Hunterdon Health
Volunteer Resources
2100 Wescott Drive
Flemington, NJ 08822
908-788-6140 phone

Hello,

Thank you so much for your interest in volunteering at Hunterdon Health. Volunteers are an important part of our team and help us in many ways. We appreciate everyone who gives us the gift of their time. Wherever you volunteer, you will make a difference!

The Summer College Volunteer Program is a vital part of Hunterdon Health as the volunteers provide that extra dimension of care and service to our patients, dedicated staff, and the community. Our mission is to recruit, train and place committed volunteers who have demonstrated they are compassionate, enthusiastic, and responsible individuals. Summer college volunteers are asked to make a dependable time commitment of 2-4 shifts per week for a minimum of 100 hours of service over the summer. The shifts will range from four to eight hours depending on the position, your schedule and the department's needs. This commitment allows summer college volunteers to make a real impact on their assigned area and provides the greatest opportunity for personal satisfaction. Volunteers that fulfill their commitment will receive a verification letter of hours and be invited to return over winter break.

Please take the time to review, complete, and sign all the included forms. You may find it easiest to print them first. Application can be mailed, emailed or dropped off when completed. **Completed application packets are due by April 20th.**

For your convenience, this is a checklist of what will need to be completed:

- Application Form
- Health Clearance Form to be completed by your Primary Care Physician (Annual Influenza vaccination is mandatory for this program and must be completed prior to submitting Health Form during the months of September thru mid-April)
- Copy of COVID Vaccination Documentation (Documentation must include Lot #'s and vaccine manufacturer. Complete attached declination if you have not been vaccinated, or have not been fully vaccinated with the 1st & 2nd dose, plus booster)
- Three Confidential References (preferably not a family member)

Once your completed application packet has been received and reviewed, you will be contacted to inform you of your status and to schedule an interview. The interview will help establish if the applicant's skills, attitude and capabilities align with Hunterdon Health's needs, mission and values This will also be a time to discuss opportunities and hopefully make a connection to a volunteer role. Please understand that submission of the application packet and an interview does not ensure placement as a volunteer. If selected to become a volunteer: your health information will be forwarded to our Occupational Health Department for approval, a background check will be completed through Volunteer Resources, and you will be invited to attend new volunteer orientation. When these requirements have been met you will be cleared to begin volunteering.

Should you have any questions along the way, please feel free to reach out to me at kkelleher@hhsnj.org. I look forward to meeting you!

Sincerely,
Kimberly Kelleher, MASC
Manager of Volunteer Services

Hunterdon Health

College Volunteer Application

Please Print or Type ■ Complete All Questions

Thank you for your interest in the Hunterdon Health volunteer program. We will contact you when we have received your application to discuss our program and your interests.

Last: _____ First: _____ MI: _____

Address: _____ Telephone: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Date of Birth: _____
Month/Day (Year Optional)

E-Mail Address: _____ Cell Phone: (_____) _____ - _____

Occupation: _____ Work Phone: (_____) _____ - _____

Emergency Contact #1: _____ Relationship: _____
(Optional)

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Other: (_____) _____ - _____

Emergency Contact #2: _____ Relationship: _____
(Optional)

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Other: (_____) _____ - _____

Highest Level of Education? _____ Area of Study/Major _____

School Name : _____ Graduation Year: _____

Have you ever had an affiliation with Hunterdon Health? ❑ Yes ❑ No _____

Why would you like to volunteer at Hunterdon Health? _____

_____

SKILLS, HOBBIES, INTERESTS:

❑ Computer ❑ Cooking/Baking ❑ Event Planning ❑ Fitness ❑ Knitting ❑ Marketing ❑ Medicine
❑ Music ❑ Photography ❑ Outgoing ❑ Reading ❑ Reiki ❑ Travel ❑ Walking ❑ Writing
❑ Language: _____ ❑ Sports: _____ ❑ Other: _____

VOLUNTEER EXPERIENCE:

❑ Hospital ❑ Nursing Home ❑ Rescue Squad ❑ School ❑ SPCA ❑ Other: _____

VOLUNTEER INTERESTS:

❑ Transport/Courier ❑ Patient Care ❑ Thrift Shop ❑ Gift Shop ❑ Information Desk ❑ Greeter
❑ Child Care ❑ Bright Side (Adult Daycare) ❑ Office Aide ❑ Other: _____

TIME AVAILABLE:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening	❑ Morning ❑ Afternoon ❑ Evening

APPLICATION STATEMENT:

Read the following carefully before signing.
I understand that nothing contained in this volunteer application or in the granting of an interview is intended to create a volunteer or employment contract between Hunterdon Health or any of its operating units (Hereandafter collectively referred to as Hunterdon Health) and myself for either volunteering, employment or the providing of benefits. No promises regarding volunteering or employment have been made to me and I understand that no such promise or guarantee is binding upon Hunterdon Health unless made in writing. I understand that, if accepted as a volunteer, the relationship between Hunterdon Health and myself is volunteerism at-will, and, therefore, my participation in Hunterdon Health's Volunteer Program may be terminated with or without cause, and with or without notice, at any time, at the option of either Hunterdon Health or myself.

Statements made by me in this application will be verified, and I hereby give Hunterdon Health the right to make a thorough investigation of my past employment, education and my references and agree to execute any and all releases necessary for Hunterdon Health to do so. I release from all liability all persons, companies and corporations supplying any information pursuant to such investigation. I release Hunterdon Health from any and all liability which might result from such investigation. Additionally, I understand that any false answer, statement or implication made by me in this application or other required documents will result in denial of acceptance into Hunterdon Health's Volunteer Program or discharge from the same. I understand that my volunteering is also contingent upon receipt of satisfactory references, criminal background investigations and the satisfactory completion of a hospital administered medical examination including drug and alcohol testing, as appropriate, and the satisfactory completion of a hospital post offer physical examination which may include, but is not limited to, any or all of the following: physical exam, blood tests, drug screen and urinalysis. Additional testing of position related skills may be required prior to volunteering. I certify that if accepted I will abide by all company rules, policies and regulations.

In connection with this application for volunteering with Hunterdon Health, I hereby understand and acknowledge that Hunterdon Health utilizes the services of a consumer reporting and an investigative consumer reporting agency, to verify the information I have provided on the volunteer application. I am hereby notified that Hunterdon Health intends to procure investigative consumer reports and I authorize the procurement of these investigative consumer reports. I understand that the reports will contain information about my background, character, general reputation, credit worthiness, mode of living and job performance. The investigative consumer reports may consist of, but not be limited to, an interview with all listed employers to verify employment, references, supervisors, criminal history, educational records, licensing agencies, governmental databases, address databases, credit history and driving history records. This authorization is valid during the course of my employment to the extent permitted by law.

I understand that, upon written request within a reasonable period of time, I am entitled to a copy of the reports and additional information concerning the nature and scope of this investigation. I understand that pursuant to the Fair Credit Report Act (FCRA), I have the right to know if adverse action is being considered against me as a result of information contained in these reports. I have the right to a copy of these reports prior to any adverse action taken against me and to dispute the accuracy of any information in the reports by contacting the consumer reporting agency(ies) listed on the bottom of this application. Hunterdon Health has provided a copy of a Summary of our Rights Under the FCRA. I understand that I may have additional rights under State law, which I may determine by contacting my state or local consumer protection agency.

The authorization for release of information includes, but is not limited to, matters of opinion relating to my character, ability, reputation and past performance. I authorize all persons, schools, organizations, companies, corporations, credit bureaus, law enforcement agencies, state agencies and courts for the purpose of criminal record research and motor vehicle agencies for the acquisition of a driving record or abstract if required to release such information without restriction or qualification to a consumer reporting and an investigative consumer reporting agency, and any of its officers, agents, employees and servants.

I certify that I have read and fully understand the questions asked in this application. I certify that all answers given by me are true, accurate and complete, and I understand that the omission and/or misrepresentation of any fact from this application or during any interview will be cause for immediate dismissal. I certify that I have read the above and that the statements on this application are true and correct.

Signature: _____ Date: _____

TABB INC.
PO Box 10, 555E. Main St
Chester, NJ 07930
(908) 879-2323 or (800) 877-8222

State of New Jersey
Department of Human Services
The Central Registry of Offenders Against
Individuals with Developmental Disabilities

Office of Inspector General
US Department of Health &
Health & Human Services
(202) 691-2311

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE MEDICAL RECORDS,

DRUG AND/OR ALCHOHOL TEST RESULTS:

SECTION ONE

I, the undersigned, hereby consent to the performance of all prescribed diagnostic tests and procedures, laboratory test and procedures, treatment and examination rendered by the Hunterdon Health's Occupational Health and their physicians on this date and forward while a volunteer of Hunterdon Health. I authorize Hunterdon Health to release to Volunteer Resources, insurer, or third party all medical findings, examination and test results, and any other medical history or treatment information necessary to determine my medical or physical condition concerning volunteering, position placement, and ability to work. I also authorize release of this information to network, consulting physicians or other parties involved in my treatment. I have read this authorization or have had it read to me. The medical records will be provided to the appropriate designated representative of Volunteer Resources, who shall maintain the confidentiality of such records as required by law. *If you would like information on Advance Directives, please see the Occupational Health receptionist.*

Signature: _____ Date: _____

SECTION TWO

If screening for the presence of controlled substances and/or alcohol is required I, the undersigned, consent to the Hunterdon Health's collection of urine, blood, breath and/or hair from me and the performance of scientifically valid tests to determine the presence, or use of, controlled substances or alcohol. Further, I authorize the Hunterdon Health to release the test results to Volunteer Resources for appropriate review. I have read this authorization or have had it read to me. The drug and alcohol test results will be provided to the appropriate designated representative of Volunteer Resources, who shall maintain the confidentiality of such records as required by law.

Signature: _____ Date: _____

SECTION THREE

I, the undersigned, authorize Hunterdon Health to release my immunization records to my healthcare providers where possible. I have read this authorization or have had it read to me. The medical records will be provided to the appropriate medical offices, who shall maintain the confidentiality of such records as required by law.

Signature: _____ Date: _____

Hunterdon Health

College Volunteer Health Clearance

APPLICANT INFORMATION

Applicant: _____ Date of Birth: _____

Address: _____ Phone: _____

Dear Healthcare Provider:
The applicant named above has applied for a volunteer position with Hunterdon Health. In an effort to streamline their application process, we kindly ask for you to review and complete all the sections of this form and attach documentation as necessary. Please include lot numbers where requested. The completed form can then be returned to the person or directly to:

Mail: Hunterdon Health Volunteer Resources ▪ 2100 Wescott Drive ▪ Flemington NJ 08822

Fax: 908-237-2338

GENERAL HEALTH INFORMATION:

Does this person have any physical/mental condition or medical problem, which may limit his/her ability to perform the work of a volunteer? ❑ Yes ❑ No

Is this person presently on any medication that would impair his/her ability to perform the work of a volunteer? ❑ Yes ❑ No

Does this person have any history of seizures? ❑ Yes ❑ No

Please indicate any volunteer activities that this individual should refrain from doing:

❑ typing ❑ filing ❑ using copiers ❑ using computers ❑ patient contact ❑ child care
❑ pushing wheelchairs/stretchers ❑ periods of sitting ❑ periods of standing ❑ excessive walking
❑ lifting over _____ lbs. ❑ Other: _____

IMMUNIZATION HISTORY:

Please complete the following immunity profile.

	1st Vaccine Date	2nd Vaccine Date	
Varicella			
Mumps			
Rubella			
Rubeola			
TDAP		(Date of last booster)	
Influenza		Lot#:	Exp:

	1st Vaccine Date	2nd Vaccine Date	3rd Vaccine Date
Hepatitis B			

	1st Vaccine Date	2nd Vaccine Date	Booster
COVID-19			
	MFR:	MFR:	MFR:
	Lot#:	Lot#:	Lot#:

TUBERCULOSIS CLEARANCE:

Please provide either documentation of IGRA testing or **two** negative TB skin tests from within the last 12 months (older tests will not be accepted) including one from the last 3 months. If person has had a positive TB test, please provide proof of a past reaction and negative chest x-ray from within the last 12 months to document that person does not have tuberculosis.

IGRA Test

Date Given: _____ Results: _____

OR

#1 Tuberculin Skin Test (TST)

Date Given: _____ RFA LFA Administered by: _____ Dose: 0.1 cc/ID

Date Read: _____ Results: _____ mm induration Read by: _____

Manufacturer: _____ Lot#: _____ Expiration Date: _____

#2 Tuberculin Skin Test (TST)

Date Given: _____ RFA LFA Administered by: _____ Dose: 0.1 cc/ID

Date Read: _____ Results: _____ mm induration Read by: _____

Manufacturer: _____ Lot#: _____ Expiration Date: _____

OR

Known History of Positive Tuberculin Test

Date: _____ Results: _____ mm induration

- ☐ Provide documentation of negative chest x-ray from within the past 12 months.
- ☐ Provide documentation of drug therapy (INH, etc.) and duration of treatment

COMMENTS:

_____

_____

_____

_____

_____

_____

HEALTH CARE PROVIDER STATEMENT:

As the health care provider for _____ (person's name), I acknowledge that this person is suitably healthy, both physically and mentally, to make a commitment to volunteer with Hunterdon Healthcare.

Printed Name: _____ Phone#: _____

Health Care Provider Signature: _____ Date: _____

Hunterdon Health

Declination of COVID-19 Vaccination

My employer or affiliated health facility, Hunterdon Health , recommends that I receive COVID-19 vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and check each box):

☐ COVID-19 vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from COVID-19, its complications, and death.

☐ If I become infected with COVID-19, even if my symptoms are mild or non-existent, I can spread COVID-19 to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.

Despite these facts, I am choosing to decline COVID-19 vaccination.

☐ I understand that I can change my mind at any time and accept COVID-19 vaccination. I have read and fully understand the information on this declination form.

Signature_____ Date_____

Name (print) _____

Department Volunteer Resources

Hunterdon Health

CONFIDENTIAL
Personal Recommendation

APPLICANT INFORMATION

I, _____, do hereby authorize the below named person to release the information requested within this reference form. I do hereby hold harmless and release said person from any liability in releasing this information to Volunteer Resources at Hunterdon Health.

Applicant Signature: _____ Date: _____

Dear Reference:
The applicant named above has applied for a volunteer position with Hunterdon Health and has provided your name as a reference. Your evaluation and comments are appreciated and will be kept confidential. Please return the completed form to the applicant in a signed sealed envelope, or directly to:

Mail: Hunterdon Health Volunteer Resources ▪ 2100 Wescott Drive ▪ Flemington NJ 08822

Email: kkelleher@hhsnj.org **Fax:** (908) 237-2338

Relationship to applicant: ☐ Employer ☐ Friend ☐ Other: _____

How long have you known the above referenced individual? _____

Volunteering within Hunterdon Health is a commitment and a considerable responsibility. Would this applicant fulfill these requirements and prove to be an asset to our healthcare facility? ☐ Yes ☐ No

	Excellent	Good	Fair	Poor
RELIABILITY: The applicant is punctual and able to make a commitment.				
COOPERATION: The applicant works well with the others.				
RESPONSIBILITY: The applicant accepts responsibility for his/her work and behavior.				
ATTENTION: The applicant is able to listen and follow instructions.				
COMMUNICATION SKILLS: The applicant speaks clearly and effectively.				
INITIATIVE: The applicant is resourceful and self-reliant in dealing with new situations.				
COURTESY: The applicant shows respect for others, accepts supervision and treats others with kindness and tact.				

Does this person maintain a neat appearance?	Yes	No	Sometimes
If you were a patient or employee at Hunterdon Health, would you like this person assigned to your area?	Yes	No	Maybe

COMMENTS

Printed Name: _____ Telephone#: _____

Signature: _____ Date: _____

Thank you for your willingness to complete the recommendation on behalf of this person. We rely on recommendations, such as yours, to help us identify those who will both match and benefit from our program.

Hunterdon Health

CONFIDENTIAL
Personal Recommendation

APPLICANT INFORMATION

I, _____, do hereby authorize the below named person to release the information requested within this reference form. I do hereby hold harmless and release said person from any liability in releasing this information to Volunteer Resources at Hunterdon Health.

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