

 **COMMUNITY
MEDICAL CENTER**

An affiliate of the Saint Barnabas Health Care System

RONALD J. DEL MAURO
Chief Executive Officer
Saint Barnabas Health Care System

STEPHANIE L. BLOOM, FACHE
Executive Director
Community Medical Center

Dear Adult Applicant:

We are pleased to learn of your interest in the Volunteer Program at Community Medical Center. Please fill out the attached application and return it to the Volunteer Resource Center at Community Medical Center at your earliest convenience.

We will be contacting you to schedule a personal interview. This will provide an opportunity for us to identify your interests, your skills and your available schedule. We will then discuss the areas of the hospital in which you may be assigned and together we will select a position that will meet with your approval.

All new volunteers are required to attend a general orientation program, submit to a criminal background check and medical screening prior to beginning their volunteer assignment.

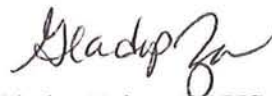
Volunteers are very special people and we appreciate your desire to serve Community Medical Center in such a special way. Your completed application can be mailed, faxed or emailed to:

Volunteer Resource Center
Community Medical Center
99 Route 37 West
Toms River, NJ 08755

732-557-4060 (fax)
cmcvolunteers@sbhcs.com (email)

Again, we thank you for your interest and we look forward to meeting you.

Sincerely,



Gladys Zakar, CAVS
Volunteer Resource Center
732-557-8000 ext. 11256



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ADULT VOLUNTEER APPLICATION

Date of Application: _____

Please fill in and returning this form to the Volunteer Resource Center, Community Medical Center, 99 Route 37 West, Toms River, NJ 08755. We will contact you to arrange an interview.

PERSONAL INFORMATION (please print)

Mr. _____ Marital Status: Single Married Widowed

Mrs.

Miss

Address _____

Home

Phone _____

Birth Date _____

Social Security No. _____

-

-

Personal Physician _____

Have you ever committed, been convicted of, pled guilty to or pled nolo contendere to a felony or a misdemeanor? (Note: Conviction of a crime is not necessarily grounds for disqualification)

Yes _____

No _____

If yes, please explain _____

Please give us the name, address and telephone number of someone who can be notified in case of emergency

VOLUNTEER EXPERIENCE

Have you ever volunteered before? Yes _____ No _____ If yes, please list the last two organization (s)

From: _____ To: _____

From: _____ To: _____

How were you referred to Community Medical Center to volunteer? _____

BACKGROUND

- Currently Employed Currently unemployed Retired

Employer _____ Work Phone _____

Occupation _____

Education _____

COMMITMENT

Volunteer work preferred:

- Patient Contact Delivery Services Clerical/Reception
 Silver Spoon Patient Feeders Cashier/Sales

Are you available year round? Yes _____ No _____ If no, when? _____

Time (s) and Day (s) available for volunteer service. Please specify hours that you can volunteer.

	Sun	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
Morning							
Afternoon							
Evening							

I have completed this application to the best of my knowledge, and verify its contents. I hereby authorize Community Medical Center to investigate all statements. I am also authorizing Community Medical Center to contact employers and/or volunteer organizations listed to verify statements or provide information.

Applicant signature _____ Date: _____

FOR VOLUNTEER RESOURCE CENTER USE ONLY

Date application received _____

COMMUNITY MEDICAL CENTER

VOLUNTEER RESOURCE CENTER

REFERENCE RELEASE

Please list the names, addresses and phone number of three references.

Please sign and date this release:

I authorize Community Medical Center Volunteer Office to contact my former employer(s), schools, companies, corporations, law enforcement agencies and other persons who can verify or provide information on my volunteer application. Further, I release from liability such former employer (s), schools, companies, law enforcement agencies, and other persons contacted by and providing information to Community Medical Center. A copy of this authorization shall be as valid and binding as the original.

Signature

Date

ADULT VOLUNTEER HEALTH HISTORY

NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SS#: _____

PHYSICIAN'S NAME: _____ PHONE# _____

PERSONAL MEDICAL HISTORY

If you have or have had any of the following, please indicate with a check by that illness.

<input type="checkbox"/> Allergies	<input type="checkbox"/> German Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Measles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Nervous
Disorders		
<input type="checkbox"/> Back Injury	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic
Fever		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Drug or Alcohol	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Shortness of
Breath		
<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Typhoid

Do you have any physical limitations? _____

Please list any medications you may take on a regular basis _____

Are you allergic to any medications? _____ Yes _____ No

Have you had any of the following inoculations?

TB Screening (Mantoux/PPD) _____ Yes _____ No If yes, date _____
(Please provide documentation)

Rubeolla (Measles) _____ Yes _____ No If yes, date _____
(Please provide documentation)

Rubella (German measles) _____ Yes _____ No If yes, date _____
(Please provide documentation)

CERTIFICATION OF TRUTH AND COMPLETENESS

I certify that all information given by me, in this history is true and complete and that I have not knowingly withheld any pertinent facts. I understand that giving any false information or omitting and pertinent data, may be cause for my release by the hospital.

Volunteer Signature _____

Date _____

BACKGROUND

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