Atlantic Health System
Chilton Medical Center

Dear Junior Volunteer Program Applicant:

Thank you for your interest in the Chilton Medical Center's Junior Volunteer Program.

This application requires completion by both you and your parents/guardians. Additionally, within the application, there is a section that needs to be completed by your school guidance counselor.

If we have any junior volunteer opportunities available, upon receipt of your application, you will be called in for an interview. PLEASE NOTE THAT YOU WILL BE CONTACTED **ONLY** IF THERE IS A VOLUNTEER OPPORTUNITY AVAILABLE. Following the interview, if accepted into the program, you will be given a "Health Certificate," and "Tuberculosis PPD Testing Form to be completed by your physician.

To verify if volunteering is right for you, please consider the following requirements for all Junior Volunteers:

- Must be high school students between the ages of 15-18
- Must complete a health certificate that provides proof of vaccinations, and the certificate must be signed by the volunteer's physician
- Must receive a **TWO-step TB test**
- Must have a flu shot, if they are providing services during the flu season (December – June)
- Must complete **50 services hours** to receive a college recommendation letter
- Must attend a 2 hour Junior Volunteer Orientation session

If you have any questions, please do not hesitate to call the Volunteer Services Office at (973) 831-5016, Monday – Friday, 8:00 a.m. to 4:00 p.m.

Atlantic Health System
Chilton Medical Center

APPLICATION FOR JUNIOR VOLUNTEER SERVICE

97 West Parkway, Pompton Plains, NJ 07444
973.831.5016 email: chiltonvolunteer@atlantichealth.org

Last name _____ **First** _____ **M.I.** _____
[PLEASE PRINT THROUGHOUT]

Address _____ **City** _____

State _____ **Zip** _____ **Home phone ( )** _____

Parent's name _____ **Work phone ( )** _____

Student's Email Address: _____

Age _____ **Date of birth** _____ **Male/Female(circle) Social Security** _____

School Name _____

Grade [CIRCLE ONE] **9 10 11 12 Graduation year** _____ **Career interest** _____

Is a family member an employee of the hospital? Where? _____

Have you ever pled guilty, no contest (no lo contender) or been convicted of a crime which has not been expunged, annulled, sealed, pardoned, or statutorily eradicated by the Court? (Before you answer, please note that a conviction or plea of guilty will not necessarily prohibit you from becoming a volunteer)

_____ **YES** _____ **NO**

If yes, please describe the nature of the crime, the date of the conviction and completion of any sentence and any subsequent rehabilitation.

_____

_____

IN CASE OF EMERGENCY:
Name _____ **Relationship** _____

Home phone ( ) _____ **Work phone ( )** _____

IN <u>YOUR OWN WORDS</u> PLEASE TELL US IN A 50-WORD PARAGRAPH YOUR REASONS FOR WANTING TO BECOME A CHILTON JR. VOLUNTEER (must be printed legibly)

_____

_____

_____

VOLUNTEER AGREEMENT

I understand that, as a volunteer, I must abide by the rules and regulations of Chilton Medical Center including the dress code and will be willing to serve at least three hours weekly in whatever service I am assigned. <u>I agree to donate a minimum of 50 hours of service before I receive a letter or recommendation.</u> I understand and agree that once I sign in for my shift I may not leave the hospital until the shift is over without the approval of a parent/guardian or the Coordinator of Volunteer Services. Once I leave the hospital grounds, I understand that the hospital will not be held responsible for me.

Date: _____ **Applicant's signature** _____

PARENTAL CONSENT

My son/daughter may serve as a Jr. Volunteer at Chilton Medical Center. I understand that final placement is contingent upon satisfactory completion of all pre-placement procedures including attendance at the entire scheduled Jr. Volunteer Orientation. In addition, I understand the importance of dependability and responsibility in the assignment. I will cooperate by providing transportation and seeing that he/she maintains the scheduled time and dresses following the Chilton dress code. I understand that my son/daughter must donate a minimum of 50 hours of service before he/she will be provided with a letter of recommendation. I understand that my son/daughter may not leave the hospital once they have signed in prior to the shift ending without my permission or the permission of the Director of Volunteers. I agree that if my son/daughter does leave the hospital prior to his/her shift ending, the hospital will not be responsible for my song/daughter.

Date _____ Parent's signature _____

*** ***

AN INSTRUCTOR OR GUIDANCE PERSON AT THE APPLICANT'S SCHOOL MUST FILL IN THE INFORMATION BELOW. THIS PERSON SHOULD THEN FORWARD THE APPLICATION TO CHILTON MEDICAL CENTER, 97 WEST PARKWAY, POMPTON PLAINS, NJ 07444.

CONFIDENTIAL RECOMMENDATION FOR JUNIOR VOLUNTEER

Student's name _____ Grade in school _____

	Excellent	Good	Average	Below Average
Attendance				
Scholastic Record				
Dependability				
Courtesy				
Willingness				
Initiative				

Comments: _____

_____

_____

_____

SIGNATURE _____

TITLE _____

SCHOOL _____

DATE _____