UNIVERSITY HOSPITAL
Newark, New Jersey

DEPARTMENT OF VOLUNTEER SERVICES
973-972-4064

APPLICATION FOR TEEN VOLUNTEER

DATE: _____

NAME: _____ PHONE: _____
Last First

ADDRESS: _____
Street City State Zip

DATE OF BIRTH: _____ SOC. SECURITY #: _____

NOTIFY IN CASE OF EMERGENCY: _____
Name Relationship

_____
Street City State Zip Phone

Name of School: _____ Grade: _____

Name of Teacher or Counselor for Recommendation: _____

Volunteer Experience: _____

Work Experience: _____

School Activities: _____

Hobbies, Interests, Skills (List): _____

Why do you want to volunteer? :
_____

_____

_____

Days Available:	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Morning	____	____	____	____	____	____	____
Afternoon	____	____	____	____	____	____	____

UNIVERSITY HOSPITAL
Newark, New Jersey

PARENTAL or GUARDIAN
PERMISSION and RELEASE for TEEN-AGE VOLUNTEERS

To All Parents or Guardians:

Your child has shown an interest in volunteering his/her services to University Hospital. Since she/he is a minor, you must give Parental or Guardian permission by signing the statement below and returning it to the Volunteer Office before the child starts his/her volunteer work.

I, _____ hereby give permission for my child/ward _____ to give volunteer services at University Hospital, and to receive the Physical Examination required for everyone who works in the hospital in any capacity, as well as for Emergency Treatment if necessary. I agree not to hold University Hospital responsible for any illnesses or injuries that might be sustained as a result of my child doing volunteer work.

Has your child been under the care of a Physician within the past two years? _____
If yes, for what ailment, and for what length of time? _____
Name of Physician: _____
Has your child ever been treated for any of the following:
Excessive cough, expectoration, difficulty of breathing or palpitation? _____
Disease of the heart or blood vessels? _____
Rupture? _____
Any form of mental illness? _____
What operations(s) has she/he had? _____

****

Please submit this completed form to:
Deirdre Watley
Manager of Volunteer Services, Room C-431
University Hospital
150 Bergen Street
Newark, NJ 07103

So that the hospital may run on schedule, we ask you to see that your child is here at the appointed time, and that only an emergency keeps him/her from being here. If something really important is going to keep him/her away, please telephone the Volunteer Office (973) 972-4064 and let us know, so that we can have someone take his/her place that day.

UNIVERSITY HOSPITAL
Newark, New Jersey

UH BACKGROUND CHECK
Regular and Volunteer Staff

_____ _____ ____ _____ _____

First Name | Last Name | MI | Social Security No. | Date of Birth

_____ _____ _____

Other Name(s) used | Telephone No. | Email

Please List all addresses for the past Ten years. If more than three, Please use the reverse side of this form.

1. _____ _____
   Full Street Address, City, State | From To
2. _____ _____
   Full Street Address, City, State | From To
3. _____ _____
   Full Street Address, City, State | From To

Current/Previous Employment Please list employment starting with the most current.

1. _____ _____ _____
Employer | Full Street Address, City, State | Phone Number

_____ _____ _____
Your Title | Supervisor's Name & Phone Number | Dates Employed: From To

2. _____ _____ _____
Employer | Full Street Address, City, State | Phone Number

_____ _____ _____
Your Title | Supervisor's Name & Phone Number | Dates Employed: From To

3. _____ _____ _____
Employer | Full Street Address, City, State | Phone Number

_____ _____ _____
Your Title | Supervisor's Name & Phone Number | Dates Employed: From To

MAY WE CONTACT YOUR CURRENT EMPLOYER? ☐ **YES** ☐ **NO**

Complete only if applying for a position which requires a valid license: _____ _____
Driver's License Number | State Issued

Please list the highest education complete:

_____ _____
Name of School or University | Address

_____ _____ _____
Degree or Diploma | Date Awarded | Name Attended Under

Professional License or Certificate:

_____ _____ _____ _____
License/Certificate Number | State Issued | Type of License/Certificate | Expiration Date

_____ _____ _____ _____
License/Certificate Number | State Issued | Type of License/Certificate | Expiration Date

APPLICANT SIGNATURE: _____ **Date:** _____

HUMAN RESOURCES USE ONLY ***Select report type and screening level by placing a check in the appropriate box.***

470 Regular Staff **3130 Volunteer Staff**	**471 Regular Staff** **480 Volunteer Staff**	**472 Regular Staff** **481 Volunteer Staff**
☐ **Level I** ☐ **Level II**	☐ **Level III**	☐ **Level IV**

Comments:

UNIVERSITY HOSPITAL
Newark, New Jersey

DISCLOSURE AND AUTHORIZATION FORM

(Faculty, Staff, Housestaff, Volunteers)

In connection with my application for employment or volunteer services with UH, I understand that a consumer report or investigative consumer report, as those are defined in the Federal Fair Credit Reporting Act as amended (FCRA), 15 USC 1681 et seq., may be obtained by UH from a consumer reporting agency. I understand that the report may include but not be limited to my consumer credit history, education, professional licensing, professional liability claims history, criminal history, driving history, personal character abilities, work habits, charges of research misconduct, mode of living, residency, immigration status, general reputation, performance, experience and other termination of past employments. I further understand that the consumer reporting agency may not give out information about me to UH without my written consent.

I understand that I am entitled to be informed if an offer of employment or volunteer assignment is withheld because of information obtained from the consumer reporting agency: and in that event, I have sixty (60) days within which to submit a written request to the consumer reporting agency which will provide me with a copy of my file and a "Summary of your Rights Under the Fair Credit Reporting Act."

I hereby authorize UH where I will be expected to work to obtain consumer reports in connection with my application for employment or volunteer service with UH. I authorize all former employers, listed references, schools, law enforcement agencies and courts, to release to UH and/ or their representative's information pertaining to me.

Note: The phrases and wording contained in this authorization are required under the FCRA. UH will not run a credit check on an applicant as part of the investigation unless the position or volunteer assignment for which applied requires financial information on a prospective candidate. The candidate will be notified if a credit check is required.

Please Print

Name: _____ **SS#:** _____

Other name(s) used: _____

Applicant Signature: _____ **Date:** ___/ __/___

UNIVERSITY HOSPITAL
Newark, New Jersey

CONFIDENTIAL

Replacement Health Questionnaire
To be completed by the Volunteer

Name (please print) _____
Last **First** **Middle**

Mailing Address _____
Street **Apt. #**

_____
City **State** **Zip Code**

Home Telephone Number: _____

Social Security Number: _____-_____-_____

Date of Birth: _____ **Age:** _____ **Birthplace:** _____

Height _____ **Weight:** _____ **Sex: Female** ____ **Male** ____

Marital Status: Married ____ **Widowed** _____ **Divorced** _____ **Single/Never Married** _____

Person to Contact in Emergency: _____ **Relationship:** _____

Address: _____

Emergency Telephone Number: _____

Primary Personal Physician: _____ **Telephone No.** _____

Have you ever been hospitalized or treated at University Hospital? Yes _____ **No** _____

Current Employer: _____ **Company Insurance:** _____

Volunteer Position Applied for (if know): _____

Department: _____ **Work location:** _____ **Work Number:** _____

How would you describe your health? Excellent _____ **Good** ____ **Fair** _____ **Poor** _____

UNIVERSITY HOSPITAL
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VOLUNTEER PLEDGE

Believing University Hospital-UH has a real need of my service while working through the Volunteer Program.

I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously

I will wear my uniform at all times while on duty at the hospital. This includes lunch hour and walking to and from my assignment. I will be careful to always wear a clean uniform and to present a neat appearance.

I will consider as confidential all information which I may hear or see directly or indirectly in the hospital.

I will report to the supervisor in the area to which I am assigned and be sure she/he knows my name, the hours and days I will be working with her/him. I will not leave my assignment without telling her/him how long I will be gone.

I understand my hours are _____ If I find I must change them, I will discuss it with the Manager of Volunteer Services.

I understand that meal vouchers or parking validation are benefits given to those volunteers who donate four hours or more on the day they volunteer

I will take my problems, criticisms or suggestions to the Manager of Volunteer Services.

If I find I cannot continue my volunteer work temporarily or permanently, I will so inform the Volunteer Office.

I will up-hold the traditions and high standards of the Hospital and the Volunteer Program.

_____ _____

(**Volunteer Signature**) **Date**

UNIVERSITY HOSPITAL
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NEW JERSEY WORKERS' COMPENSATION ACT

I, _____ understand and agree with the following conditions concerning services performed by me as a volunteer worker.

It is understood that Volunteer Workers are not covered by the New Jersey Workers Compensation Act. (This does not apply to statutory exception for volunteer ambulance drivers).

It is understood that if a Volunteer Worker is uninsured while performing services on UH premises the Hospital will provide at the time of injury reasonable emergency medical treatment for the injury without charge, regardless of apparent fault and that is it also understood that the provision of emergency medical services does not constitute an admission of liability on the part of University Hospital.

_____
Signature of Volunteer Worker

_____
Date

Name (please print): _____

Last First Middle

	NO	YES	PLEASE EXPLAIN ALL YES ANSWERS
Tuberculosis skin test (PPD) in the past 12 months?			
Tuberculosis skin test (PPD) more than 12 months ago?			
Positive or abnormal tuberculosis skin test ever?			
Tuberculosis?			
Told you need medicines for exposure to tuberculosis or for tuberculosis?			
Immunized with the BCG (Bacille Calmette-Guein) tuberculosis vaccine?			
Lived or traveled outside the United States or Canada?			
Close contact with a family member or other person who had tuberculosis?			
Exposure to tuberculosis in a previous job?			
Not immunized for tetanus (tetanus shot) in the past 10 years?			
Received a blood transfusion ever?			
Hepatitis or jaundice?			
Immunized with three doses of hepatitis vaccine?			

Additional Comments:

Name (please print): _____
Last First Middle

GENERAL HEALTH HISTORY	NO	YES	PLEASE EXPLAIN ALL YES ANSWERS
Visited a physician in the past year?			
Absent from work or school for a medical reason in the past year?			
Health worsened in the past year?			
Ever absent from work or school for an illness or injury related to work or due to exposure to chemical or other hazards?			
Wear prescription eyeglasses or contact lenses?			
Recurrent ear infections or perforated eardrum?			
Difficulty hearing?			
Allergies to medicines, food, animals, or other substances in the environment?			
Hay fever or other allergies?			
Any x-ray picture during the past year?			
An abnormal chest x-ray ever?			
Prescription medications over the past month?			
Any other medicines, including pills for colds, dieting, and headaches, vitamins, and eye and nose drops over the past month?			
Any medical condition that requires you to restrict your activity?			
Ever advised to change jobs or work assignments because of any health problem or injury?			

Additional Comments:

Name (please print): _____
Last First Middle

NONCOMMUNICABLE DISEASES HISTORY	NO	YES	PLEASE EXPLAIN ALL YES ANSWERS
Chest pain when you exert yourself, for example, when climbing stairs or running?			
Coronary artery diseases or other heart diseases?			
Had a heart attack, coronary bypass surgery, or any treatment for coronary artery disease?			
More than borderline high blood pressure that is not being treated?			
Quickly become short of breath when climbing stairs or running?			
Asthma?			
Chronic cough or other respiratory problems, for example, emphysema or bronchitis?			
Any other medical problems not mentioned above?			

Additional Comments:

Name (please print): _____
Last First Middle

	NO	YES	PLEASE EXPLAIN ALL YES ANSWERS
Smoke cigarettes currently?			
Smoked cigarettes ever?			
Drink alcohol, including beer, wine, or other liquor?			
Used non-medicinal ("recreational") drugs?			
Difficulty wearing medical (latex) gloves or other latex products?			

I certify that the above is accurate and true to the best of my knowledge.

_____
Signature Date

UNIVERSITY HOSPITAL
Newark, New Jersey

CONFIDENTIALITY AGREEMENT
VOLUNTEER SERVICES DEPARTMENT

I UNDERSTAND AND AGREE THAT IN THE PERFORMANCE OF MY DUTIES AS A VOLUNTEER OF UNIVERSITY HOSPITAL, I MUST HOLD MEDICAL INFORMATION IN CONFIDENCE. FURTHER, I UNDERSTAND THAT INTENTIONAL OR INVOLUNTARY VIOLATION OF UNIVERSITY HOSPITAL'S CONFIDENTIALITY MAY RESULT IN TERMINATION OF MY SERVICES AS A VOLUNTEER.

SIGNATURE **DATE**

_____ _____

UNIVERSITY HOSPITAL
Newark, New Jersey

CONFIDENTIALITY STATEMENT FOR INFORMATION SECURITY

In recognition of the confidential nature of patient records and/or employee data to which I may have access, either as part of my duties at University Hospital, or because of other reasons. I, _____ understand and will comply with the following:

- ☐ I will not misuse or disclose any information without proper authorization, nor alter patient or personnel records. I will not discuss patient or employee information except as it relates to my job.

- ☐ I will not permit any other individual to use my information systems password to gain access to the above-mentioned information. I am responsible for any information entered into the computer system under my user ID and password. I will report problems related to my password/system access to my supervisor. I will request modification to my system password immediately if I suspect that someone has gained access to my sign-on password.

- ☐ I will file written/printed information in a secure place and/or dispose of it with proper regard for privacy and confidentiality.

- ☐ I will not access, report on or extract information that is not consistent with my normal job functions and responsibilities.

- ☐ I will not leave a secured computer application unattended while signed-on.

I recognize that a violation of the above conditions may constitute grounds for disciplinary action, up to and including termination of volunteer assignment.

_____	_____	_____
Signature	Social Security #	Date

_____
Department

UNIVERSITY HOSPITAL
Newark, New Jersey

TERMINATION OF A VOLUNTEER ASSIGNMENT

I understand and agree that as University Hospital appreciates my contributions of service time to the hospital.

I _____ agree to perform only the volunteer duties that are listed in the position description that I signed when commencing my volunteer assignment. I understand that any assistance I provide will not include any duties that require hands on contact with the patients.

I understand that University Hospital is not obligated to have volunteer assistance but has decided to have assistance at its own discretion and has the right to terminate a volunteer's assignment at anytime as it may see necessary.

I have read the above information and am in full understanding.

Volunteer Name (Print) _____

Volunteer's Name (Sign) _____

Date: _____

Volunteer Medical Form

To be completed by volunteer's Physician prior to commencing service at University Hospital

Name: _____

Date of Birth: _____ SSN: _____

	Date Given	**Date Read & Results**
Physical Exam:	_____	_____
Mantoux Two Step/ Tuberculin Skin Test	_____ 1st	_____
Chest X-Ray- (Required if PPD + And no prior history)	_____	_____

Serologic Tests:

Hepatitis B *Ab*:	_____	Susceptible/Immune_____
*Measles (Immunity or Vaccination Required)	_____	Susceptible/Immune_____
*Rubella (Immunity or Vaccination Required)	_____	Susceptible/Immune_____
*Varicella (Immunity or Vaccination Required)	_____	Susceptible/Immune_____
Other	_____	

***Must be reported if cleared for any assignment.**

Immunization Provided:

Hepatitis B #1	_____
Hepatitis B #2	_____
Hepatitis B #3	_____
MMR #1	_____
MMR #2	_____
Polio, Oral	_____
Tetanus	_____
Varicella	_____
Other	_____

Other Comments:

☐ Patient has no communicable disease
and
☐ Cleared for any position
☐ Cleared for Limited assignment

_____

Physician's Signature Date

_____

Name (Please Print) Title NJ License #

September 14