

Dear Prospective Volunteer.

Thank you for your interest in the volunteer program at Robert Wood Johnson University Hospital Rahway. We are happy to know that you are considering becoming a part of the hospital team. At RWJUH Rahway, you will become an integral part of the hospital family. There is no doubt volunteers really do make the difference!

Please complete the enclosed application and return it to the Volunteer Services Office. You will then be contacted for an interview if an assignment corresponds with your skills and availability. There are times when we do not have placements available but we will hold on to your application.

Volunteers serve in a variety of ways within the hospital. Some openings involve patient contact, while others do not. Some assignments involve office duties, while others keep you on the move. Assignments include: assisting on nursing floors; performing clerical and receptionist duties in various areas; stocking isolation equipment.

The hours a volunteer works depend on the needs of the department, as well as your preferred hours and availability. We do request that volunteers serve in a particular service on the same day and hours each week if possible. Training varies, some assignments receive "on the job training", while others may require a more formalized training period.

Each volunteer is required to fill out an application, have a personal interview and attend a general orientation for new volunteers. All volunteers must complete the mandatory medical clearance and vaccine program documented in the back of this application. All volunteers are required to provide their own transportation and be able to perform tasks without daily staff supervision.

If you would like to volunteer in the Gift Shop as part of the Hospital Auxiliary, please call 732-499-6068 for additional information.

I look forward to the opportunity of meeting with you and exploring the exciting challenges and rewards of becoming a Robert Wood Johnson University Hospital Rahway Volunteer.

Sincerely,

Bridget Baldwin

Bridget Baldwin, Volunteer Service Coordinator

Volunteer Application

Opportunities for volunteers are provided without regard to race, color, religion, gender, national origin, marital status, age, disability, sexual preference, military status and/or obligation or any other characteristics that are protected by applicable law. All opportunities to volunteer at RWJUHRahway are contingent upon a criminal background review.

Please write or print clearly

Name: _____ Date: _____

Address: _____ City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail address: _____

In case of emergency, please notify: _____ Telephone #: _____

Relation: _____

In order to make the best possible volunteer assignment area match your interests, experiences and skills, we need to have a clear understanding of your work, education and social background.

Why are you interested in volunteering at this Hospital? E.g., to help within the hospital, school requirements, learn new skills, keep busy, etc. _____

How were you referred to us? _____

If you know any current or former volunteers at RWJUHRahway, please list name(s):

Present employer and job title _____

If not currently working, what was your last employer and job title?

List any skills, special training and hobbies you may want to share with patients.

Have you ever volunteered before? Yes _____ No _____

If you answered yes, what did you do and where was your assignment.?

What is the highest grade you completed in school? _____

Are you interested in patient contact? Yes ___ No ___ Office Assignments? Yes ___ No ___

Time available to volunteer Mornings _____ Afternoons _____

Which days of the week? _____

Are there any types of assignments in the hospital you would **not** like to do? _____

There are no assignments later than 6 p.m. and no weekend assignments

List References: (Personal or Professional) Please do not list relatives.

1. Name _____

Complete Street Address (street, city, state, zip code)

Address _____

Phone # _____

2. Name _____

Address _____

Phone # _____

Have you ever been convicted of a crime (that was **not** annulled or sealed by the court)?

Yes _____ No _____

If Yes, please explain. _____

Signature

Date

Your signature above allows us to check references and do a criminal background check. It also indicates that all information provided is true and correct.

For Volunteer Office use only.

Approved _____

Hold _____

Orientation _____

BACKGROUND INVESTIGATION AUTHORIZATION

PLEASE READ CAREFULLY

I, (*print first and last name*) _____, voluntarily and knowingly authorize and consent that Robert Wood Johnson University Hospital at Rahway (RWJUH at Rahway), for employment purposes only, procure or have prepared a consumer or investigative consumer report as part of the procedure for processing my application for employment.* In the event that I am hired, employed or contracted by RWJUH at Rahway, this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer report(s) at any time during my employment. I understand that such report(s) may include information regarding my prior employment, military record, education, professional or occupational license (including license number, status, expiration date, actions and disciplinary history), certification or credentials, criminal record, character, general reputation, and/or personal characteristics. I understand that upon written request to RWJUH at Rahway, I will be informed of whether an investigative consumer report was requested, given information as to the nature and scope of the report or investigation, informed of the name and address of the consumer reporting agency furnishing the report**, and provided with a Summary of Rights Under the Fair Credit Reporting Act.

Type of professional or occupational license or certification: _____
(*i.e.: Physician, Registered Nurse, Licensed Practical Nurse, etc.*)

License or Certification Number: _____

Signature

Date

In addition, the following information (your date of birth) is being gathered not for employment decisions but in order to obtain a criminal background investigation. This information (date of birth) will be kept confidential and will in no way be part of any personnel decision. Your response is strictly voluntary. However, please be aware that if you chose not to provide the requested information, the Hospital may not be able to obtain a background check for you which will affect the processing of your employment application.

Yes - I understand and my date of birth is: _____
Social Security Number: _____

No - I understand, but I do not wish to furnish this information

Signature

Date

* I release RWJUH at Rahway and its affiliates and employees from all liability for requesting and/or acting on any such report(s) and release all other parties from liability for furnishing such information.

** You may contact TABB INC., P.O. Box 10, 555 East Main St., Chester, NJ 07930 with questions regarding the report(s) and/or VeCred, 760 Alexander Road, P.O. Box 1, Princeton, NJ 08543 with questions regarding licensure information.

Medical Clearance Information

In order to promote the health and safety of the volunteers and staff, the Volunteer Department requires the following before an official volunteer start date can be arraigned.

- **All new Volunteers must have mycobacterium Tuberculosis (TB) infection screenings:**
New volunteers are to undergo a two-step TST (tuberculosis skin test, also known as PPD test) Both steps should be completed prior to starting Volunteer work in the hospital. Thereafter, annually, a single PPD skin test is required. All PPD's must be read 48 to 72 hours after being placed.

If a PPD is read Positive, the following is required:

- An evaluation by a Physician (MD/DO) or Advanced Practice Nurse Practitioner (AP/NP) to rule out active Tuberculosis infection, and must include the following:
 - An Interferon Gamma Release Assay (IGRA) blood test (TSPOT® or QFTG®); and
 - A chest x-ray is required; and must be negative for active/contagious Tuberculosis infection. (The chest x-ray must be performed within 12 months of the New Volunteer's start date.)
- It is the responsibility of the potential volunteer to obtain these results and readings.

- **All New Volunteers must demonstrate "proof of immunity" to: hepatitis B, measles (rubeola), mumps, rubella (German measles), varicella (chickenpox), and pertussis (whooping cough virus), and influenza (seasonal).**

- Rubella (German Measles)- a Positive IgG titer or proof of **1 MMR** vaccine.
- Rubeola (Measles) - a Positive IgG titer or proof of **2 MMR** vaccines, given at least 4 weeks apart.
- Mumps- a Positive IgG titer or proof of **2 MMR** vaccines, given at least 4 weeks apart.
- Varicella (Chickenpox)- a Positive IgG titer or **2 VARIVAX** vaccines, given at least 4 weeks apart.
- Hepatitis B- a Positive hepatitis B surface **Antibody** titer; or proof of vaccination with two complete hepatitis B vaccine series (6 vaccines); or a signed OSHA Hepatitis B Vaccine Declination.
- Tdap (Tetanus, diphtheria, acellular **pertussis**)- proof of vaccination with this adult vaccine (Adacel® or Boostrix®). The childhood vaccines called DTAP are NOT acceptable.

- **Seasonal Flu Shots**

If you are starting during flu season you must receive the Influenza vaccine.

Influenza vaccine (seasonal, between September 1st and March 31st)- proof of vaccination or the Individual has provided proof of an "Influenza Vaccine Exemption Letter" from the RWJBH Influenza Vaccine Exemption Committee.

To be completed by a Physician

| | |
|--|---------------------------------|
| TITLE: NEW VOLUNTEER Medical Clearance Policy EFFECTIVE DATE: 8-23-2017 | Corporate Care Policy #6 |
|--|---------------------------------|

| | |
|---|--------------------|
| Attachment #1 New Volunteer Pre-placement Physical Checklist | |
| Name: | Phone Number: |
| ADULT (18 y/o or older) OR TEEN (17 y/o or younger) | Date of Birth: |
| Email: | |
| Department: VOLUNTEER- RAHWAY | Social Security #: |

Health Attestation- All the following has been completed on the above named individual:
1. Physical examination within past 12 months showing Volunteer is 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-plant: _____ Date PPD-read: _____ Result: _____ mm induration

PLEASE NOTE: If a PPD is read Positive (or ≥ 10 mm induration) all the following is required:
- 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
- A chest x-ray negative for active/contagious TB within the 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 for immunity**; or a signed OSHA Hepatitis B vaccine Declination Form (see OSHA Bloodborne Pathogens Standard 29 CFR 1910.1030).
f. Tdap (Tetanus, diphtheria, acellular pertussis)- proof of **vaccination** with this adult vaccine (Adacel® or Boostrix®). (The childhood vaccines called DTAP are NOT acceptable substitutions).
g. **Influenza vaccine** (seasonal, between September 1st and March 31st)- proof of vaccination or proof of an "Influenza Vaccine Exemption Letter" from RWJBH Influenza Vaccine Exemption Committee.
DATE of this season's INFLUENZA Vaccine: _____

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

EXCEPT: _____
(Please LIST only those medical tests or vaccines NOT available in your medical office)

| | | |
|--|-------------------|-------------------|
| Physician SIGNATURE (conducting exam) | PRINT Name | Date |
| Physician Address | Telephone Number | License # / State |

Please return the completed form to:
Bridget Baldwin Volunteer Services
865 Stone St. Rahway, NJ 07065
Fax: 732-680-7910