Atlantic Health

New Adult Volunteer Packet

Thank you for your interest in our Adult Volunteer Program at Atlantic Health CentraState Medical Center. Our Adult Volunteers, ages 18 and over, are a dedicated and loyal group that is an important part of our team here at CentraState!

If you are a *college student*, please contact Volunteer & Guest Services and Spiritual Care to receive the New College Student Volunteer Packet.

Steps required to begin volunteering:

1. Fill out Interest Form on website
2. Complete ***New Adult Volunteer Packet,*** **including** ***Health Clearance Form*** This is the Packet.
3. Attend an Interview to discuss goals of volunteering, volunteer positions, and shifts.
4. Background Clearance processed by CentraState.
5. Attend **Mandatory Volunteer Orientation** in its entirety.
6. **Begin to volunteer (placement not guarenteed)**

Your Adult Volunteer Application includes:

1. ***Adult Volunteer Info Form***
2. ***Volunteer Pledge & Letter of Recommendation***
3. ***Volunteer Service Agreement***
4. ***Adult Volunteer Health Clearance Form*** (Must be completed by Physician)
   (Please attach a copy of your **resume** *if applicable. We hold Completed Forms for 6 months).*

Please print forms for signatures. Once all forms are completed and signed, please scan and email via attachment (PDF/Jpeg ONLY - do NOT send in Google Docs/Links) to CS_Volunteers1@atlantichealth.org. **No in person drop offs are accepted.**

While we will make every attempt to find an appropriate placement for each applicant, we cannot guarantee a volunteer position due to availability, departmental needs, and number of applications received. Volunteers are asked to serve a minimum of *1 day a week for a 4 hour shift*. Volunteers serve a consistent shift each week.

We hope that your volunteer commitment at Atlantic Health CentraState Medical Center will be fulfilling and educational. If you have any questions, please contact us. We look forward to having you join our community.

Joe Licata, Manager
Volunteer & Guest Services and Spiritual Care

Atlantic Health

Adult Volunteer Info Form

Have you ever submitted a Volunteer Application Form in the past? Yes ___ No ___

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Shirt Size [Circle One]:** S M L XL XXL Other:

***Email:** _____ **Primary Phone**:_____

*In order to be more environmentally conscious, we will communicate predominantly via email.

Emergency Notification: _____ **Relationship:**_____

Primary Phone: (____)_____ **Secondary Phone:** (____)_____

Areas of Interest *(Schedule)* -- We will schedule your 4-hour shift based on your availability and the needs of our departments. Please indicate below which area/s of interest you had in mind. Please note at this time we have no clerical/office volunteer roles available.

___Patient Interaction
___Spiritual Care
___Information Desk
___Pet Therapy (certification required)
___Food and Nutrition
___Surveyor
___Patient Transport

_____ _____ _____

Date **Signature** **Print Full Name**

Atlantic Health

Volunteer Pledge

☐ I understand and agree that in the performance of my duties as a volunteer of Atlantic Heath CentraState Medical Center, I must hold medical information in confidence. This includes any patient information that I may come across in the line of duty or inadvertently, regardless of how it is presented to me [printed/written form, spoken word, computerized, facsimile, etc.]. I also understand that patient information is only accessible to fulfill the obligation for information needed to serve the patient, the institution and the community. I further understand that any violation of the confidentiality of medical information may result in termination of my services as a volunteer.

_____	_____	_____
Date	**Signature**	**Print Full Name**

Letter of Recommendation

A letter of recommendation is required for all volunteers. The letter should be written by someone that knows you well. **It cannot be written by a family member (this includes "in-laws").** Individuals can include teachers, guidance counselors, coaches, managers, coworkers, etc. Applicants, please copy the following instructions and provide to the individual doing the Recommendation.

Instructions for Individual Writing Letter of Recommendation:

- Letter shall be considered confidential and should not be shared with the applicant.
- Letters should be emailed directly to Volunteer Services. Please email to *CS_Volunteers1@atlantichealth.org.* Please include the name of the applicant in the Subject Line of the email.
- Please include your contact information in your letter in the event we need to contact you. Please also include your relationship to the student.
- If you have any questions, please contact us at 732-294-2622.

Name of Recommender: _____
Title: _____
Contact Information (Email or Phone Number): _____

***** *We will NOT contact you if we do not receive your Letter of Recommendation. It is your responsibility to ensure we receive it.* ***Please turn in this form with your Application so we have record of who is writing your Letter.***

Atlantic Health

Infection Control Staff Only:
*Approved:*_____
*Denied:*_____

Adult Volunteer Health Clearance Form

This form MUST be completed i*n full* by your personal Physician.

We suggest checking with your insurance company to ensure coverage for items below. CentraState is **not** responsible for Insurance or Doctor Fees.

_____ _____
Full Name of Volunteer **Date of Birth**

A. To my medical knowledge, this applicant is capable of performing volunteer assignments:

___ With no restrictions
___ With restrictions (physical/emotional/allergies/precautions/religious to be observed) please describe:
_____
_____

B. Immunity of the following (*Please Provide Immunization Dates OR Titers*):

Disease	2 Immunization Dates [two required]		Titer Result with Date Pos.	Neg.
Measles				
Mumps				
Rubella				
Varicella [Chicken Pox]				

C. Immunization Dates: **TDap:** _____ **Flu Vaccine (required after September 1):** _____

D. Tuberculin (TB) Test Options *(You only need to do one of the following three steps)*

If a TB Test was done within the past 12-months, those results can be submitted

1) **Blood Test for IGRA (Quantiferon/QFT)(quickest results)**

Date	Result

2) **Two-Step TB Skin Tests [Mantoux/PPD/TST]** (***2 tests** given 1-3 weeks apart)

Date Administered	Date Read	Result
1. _____		
2.		

3) **Chest x-ray (if you test positive for TB only)**

Date Administered [within last year]	Date Read	Result

Name of Physician_____

Address/City/State/Zip Code_____

Phone Number: _____