	___Visiting Patients
___ Transporting Patients	___ Feeding Patients
___ Pastoral Care	___ 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

Have you ever been convicted of a crime? Yes ____ No ____. If yes, please explain the nature of the crime, when and where it occurred, and the outcome.

_____

_____

_____

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, Coordinator, Volunteer Services, at 732-923-6670.

Department of Volunteer Services
Professional Reference Check

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Print name: _____ Signature: _____

Date: _____ Telephone Number: _____

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

New Volunteer HEALTH CERTIFICATE (2 pages):

Attachment #1 The completed form must be provided along with ID (Identification)to the hospital Employee Health/Corporate Care clinic.

A. New Volunteer to complete this section:

Patient (Volunteer) Name (PRINT) _____ Date_____
Patient Address: _____
☐ Adult (≥ 18 y/o) ☐ Minor (≤ 17y/o) Social Security #_____ Birthdate_____
Cell/Home Phone #_____ Email Address: _____

***Minor Volunteers** – Parent/Guardian Consent: I hereby give my consent for this Health Certificate to be completed by the physician named below and reviewed by a RWJBarnabas HEALTH (RWJBH) Corporate Care/Employee Health clinic staff member, so that my son/daughter/dependent may Volunteer at a RWJBarnabas HEALTH medical facility. (I give my consent for the above named minor, age 16 or 17 y/o, to have their PPD skin test (for TB screening) completed at the RWJBH Corporate Care/Employee Health clinic, if requested.)
Signature of Parent or Legal Guardian:_____
Print Name of Parent or Legal Guardian: _____
Phone # of Parent/Guardian: _____Email of Parent: _____

Volunteer's PHYSICIAN NAME (PRINT)_____
Volunteer's PHYSICIAN Address: _____
Physician PHONE #:_____ Fax #:_____

In order to participate in the RWJBarnabas HEALTH Volunteer Services, a New Volunteer must comply with the following vaccine / proof of immunity requirements and *mycobacterium tuberculosis* (TB) screening tests. If documentation of required vaccines is not available, then medical documentation of a "Positive" IgG titer blood test is REQUIRED; lab report must be attached. Additionally, all New Volunteers require proof of immunity to the hepatitis B virus (a Hepatitis B Surface ANTIBODY blood test titer that is "Positive").

B. The volunteer's PERSONAL Physician to complete and SIGN this section.

Required Vaccinations for Volunteers	**DATE(s) of Vaccination** 1st dose date - 2nd dose date - 3rd dose date		**IgG Titer** blood test Date - **Must attach LAB REPORT**.
MMR (measles (rubeola), mumps, rubella) (2 doses required)	-	OR	
Varicella (chickenpox) (2 doses required)	-	OR	
Hepatitis B : all required: **- 3 vaccine doses, and** **- Hepatitis B Surface ANTIBODY, Qualitative, blood test, to show proof of immunity.** **(CPT code- 86706; LabCorp#- 006395; Quest-"Hepatitis B Surface Antibody, Qualitative"**	-	**AND**	**Hepatitis B Surface ANTIBODY titer test Date - Must attach LAB report.** **If Negative- MUST start the Hepatitis B vaccine series.**
Tdap (tetanus,dipth, **pertussis**) (**1 dose required**)			
Influenza (required: September 1st - March 31st)			

→Physician Signature_____Date_____

C. The Personal Physician (or the hospital's Corporate Care/Employee Health clinic) to complete the following tuberculosis (**TB) screening tests**:

	DATE PPD-Plant	**Mfg / Lot # / Expiration**	**Location** (L or R)	**DATE PPD-READ /** Signature	**RESULT** **mm indur.** / Pos. or Neg.
TST/PPD #1 (Must be within **past 12 months**)		/ /		/	
TST/PPD #2 (Must be within **past 2 months**)		/ /		/	

If a PPD is "Positive": an IGRA blood test is Required (QuantiFERON TB-Gold (QFTG) or T-SPOT)	**DATE of Interferon Gamma Release Assay (IGRA):**	**NAME of IGRA test:** (T-SPOT or QFTG)		**IGRA RESULT:** (Pos. or Neg.) **Must attach LAB report**	**If IGRA is "Positive": -CXR required (attach report) and the - TB Questionnaire is required (see below).**

→Physician Signature_____ Date_____

D. Diagnosis of Latent TB (tuberculosis): The Volunteer's PERSONAL Physician (Or County Health Dept.) is to complete this section, ONLY FOR New Volunteers with a LATENT TB INFECTION. This section is required for all New Volunteers with a "Positive" IGRA and "Negative" Chest X-ray.

1. Does the Patient (Volunteer) have any of the following: Circle response
   - Chronic cough > 3 weeks? Yes / No
   - Coughing up blood? Yes / No
   - Night sweats (unexplained)? Yes / No
   - Fever or chills? Yes / No
   - Unexplained weight loss (not intentional)? Yes / No
   - Unexplained fatigue? Yes / No
   - Loss of appetite? Yes / No

2. Was the Patient (Volunteer) treated for their Latent TB infection, for 6 to 9 months? Yes / No

If "Yes": WHEN and WHAT medications?_____

If "No": Why not?_____

PERSONAL Physician (or County Health Dept.) Signature_____ Date_____

PERSONAL Physician (or County Health Dept.) PRINT Name _____

Personal Physician (or County Health Dept.) Address: _____

Personal Physician (or County Health Dept.) Phone #:_____ Fax #:_____

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
Hepatitis B	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.
Flu (Influenza)	Get 1 dose of influenza vaccine annually.
MMR (Measles, Mumps, & Rubella)	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 MMR ACIP vaccine recommendations.
Varicella (Chickenpox)	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.
Tdap (Tetanus, Diphtheria, Pertussis)	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.
Meningococcal	Those who are routinely exposed to isolates of *N. meningitidis* 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.

RWJBarnabas HEALTH (BH)- Corporate Care / Employee Health clinic

Attachment #4 **Medical Clearance Form - New VOLUNTEER Applicant.**

Volunteer Name:_____ DOB: _____

Volunteer applicant Assignment (if known):_____

_____ NOT medically cleared to Volunteer in BH Hospital/ Medical Center/ Clinics.

_____ YES medically cleared to Volunteer in BH Hospital/ Medical Center/ Clinics.

_____ YES medically cleared to Volunteer in BH Hospital/ Medical Center/ Clinics- with the following Restrictions/Limitation: _____

_____

_____

_____ _____

RWJBarnabas HEALTH Nurse Practitioner/Physician (NP/MD) Date