RWJBarnabas HEALTH | Trinitas Regional Medical Center

TEEN VOLUNTEER APPLICATION

Thank you for your interest in volunteering with RWJBH – Trinitas Regional Medical Center. Please be advised that each participant must complete the following requirements:

- ☐ Must be **15 years or older**.
- ☐ Completed application by the applicant (**not the parents**) with all required signatures (**do not use school email** as some schools block outside emails).
- ☐ In person or virtual interview before completing the medical forms.
- ☐ Corporate Care Medical forms must be completed, signed, and stamped by a medical provider. They can be found on the Trinitas website (click Volunteer).
- ☐ Photo ID
- ☐ September through April only: Proof of influenza vaccination for the current season

We will:

- ☐ Perform 10-panel drug screening test with chain of custody.
- ☐ Provide a volunteer ID badge (Subject to a refundable deposit).
- ☐ Volunteer uniform (Subject to a refundable deposit).

Please return all documents by email, fax, or mail. If you have any questions, please feel free to contact edith.thomas@rwjbh.org.

Johanna Thomas | Director, Volunteer Services
Trinitas Regional Medical Center | 225 Williamson Street | Elizabeth | NJ 07202
☎ 908.994.5164 Office | Fax: 908.994.5638 | ✉ edith.thomas@rwjbh.org

RWJBarnabas HEALTH | Trinitas Regional Medical Center

TEEN VOLUNTEER APPLICATION
Please print legibly

Name: ____Date of Birth: _____________ _____

Address:___________________________ City__________________ State_____ Zip Code__________

Cell Phone: _________________________ E-mail____

Parent or Guardian's Name:__________________________ Parent's phone:_______________________

Parent email's address:____

School (name/address): ____

Interests and Hobbies: ____

Volunteer Experience: ____

Why do you want to be a Volunteer at Trinitas Regional Medical Center? ___________________________

____

Preferred Department/Experience: ____

Please list day(s) and time(s) you would like to Volunteer. ______________________________________

Who referred you to this Medical Center? ____

EMERGENCY CONTACT:

Name:_____________________________ Relationship:________________________________

Address:_______________________ City & State______________ Phone # ____________________

References: 1. ____
Name Relationship to you Phone No.

2. ____
Name Relationship to you Phone No.

Consent to Volunteer:

I understand that this is an application for and not a commitment or promise of volunteer opportunity.
I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with RWJBH - Trinitas Regional Medical Center that is true, correct and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for a volunteer position with Trinitas Regional Medical Center or my termination as a volunteer.

Consent to photograph:

I give RWJBH - Trinitas Regional Medical Center ("TRMC"), Elizabeth, NJ, my consent to photograph, record, or film/videotape me/my child ("photograph"), or to interview me/my child. I also give TRMC my consent to use those photographs or interviews and other information about me/my child in any publication or advertising materials (printed or electronic) or for any lawful purpose. I understand and agree that TRMC may distribute my/my child's photograph and/or interview information to other organizations for use in promoting volunteer services. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or name or my child's photograph and/or name.

I understand that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Volunteer Services Department at Trinitas Regional Medical Center, 225 Williamson Street, Elizabeth, NJ 07202. I understand that my revocation will not apply to information that has already been released in response to this authorization. I further understand that this consent is expressly intended to release all personnel of Trinitas Regional Medical Center, as well as the attending physician and consultants, from any claim arising out of the use of such interviews, photographs and/or videotape

____

____

Signature of Parent or Guardian   Date

RWJBarnabas HEALTH | Trinitas Regional Medical Center

Dear Parent or Guardian:

Your child has expressed an interest in becoming a Volunteer at Trinitas Regional Medical Center. We would be very happy to accept your child as a member of the Trinitas Teen Volunteer Program, if you approve of the following:

- ☐ **Your child is 15 years of age or older**.
- ☐ Both you and your child understand that volunteering is now your child's responsibility and should be taken seriously. Your child agrees to complete a **minimum of at least three months of weekly volunteering**. Your child must follow all rules and regulations established and be regular in attendance. We will be depending on your child to be here on the days on which he/she is registered. Should a volunteer be negligent of duties, it may be cause for dismissal from the program.
- ☐ Your child is not to be at the hospital on any other days or times than those assigned except when visiting a patient.
- ☐ Your child is at the hospital as part of our Volunteer Program. Excessive socializing on the premises may result in termination.
- ☐ It is the duty of the parent/guardian to assume responsibility for transportation to and from the hospital.
- ☐ Unless there is an emergency, Volunteers may not make or receive phone calls.
- ☐ Uniforms are required. A $15 deposit is required which will be returned when the volunteer returns the uniform. Uniforms must be worn at all times, and it is the responsibility of the Volunteer to keep their uniform neat and clean.

My child ____________________ is 15 years of age or older and has my consent to perform volunteer services at Trinitas Regional Medical Center on the day/days for which my child is scheduled and to adhere to the rules and regulations of the Volunteer Program.

____

Signature Date

Please check one: ☐ Parent ☐ Guardian

RWJBarnabas HEALTH | Trinitas Regional Medical Center

HIPAA/CONFIDENTIALITY AGREEMENT

I, an employee or agent of Trinitas Regional Medical Center (TRMC), acknowledge the confidentiality of patient health care information ("Confidential Patient Information") that I may receive or have access to in the course of providing patient care or other services at any TRMC Facilities at which I am assigned. Patient and personnel information including medical, financial, social and spiritual information from any source and in any form, including oral communication, audio recording, written and electronic display, is strictly confidential. Access to confidential patient and personnel information is permitted only on a need-to-know basis. It is the policy of TRMC that all users respect and preserve this right to privacy and confidentiality. Violations of this policy include, but are not limited to:

- Accessing information that is not within the scope of your job.
- Disclosing, misusing without proper authorization, or altering patient or personnel information.
- Disclosing your sign-on code and password or using another person's sign-on code and password for accessing electronic or computerized records.
- Accessing the information of a colleague or co-worker who is not assigned to your care or treatment.
- Leaving a secured application unattended while logged on; and
- Attempting to access a secured application without proper authorization.
- Patient information is the patient's private property lent to the Hospital and its staff for a specific and mutually agreed upon purpose.
- All information about a patient is to be kept confidential at all times. Remember; do not discuss patient information in the elevator, lobby or cafeteria. Be careful when utilizing the speakerphone that patient information is not broadcasted for everyone in the surrounding area to hear, breaking patient confidentiality. Do not post patients' names publicly, for example on walls, doors, bulletin boards, etc.
- Except when required by law, patient information is not to be released to any person or department not directly involved in the delivery of patient care, without expressed written permission by the patient or legally authorized representative.
- Family access to a patient's record may be permitted <u>only</u> with patient consent.

- All patients are legally entitled to confidentiality regardless of race, gender, religion, age and socioeconomic or criminal status; and

- An employee, physician, volunteer or trustee admitted to Trinitas Regional Medical Center as a patient also has the same right to confidential treatment of their personal information. DO NOT SHARE THEIR ADMISSION unless requested to do so by the patient.

I have read the above statements and understand and agree to my role in Patient Confidentiality at Trinitas Regional Medical Center.

Violations of this policy may constitute grounds for disciplinary action up to and including termination of employment or loss of hospital privileges in accordance with Hospital procedures and/or federal or state law, and/or legal action. I shall maintain the confidentiality of Confidential Patient Information, and in doing so shall comply with all applicable state and federal laws and regulations, including without limitation, the privacy provisions under Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the policies and procedures of each TRMC facility where I am assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with TRMC.

HIPAA ACKNOWLEDGEMENT & EMPLOYEE CONFIDENTIALITY

______________________________	______________________________
Signature	Date
______________________________	______________________________
Name (Print)	Department

RWJBarnabas HEALTH | Trinitas Regional Medical Center

Student's Name____

School Name_____________________________________ Grade______

Parent or guardian consent to release school records

I authorize a representative of the aforementioned school to complete the School Guidance Counselor Evaluation Form in connection with the above student's application to participate in the Teen Volunteer Program at RWJBH Trinitas RMC. I understand the purpose of this form is to aid RWJBH Trinitas RMC in selecting qualified student volunteers. All information provided by the school will remain confidential.

Signature of Parent or Legal Guardian
______________________________Date________________

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 and maturity to interact with hospital patients.

I (do, do not) recommend this candidate to be accepted to the Teen Volunteer program at RWJBH Trinitas Regional Medical Center.

Comments____

Signed__________________________________Date_________________

Print Name & Title____

Completed guidance evaluations can be returned to edith.thomas@rwjbh.org.

RWJBarnabas HEALTH | Trinitas Regional Medical Center

Dear Parent or Guardian:

Your permission is necessary for ______________________________ to have a drug screen performed by Corporate Care, our employee health department.

I give permission to Corporate Care to complete a 10-panel drug screen.

Parent/Guardian signature: __________________________ Date: _________________

Flu season only (September – April):

I have been informed that the flu vaccination is part of the medical requirement to become a volunteer at Trinitas Regional Medical Center. If my child becomes a volunteer, I am required to provide documentation of my child's flu vaccination or provide documentation that I am declining to have my child vaccinated due to medical or religious reasons (documentation must come from your physician or clergy on letterhead). I understand that my child cannot volunteer until proper documentation is provided.

Parent/Guardian signature:_______________________ Date: _____________________

RWJBarnabas HEALTH | Trinitas Regional Medical Center

CONSENT AND RELEASE OF LIABILITY

I understand that I (or my minor child or ward) am freely serving as a volunteer for Trinitas Regional Medical Center/RWJBH, a nonprofit organization, or one of its affiliates ("Trinitas").

I attest that I am over 18 years of age, and I warrant that I have legal authority to execute this agreement on my own behalf, or in the case of a minor, on his/her behalf. I attest that I (or my child or ward) is physically fit and prepared for events that require some physical agility. I understand that I have the opportunity to inquire as to specifics of the physical activities contemplated by Trinitas prior to signing this waiver.

In regard to this waiver, I, hereby release and hold harmless Trinitas, its owners, affiliates, officers, volunteers, staff (all of whom are referred to as "Releasees") with respect to any and all injury, disability, death, or loss or damage to person or property, whether caused by the negligence of the releasees or otherwise.

I have read this release of liability and assumption of risk agreement, fully understand its terms, understand that I have given up substantial rights by signing it and sign it freely and voluntarily without inducement.

Name of Participant: (print) ____

Participant's Signature__________________________ Date: _____________

Parent or Legal Guardian's
Signature____________________________________Date_______________