



Dear Teen 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.

Teen Volunteer Applicants (ages 14-17)

- \_\_\_\_\_ Application
- \_\_\_\_\_ Parental Consent
- \_\_\_\_\_ 2 Professional References
- \_\_\_\_\_ Pre-Placement Physical Checklist completed by your physician

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 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.siemientkowski@rwjbh.org](mailto:laura.siemientkowski@rwjbh.org).

Sincerely,

Laura A. Siemientkowski  
Manager, Office of Volunteer Services



Dear Parent:

Your son/daughter has inquired about becoming a Teen Volunteer Ambassador at Monmouth Medical Center. We are happy to introduce him/her to the volunteer experience at our hospital; however, it is the policy of this institution that minors who wish to volunteer must complete an application and have parental consent to volunteer.

If you agree to allow your son/daughter to be considered to become a volunteer, please sign the attached consent form to accompany the completed application. The attached professional reference forms must be provided to two references to complete. One must be a school reference such as a guidance counselor, coach or teacher and the other can be anyone with the exception of an immediate family member. You will also find a Doctor's Release form which must be completed by your child's physician. Please be assured that all information will be kept in strict confidence.

Upon receipt and consideration of the completed application, your son/daughter will be contacted for an interview to discuss the exciting volunteer opportunities at Monmouth Medical Center.

Parents are encouraged to become involved with the Volunteer Program at Monmouth Medical Center as well. If you should have any questions regarding your child's participation in the program or would like information on becoming a volunteer yourself, please do not hesitate to contact my office.

Sincerely,

Laura A. Siemientkowski  
Manager, Office of Volunteer Services



Office of Volunteer Services  
Parental Consent Form

This consent form assures that you understand and agree to the following:

1. Your son/daughter meets the age requirement of 14 years of age.
2. He/she volunteers with your approval.
3. Both you and he/she realize that volunteering at Monmouth Medical Center is a very important commitment. Your child must follow all rules and regulations established by the Office of Volunteer Services and Monmouth Medical Center, especially as it relates to attendance at volunteer orientation and maintaining patient confidentiality at all times.
4. He/she must be regular in attendance and in the proper uniform.
5. He/she commits to volunteering 150 hours annually with a minimum commitment of one year of service.

It is the policy of Monmouth Medical Center that any minor volunteering should have a parent's consent for any emergency treatment needed while volunteering. I hereby give permission for my child to perform volunteer services at Monmouth Medical Center. I realize the need for him to be dependable, courteous and uphold the hospital code of ethics. I will be glad to cooperate with him/her in complying with the rules and regulations set up for both the volunteer's and hospital's protection. I will not hold Monmouth Medical Center responsible for any illness or injury incurred by my son/daughter, which is related to a previously existing medical condition/disability. I understand that it is my responsibility to inform the Office of Volunteer Services of any such pre-existing condition/disability prior to my child's receiving his/her assignment.

I give permission to the provided references to release information on my child as requested on the reference form by the Office of Volunteer Services at Monmouth Medical Center. It is my understanding that all information will be kept in strict confidence.

\_\_\_\_\_  
Name of Parent or Guardian (Please Print)

\_\_\_\_\_  
Signature of Parent or Guardian

Date: \_\_\_\_\_

# Teen Volunteer Application





**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"/> Reading to Patients   | <input type="checkbox"/> Visiting/Listening |
| <input type="checkbox"/> Transporting       | <input type="checkbox"/> Feeding Patients      |   |
| <input type="checkbox"/> Pastoral Care      | <input type="checkbox"/> Other (specify) _____ |   |

Personal Skills:

- Arts and Crafts
- Musical Instrument
- Recreation Leader

Additional Skills/Comments: \_\_\_\_\_

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Teen Program Information (please check the appropriate program):

- Summer Teen Volunteer Ambassador Program (Mid-May to Mid-August each summer)
- Year-Round Teen Volunteer Ambassador Program (4 hours per week for 12 months)

**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 can 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 they will be 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? \_\_\_\_\_
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Print name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

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? \_\_\_\_\_
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  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? \_\_\_\_\_
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Print name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you have any questions, please contact Laura Siemientkowski, Manager, Department of 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.

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

Name:	Phone Number:
ADULT (18 y/o or older) <b>OR</b> 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  $\geq 10$  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
<a href="#"><u>Hepatitis B</u></a>	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.
<a href="#"><u>Flu (Influenza)</u></a>	Get 1 dose of influenza vaccine annually.
<a href="#"><u>MMR (Measles, Mumps, &amp; Rubella)</u></a>	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 <b>measles or mumps</b> (i.e., no serologic evidence of immunity or prior vaccination), <b>get 2 doses of MMR</b> (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 <b>rubella</b> , <b>only 1 dose of MMR</b> 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 <a href="#"><u>MMR ACIP vaccine recommendations</u></a> .
<a href="#"><u>Varicella (Chickenpox)</u></a>	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 <b>2 doses of varicella vaccine</b> , 4 weeks apart.
<a href="#"><u>Tdap (Tetanus, Diphtheria, Pertussis)</u></a>	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.
<a href="#"><u>Meningococcal</u></a>	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  $\geq 18$  years. **For prevention of rubella, 1 dose of MMR vaccine is recommended for persons aged  $\geq 12$  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**- Prevacination 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.

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: \_\_\_\_\_