Hackensack
Meridian *Health*
Pascack Valley Medical Center

Dear Prospective Volunteer:

Thank you for your interest in Hackensack Meridian *Health* Pascack Valley Medical Center Volunteer Services Program. Joining our dedicated team of volunteers can be a richly rewarding experience for you. Through volunteering you will find challenging, enjoyable activities that will satisfy you while you perform a valuable service to others. To be considered for available volunteer opportunities at Hackensack Meridian *Health* Pascack Valley Medical Center, the Adult Application Form and the Health Immunization forms will need to be completed. Additionally, all prospective adult volunteers (ages 18 and above) must submit to a background check.

By completing the application our office can determine the best use of your availability and talents. Please be very specific about which days and times you are able to volunteer; and note that **you must be able to commit to volunteering at least 75 hours per year.**

The completion of the health certificate form must be done by your personal physician. You will not be able to become a volunteer at the hospital until we have received your completed health form accompanied by your application.

When the completed application, health certificate form and the results of the background check are received, you will be contacted by our office to arrange a convenient time for an interview so we can discuss the role you would like to take on as a Volunteer, as well as what volunteer positions are currently available.

I thank you for your interest in our program, and we look forward to hearing from you.

Sincerely,

The Marketing Department
Dawnn.DePalma@Hackensackumcpv.com
Phone: 201-383-1020

Hackensack
Meridian *Health*
Pascack Valley Medical Center

## Adult Volunteer Application Form

**Please Check:** Miss _____ Mrs. _____ Ms. ______ Mr. _____ **Date**: ___/_____/________________

**Name:** ____________________________________________ **SSN:** ___/_____/_________________

**Full Address:** _____________________________________________________________________

______________________________________________________________________________________

**Home Phone:** (______) _____ - _______ **Cell Phone:** (_______) _____-_______

**May we contact you at work?** ☐ Yes ☐ No **E-Mail Address:** ________________________________

**Birth Date:** ____/_____/______ **(Year optional)**

**Physical Limitations/Disabilities:** ☐ Yes, please explain ______________________ ☐ No

**Current Status:** ☐ Student ☐ Employed ☐ Unemployed ☐ Retired

**Employed By:** ___________________________________________________________________________

**Occupation (past/present):** _______________________________________________________________

**Interests/Skills:**

☐ Typing/word processing ☐ Clerical/non-typing ☐ Computer

☐ People skills ☐ Record keeping ☐ Mailings

☐ Other, please list: ______________________________________________________________

**Foreign Languages:** _____________________________________________________________________

**Volunteer Experience:** __________________________________________________________________

**Volunteer Work Preference:**

☐ Patient contact ☐ Non-patient contact ☐ Clerical

☐ Other (please list): _______________________________________________________________

**Availability Days**: __________________ **Availability Times:** ______________________________

**Are you available throughout the year? If no, when are you available?** ______________________________

________________________________________________________________________________

**Personal Reference:**
**(please exclude relatives)**

________________________________________________________________
Name Telephone

________________________________________________________________
Street Address Town State Zip

**Personal Physician:**

________________________________________________________________
Name Telephone

________________________________________________________________
Street Address Town State Zip

**In an emergency, notify:**

________________________________________________________________
Name Home Telephone

________________________________________________________________
Business Phone Relationship

**Are you required to volunteer?** ___ Yes ___ No **If yes, how many hours?** _______________

**Have you previously volunteered for Hackensack Meridian *Health* Pascack Valley Medical Center?**
________________________________________________________________________________

**How did you hear about the Hackensack Meridian *Health* Pascack Valley Medical Center?** __________
________________________________________________________________________________

**Have you ever been convicted of a crime other than minor traffic violations?**

____ Yes ____ No If yes, please describe:__________________________________________________

________________________________________________________________________________

**Please give any other information you feel is pertinent to your application:** ____________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**The above information is accurate and correct to the best of my knowledge. I authorize Hackensack Meridian *Health* Pascack Valley Medical Center to conduct a thorough background check that my include a police or reference check.**

________________________________________ ________________________________________

**Signature** **Date**

Hackensack Meridian *Health*

Pascack Valley Medical Center

**Immunization Record for Volunteers**

Name: ______________________________________________ DOB: ___/___/___

Address: ____________________________________________________________

Telephone Number: ____________________________________________________

| IMMUNIZATION | YES/DATES | NO |
|---|---|---|
| **Hepatitis B:** (Must have one of the following)<br>A. Proof of having all three doses of the Hepatitis B Vaccine._____<br>B. Documentation of a positive Hepatitis Surface Antibody (HBsAb) _____<br>C. Vaccine Waiver Form: (see attached)_____ | | |
| **Rubeola (Measles):**<br>A. Rubeola Titer – demonstrate immunity with attached titer results | | |
| **Rubella (German Measles)**:<br>A. Rubella Titer– demonstrate immunity with attached titer results | | |
| **Mumps:**<br>A. Mumps Titer: – demonstrate immunity with attached titer results | | |
| **Varicella Titer:** (Must have one of the following)<br>A. Proof of two doses of varicella vaccine, 4-8 weeks apart _____<br>B. Varicella Titer: – demonstrate immunity with attached titer results | | |
| **Tuberculosis Skin Testing (TST)*:**<br>A. **No signs and symptoms of active TB and** Two-step TST (2 Mantoux tests given within 1-3 weeks of each other) within the past 12 months, OR<br>B. Single TST if one documented negative TST within the past 12 month, OR<br>C. Prior documentation of negative results of 2 Mantoux tests performed within 12 months preceding work at MH. | | |

| | | |
|---|---|---|
| D. Adequate two-step TST followed by annual testing.<br><br>If positive TST :<br>E. Documentation of test result & negative chest X-ray in the past 6 months, &.<br>F. Documentation that individual does not have active tuberculosis infection.<br>G. If latent tuberculosis infection, documentation of adequate treatment if individual was treated.<br>If evaluated with blood assay for *Mycobacterium tuberculosis* (BAMT), those results should be submitted instead of TST. | | |

**Contagious Diseases:**

This individual named on this form is free from contagious disease. Yes ______ No ______

================================================================

______________________________ ____________

Signature of Volunteer Date

______________________________ ____________

**Signature of health practitioner (REQUIRED)** Date

______________________________

Name & Title of PV staff who reviewed record

**Hepatitis B Vaccination Declination**

I, ________________________________________, understands that due to my

*print*

occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I have declined to be vaccinated for hepatitis B. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

____________________ ________________________________________

Date Signature

# TABB INC.

## NOTIFICATION / AUTHORIZATION / RELEASE OF INFORMATION

NAME____________________________________________ DATE___________________
PLEASE PRINT

In connection with my application for employment with **Hackensack Meridian *Health* Pascack Valley Medical Center** (hereafter referred to as the **COMPANY**), I authorize the procurement of a consumer report and understand that the report will contain information about my background, character, general reputation, mode of living, credit worthiness and job performance. I understand that, upon written request within a reasonable period of time, I am entitled to 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 this report, that I have the right to a copy of this report prior to any adverse action taken against me and to dispute the accuracy of any information in the report by contacting the consumer reporting agency, **TABB, INC.**, whose address and telephone number are listed on the bottom of this form. I understand that I may have additional rights under State law which I may determine by contacting my State or local consumer protection agency. I hereby release the **COMPANY, TABB, INC.,** their officers, agents, employees, and servants from any liability arising from the preparation of this report or investigations relating thereto.

This 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, companies, corporations, credit bureaus and law enforcement agencies to release such information without restriction or qualification to **TABB, INC.,** and any of its officers, agents, employees and servants. I voluntarily waive all recourse and release the above sources and firms, including the above named Company and **TABB, INC.,** from liability for complying with this authorization. I understand that any offer of employment from the above named Company will be contingent upon the results of a number of factors including this background check.

The phrases and wording contained in this authorization are required under the FCRA. The **COMPANY** will not run a credit check on an applicant as part of the background investigation unless the position for which applied requires financial information on a prospective candidate. The candidate will be notified in writing if a credit check is required for the position to which you applied.

**TABB, INC. will not sell any of the personal information provided below or use this information for any purposes other than employment verification and criminal record searches.**

SOCIAL SECURITY NO.: ______________________________________ DATE : ______________________

SIGNATURE:__________________________________ OTHER NAME(S) USED:_______________________

TABB INC., P.O. Box 10; Chester, NJ 07930
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