Trinitas Regional Medical Center | RWJBarnabas HEALTH

Thank you for your interest in volunteering at Trinitas Regional Medical Center.

Please be advised that each participant in the Trinitas Regional Medical Center Volunteer program must complete the following requirements:

- ID badge is required (supplied by Trinitas RMC) Subject to a returnable deposit
- Volunteer Jacket is required (supplied by Trinitas RMC) Subject to a returnable deposit

Please print out the application and return it along with your **immunization record** and **proof of COVID VACCINE and BOOSTER**.

If you have any questions, please feel free to contact me at lisa.liss@rwjbh.org or 908-994-5164.

Yours truly,

Lisa E. Liss

Lisa E. Liss | Volunteer Service Director
Trinitas Regional Medical Center | 225 Williamson Street | Elizabeth | NJ 07202
☎ 908.994.5164 Office | Fax: 908.994.5638 | ✉ Lisa.Liss@rwjbh.org

Trinitas Regional Medical Center | RWJBarnabas HEALTH

We will perform for you:

- ☐ 10-panel drug screening test with chain of custody performed by Trinitas.
- ☐ Two separate 2-step PPD/Mantoux tests. Or you may provide documentation of a Tspot or Quantiferon Gold, current within 3 months for those 16 years of age and older

Please provide:

- ☐ Proof of influenza vaccination for the current season for any period of time on campus from October 1st through the end of flu season (vaccination record).
- ☐ Proof of annual physical exam.
- ☐ Proof of Measles, Mumps and Rubella- MMR.
- ☐ Proof of Tdap, Hepatitis B surface antibody and Varicella (immune titers).
- ☐ Negative two-step PPD or Quantefiron Gold current within 3 months for those 15 years of age and younger.
- ☐ Copy of photo ID

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APPLICATION FOR TEEN VOLUNTEER

Please print legibly

Name: _____ **Date:** _____

Home Address: _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth: _____ **Home Phone:** _____

Cell Phone: _____ **Personal E-mail** _____

Parent or Guardian's Name: _____ **Cell phone:** _____

Parent email address: _____ **Last four of YOUR SS#** _____

Address: _____

Name of School: _____

Address of School: _____

Interests and Hobbies: _____

Volunteer Experience: _____

Type of Volunteer Work Preferred: _____

Why? _____

Who referred you to this Medical Center? _____

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

PERSON TO BE CONTACTED IN AN EMERGENCY:

Name: _____ **Relationship:** _____

Address: _____ **City & State** _____ **Phone #** _____

Career Planned: _____

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

References: 1. _____

Name **Relationship to you** **Phone No.**

2. _____

Name **Relationship to you** **Phone No.**

Trinitas Regional Medical Center | RWJBarnabas HEALTH

Please read the following carefully before signing this application:

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 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. I give 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 07207. 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**

Trinitas Regional Medical Center | RWJBarnabas HEALTH

DO NOT WRITE ON THIS PAGE

TO BE COMPLETED BY VOLUNTEER OFFICE:

INTERVIEW DATE: _____

ORIENTATION DATE: _____

STARTING DATE: _____ **PRECEPTOR:** _____

VOLUNTEER ASSIGNMENT: _____

DAY:_____ **TIME:**_____

PHYSICAL LIMITATIONS: _____

_____

_____

REMARKS: _____

_____

_____

Trinitas Regional Medical Center | RWJBarnabas HEALTH

PLEASE READ THE FOLLOWING CAREFULLY

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 him/her as a member of the Trinitas Teen Volunteer Program, if this meets with your approval.

We would appreciate it if you would sign the consent form below and have your child return it to us as soon as possible since it becomes part of their permanent record.
The form assures Trinitas Regional Medical Center that:

1. **Your child is 14 years of age or older.**
2. **Your child volunteers with your approval.**
3. **Both you and your child realize that volunteering is now your child's responsibility and should be taken very seriously. Your child agrees to complete a minimum of 50 volunteer hours. 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.**
4. **Your child is not to be at the Hospital on any other days or times than those assigned except when visiting a patient.**
5. **Your child is at the Hospital as part of our Volunteer Program. Excessive socializing on the premises may result in termination.**
6. **It is the duty of the parent/guardian to assume responsibility for transportation to and from the Hospital.**
7. **Unless there is an emergency, Volunteers may not make or receive phone calls. Please arrange transportation ahead of time.**
8. **Uniforms are required. A $15 deposit is required which will be returned when the volunteer no longer participates in our Volunteer Program. Uniforms must be worn at all times and it is the responsibility of the Volunteer to keep their uniform neat and clean.**

Director - Volunteer Services
Trinitas Regional Medical Center

TO: DIRECTOR OF VOLUNTEER SERVICES

My child _____ is 14 years of age or older and has my consent to perform Volunteer work 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**

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VOLUNTEER SERVICES DEPARTMENT

THIS HEALTH CERTIFICATE MUST BE COMPLETED BY A PHYSICIAN BEFORE APPLICANT MAY VOLUNTEER AT TRINITAS REGIONAL MEDICAL CENTER.

VOLUNTEER APPLICANT: _____

ADDRESS: _____

1. TO MY KNOWLEDGE THIS APPLICANT:

IS FREE FROM CONTAGIOUS DISEASE AND CAPABLE OF PERFORMING VOLUNTEER ASSIGNMENTS AT TRINITAS REGIONAL MEDICAL CENTER.

YES _____ **NO** _____

2. HAS THE FOLLOWING PHYSICAL AND/OR EMOTIONAL CONDITION REQUIRING RESTRICTIONS AND/OR PRECAUTIONS TO BE OBSERVED:

PLEASE NOTE RESTRICTIONS AND/OR PRECAUTION:

_____

_____

_____

HAS NO RESTRICTIONS:

_____ _____ _____

PHYSICIAN'S NAME (PLEASE PRINT) **PHYSICIAN'S SIGNATURE**

_____ _____ _____

PHYSICIAN'S ADDRESS **DATE**

PLEASE RETURN COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.

Trinitas Regional Medical Center | RWJBarnabas HEALTH

To the Guidance Counselor:

Mr./Miss _____ has expressed an interest in becoming a Teen Volunteer at Trinitas Regional Medical Center.

In order to insure the selection of the most eligible applicants, we would appreciate your cooperation by completing the following questionnaire. If you have any questions, please feel free to contact Lisa Liss, Director of Volunteer Services at (908) 994-5164.

Thank you for your assistance.

1. **Scholastically, the applicant is considered:**

   Excellent _____ Good _____ Fair _____

2. **The applicant is cooperative and accepting of authority:**

   Excellent _____ Good _____ Fair _____

3. **The applicant is conscientious:**

   Excellent _____ Good _____ Fair _____

4. **The applicant is willing and able to follow directions:**

   Excellent _____ Good _____ Fair _____

5. **The applicant's attendance and tardy record is:**

   Excellent _____ Good _____ Fair _____

6. **The applicant is in good health:**

   Excellent _____ Good _____ Fair _____

I recommend the applicant as a Teen Volunteer:

With enthusiasm _____ For a trial period _____ I would not recommend _____

_____ _____

Signature Date

_____

School

Trinitas Regional Medical Center | RWJBarnabas HEALTH

Dear Parent or Guardian:

Your permission is necessary for _____to have a two–step Mantoux Test for TB. If the Mantoux Test for TB is positive, it will be necessary to have a chest x-ray performed. If the Mantoux Test for TB is positive, a urine test for pregnancy will be required for all females. A drug screen will be performed.

*** I have been informed that the flu vaccination is part of the medical requirement to become a volunteer at Trinitas Regional Medical Center. If I apply and am accepted to become a volunteer, I am required to provide documentation that I have received a current flu vaccination, or provide documentation that I am declining the flu vaccination due to medical or religious reasons (documentation must come from your physician or clergy on letterhead). I understand that failure to provide documentation will jeopardize my volunteer status.

***Parent/Guardian Initials:_____

PLEASE SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORD ALONG WITH THIS APPLICATION. THIS CAN BE OBTAINED FROM YOUR CHILD'S PHYSICIAN OR SCHOOL NURSE.

Please sign below to indicate your approval.

Sincerely,

Lisa E. Liss
Lisa E. Liss
Director - Volunteer Services

I give permission to the staff of Trinitas Regional Medical Center to complete all hospital requirements for pre-placement tests.

_____ _____
Parent or Guardian Signature **Date**

_____
Relationship

Trinitas Regional Medical Center | RWJBarnabas HEALTH

I have been informed that the flu vaccination is part of the medical requirement to become a volunteer at Trinitas Regional Medical Center. If I apply and am accepted to become a volunteer, I am required to provide documentation that I have received a current flu vaccination, or provide documentation that I am declining the flu vaccination due to medical or religious reasons (documentation must come from your physician or clergy on letterhead). I understand that failure to provide documentation will jeopardize my volunteer status.

Due to Covid 19, I also understand that I must wear a face covering at all times while on duty at Trinitas Regional Medical Center. I must self screen by taking my temperature twice per day and will have my temperature taken upon entering the facility. I further understand I will be required to be screened once I enter the department to which I have been assigned.

Name: _____
Please Print

Signature: _____

Date: _____