Dear Applicant,

Attached is a volunteer application for Chilton Medical Center. Please complete and return to Chilton Medical Center, Volunteer Office, 97 West Parkway, Pompton Plains, NJ 07444 or email it to Chiltonvolunteer@atlantichealth.org. Based on the information provided in the application, if there is an appropriate fit at the time of submission, the Volunteer Office will call you to schedule an in-person interview. If there is not an appropriate position available at the time your application is received, it will be held for three months. If something becomes available within the three month period, the Volunteer Office will contact you. You will only be called if there is a position available that matches the skill set provided on the application; therefore, it is important to please be specific and share as much information as possible.

Please note that we require a commitment of at least six months from our Volunteers. If you are selected for a volunteer position, you will be given a health certificate form to be completed by your physician. This forms includes documentation of receipt of Tdap vaccine as well as documentation of immunity to measles, mumps, rubella and varicella. Additionally, 2 skin TB tests will be required as well as a flu shot in order to volunteer during the December through May flu season.

A CRIMINAL BACKGROUND CHECK IS PERFORMED ON ALL ADULT VOLUNTEERS. BECAUSE OF THIS REQUIREMENT, YOU MUST HAVE A VALID SOCIAL SECURITY NUMBER IN ORDER TO VOLUNTEER AT CHILTON MEDICAL CENTER.

Thank you for your interest in the Volunteer Program at Chilton Medical Center.

Sincerely

Susan Gavin
Coordinator of Volunteer Services
To be considered for a volunteer position at Chilton Medical Center, please complete the application and return via email to chiltonvolunteer@atlantichealth.org or via mail to Chilton Medical Center, Volunteer Office, 97 West Parkway, Pompton Plains, NJ 07444.

Last Name: 
First Name: 
Address: 
City: 
State: 
Zip: 
Home Phone: 
Work Phone: 
Cell Phone: 
Email: 

May we contact you at work?  □ Yes  □ No

Emergency Contact Information:
Name: 
Phone: 
Relationship: 

Employment Information
Employer: 
Address: 

Are you a current or former employee of any healthcare facility affiliated with Atlantic Health System?  □ Yes  □ No

Education and Skills
High School: 
College: Degree: 
Other Education (Special Training, Graduate, Nursing, etc.): 

ADULT VOLUNTEER APPLICATION
Are you fluent in any language other than English? □ Yes □ No

If so, what language? [ ]

Are you currently enrolled in an RN or LPN program? □ Yes □ No

Are you a retired RN or LPN? □ Yes □ No

Do you have any professional skills you may be interested in lending to volunteering at Chilton Medical Center? □ Yes □ No

Criminal History

Have you ever been convicted or pleaded guilty to a crime or criminal offense, other than a minor traffic violation, which has not been expunged or sealed by a court?

□ Yes □ No

If yes, please explain:

[ ]

Onboarding and Service Commitments

Are you able to complete a volunteer commitment of once a week for a minimum of six months?

□ Yes □ No

Are you able to undergo mandatory screening and requirement, including: Physical (done at your cost), two tuberculosis tests, criminal background check, interview, orientation, and reference letters (process takes up to one month from the interview)?

□ Yes □ No

Availability

Please indicate when you are available for a volunteer assignment.

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Please list your top three position or areas for volunteering:

1. 
2. 
3. 

Have you already made contact with a person or department at Chilton Medical Center regarding a specific volunteer position?

☐ Yes  ☐ No

If so, please list the name of the person, the phone number, and the volunteer position.

Name: ___________________________  Phone: ___________________________

Position: ___________________________

**Applicant Authorization**

I understand that completing this application and/or the interview/screening process are not promises of an offer of assignment. As a volunteer, I have no expectation of compensation for services provided. If I have provided false or misleading information, I acknowledge that Atlantic Health System may terminate any volunteer assignment immediately.

Name (Printed): ___________________________  Date: ___________________________

Signature: ___________________________