HUDSON
REGIONAL HOSPITAL

Dear Friend:

Thank you for inquiring about our Hudson Regional Hospital Volunteer Program. Attached are a Release Authorization form and an Application for you to fill out and return via mail or email.

To ensure the safety of our patients, staff and volunteers, Hudson Regional Hospital requires any applicant over the age of 18 to a background screening, so a valid social security number is required by applicants. You will also be asked to attend a mandatory 2 hour orientation session and once all requirements have been satisfied, you will be cleared to begin volunteering. At that time, hours and availability will be discussed.

The orientation consists of a tour of the hospital and a general overview of Hudson Regional Hospital and our Volunteer Program.

Volunteers at our facility perform countless valuable services including working on units ensuring patient comfort or assisting staff members in various departments. It is our mission to achieve the hospital's continuing goal to provide the best possible health care to the communities we serve.

We welcome you to join us!

Sincerely,

Sabina Sanchez

Sabina Sanchez
Community Services Department
ssanchez@hudsonregionalhospital.com

HUDSON REGIONAL HOSPITAL
VOLUNTEER APPLICATION

Name: _____ **Date:** _____

Address: _____ **Home Phone:** _____

_____ **Date of Birth: MO.** _____ **DAY** _____

E-Mail: _____ **Personal Physician** _____

Employer: _____ **Address:** _____

Address:_____ **Physician Phone:** _____

Office Phone: _____

In case of Illness, Notify (Name) _____ **Phone:** _____

Education (last year attended, degree awarded): _____

Special Training (specify): _____

Volunteer Experience: _____

Please list two references (friend, physician, clergy, employer, PLEASE NO FAMILY MEMBERS OR ANYONE WHO LIVES WITH YOU) who we may contact:

Name: _____ **Address:** _____

Email: _____ _____

Name: _____ **Address:** _____

Email: _____ _____

Have you ever been convicted of a felony or serious crime? Yes _____ **No** _____
If yes, explain. (The existence of a conviction does not constitute an automatic bar to volunteering.)

Why are you interested in volunteering? _____

_____

Are you interested in direct involvement with patients? Yes ( ) No ( )

Please circle any of the following in which you are skilled:

NURSING TYPING COMPUTER LIBRARY SCIENCES

Hobbies (specify) _____ **Foreign Language (specify)** _____

	A.M.	P.M.	EVENING
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

I understand that any misleading or false statements, or subsequently discovered material omissions would be cause for immediate dismissal after starting volunteering. I understand that my volunteering is contingent upon completion of all application requirements. I will notify Volunteer Services if I an unable to keep my volunteer assignment. I agree to abide by the requirements and regulations of Hudson Regional Hospital and the service to which I am assigned. I will keep in confidence all information I may hear concerning a patient, doctor, employee, or volunteer.

SIGNATURE

_____

Please return to:
Hudson Regional Hospital
Attn: Volunteer Office
55 Meadowlands Parkway
Secaucus, NJ 07094

FOR VOLUNTEER OFFICE USE

Reference Forms Sent:_____ Returned:_____

Dr. Release Sent:_____ Returned:_____

Interview Date:_____ By:_____

New Volunteer Orientation:_____ Uniform given:_____

Health Form Given:_____ Safety Film Reviewed:_____

Start Date:_____ Department Notified:_____

Permanent Placement:_____

HUDSON
REGIONAL HOSPITAL

Volunteer Medical History

Name:_____

Address:_____

Date of Birth:_____**Sex:**_____

Family Physician:_____

Address:_____**Phone:**_____

MEDICAL HISTORY: Have you ever had or do you presently have:	**YES**	**NO**	**EXPLAIN**
Breathing Problems (asthma, emphysema, etc)	_____	_____	_____
High or Low Blood Pressure	_____	_____	_____
Heart Problems/Poor Circulation	_____	_____	_____
Back Problems	_____	_____	_____
Arthritis	_____	_____	_____
Hearing Problems	_____	_____	_____
Visual Problems (glasses, glaucoma, cataracts)	_____	_____	_____
Nervous Condition	_____	_____	_____
Chronic Illness (diabetes, epilepsy, etc)	_____	_____	_____
Allergies	_____	_____	_____
History of any surgery	_____	_____	_____
History of any work related injury	_____	_____	_____
Are you taking any medications?	_____	_____	_____

When was your last Tuberculosis test? _____

Were your results significant? _____**Yes** _____**No**

If yes, are you currently receiving treatment? _____**Yes** _____**No**

IMMUNE STATUS: **Have you ever had or been vaccinated or tested for:**

German Measles (Rubella) *Documentation Required _____

Measles (Rubeola) For those born after 1956 *Documentation Required _____

Chicken Pox (Varicella) _____

Shingles _____

Any other contagious disease _____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Date:_____ Signature_____

Parent/Guardian Signature_____

Disclosure and Release

Hudson Regional Hospital may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your criminal history, education and/or employment history conducted by Accutrace, Inc. P.O. Box 624, Bryn Mawr, PA 19010 or by contacting us at 1-888-54 -TRACE or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment is limited to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Accutrace, Inc. or another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. □

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. □

< Please Print Clearly >

Applicant's Name: _____
First M.I. Last

Signature: _____ **Date:** _____mm/_____dd/_____ yyyy

		-			-														-			-				

Date of Birth (mm/dd/yyyy) Social Security No

Driver's License No. state

PROFESSIONAL LICENSE/CERTIFICATE NUMBER STATE PROFESSION

SCHOOL/UNIVERSITY NAME DEGREE/DIPLOMA TYPE DATE RECEIVED

Current Address city state zip

No. of Years at Current Address _____

Previous Addresses within the Past 7 Years (Use back if additional space is needed)

Address city state zip

Address city state zip