

# JFK

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## MEDICAL CENTER

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Dear Adult Volunteer Applicant:

We are delighted that you are interested in Volunteering at the JFK Medical Center. Enclosed are the Application, Health Questionnaire, Doctor Reference Form and Medical Information Form. All required documentation must be furnished to complete the application process. You will be called to schedule an interview appointment as soon as your application is complete. The interview is approximately one (1) hour long. If you are unable to keep your scheduled appointment, please call to reschedule. The office telephone number is 732.321.7083. The office fax number is 732.744.5808.

### *VOLUNTEER APPLICANT'S RESPONSIBILITIES*

- The Doctor Reference Form needs to be completed by your doctor. Usually you can just drop it off at your doctor's office and it can be faxed back to us.
- Proof of immunization is required and should be attached.
- All information on the Medical Information form must be complete.
- Two (2) letters of reference need to be submitted with the application from non-family members.
- You will be required to present certain documents that establish your identity. A list of acceptable documents is attached. This document can be brought to the interview and we will copy it (i.e. photo Driver's License or Passport).
- You will be scheduled during your Interview for a 2-step Tuberculosis (TB) test that must be completed within 21 days. This will involve a trip to Occupational Health on 2 consecutive Wednesdays for the injection and 2 consecutive Fridays to check for a reaction. This is scheduled between 3-4:45 PM. If there is a reaction, you will be required to have a chest x-ray and a visit to your private physician to discuss therapy. This must be completed before you are given an orientation date.
- All Volunteer applicants are required to attend a General Orientation meeting during which various policies and procedures of the Medical Center are discussed.

We look forward to meeting you and thank you for your interest in our program.

Sincerely,

Christine Ann Piterski, MA  
Director Volunteer Services

Affiliates of SOLARISH Health System

JFK Medical Center • Muhlenberg Regional Medical Center • JFK Johnson Rehabilitation Institute • New Jersey Neuroscience Institute  
The Women's Auxiliary Pavilion • JFK Hartwyck Nursing, Convalescent & Rehabilitation Centers • Muhlenberg Schools of Nursing,  
Medical Imaging & Therapeutic Sciences Mediplerx Surgery Center • Diabetes Center of New Jersey • Whispering Knoll - Assisted Living Community

65 James Street, P.O. Box 3059, Edison, New Jersey 08818-3059 (732) 321-7000 [www.solarishs.org](http://www.solarishs.org)





**MEDICAL CENTER**

**Volunteer Location Preferred:**

JFK Medical Center: \_\_\_\_\_  
Hartwyck Nursing, Convalescent and Rehabilitation Centers at:  
Oak Tree, Oak Tree Rd. \_\_\_\_\_  
Cedar Brook, Park Ave. \_\_\_\_\_  
Edison Estates, Brunswick Ave. \_\_\_\_\_  
Whispering Knoll: \_\_\_\_\_

**ADULT APPLICATION FOR VOLUNTEER SERVICE**

**PERSONAL:**

\_\_\_\_\_  
(Please print) Last Name First  
Address \_\_\_\_\_  
Street Town State Zip  
Home Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Cell # \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
JFK Auxiliary Member Yes \_\_\_\_\_ No \_\_\_\_\_  
If referred by another Volunteer, please indicate their name:

\_\_\_\_\_  
(Please print) Last Name First

**EMPLOYMENT:**

Current Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Previous Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Does your employer have a Matching Fund Program for Volunteering? Yes \_\_\_\_\_ No \_\_\_\_\_  
Were you ever employed by JFK Medical Center or an Affiliate? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, where \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_  
Are you retired from JFK or an affiliate? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you have any relatives in our employ? If yes, please state your relationship?  
What Department? \_\_\_\_\_

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*print name last, first*

**EDUCATION & EXPERIENCE:**

	School Name and Address	Indicate last Year Complete	Graduated		List Diploma or Degree
			Yes	No	
High School					
College or University					
Other training Or education					

Special Training, Skills, or Interests: \_\_\_\_\_

Prior Volunteer Experience: \_\_\_\_\_

Duties: \_\_\_\_\_

**VOLUNTEER INTERESTS:**

How did you learn about volunteering at JFK? \_\_\_\_\_

Reason for interest in volunteering at JFK: \_\_\_\_\_

Volunteer Assignment Preferred:

Patient Contact: \_\_\_\_\_ Non-Patient Contact: \_\_\_\_\_

Time(s) & Day(s) available for volunteer service: \_\_\_\_\_

Have you ever been convicted of a crime? Yes \_\_\_ No \_\_\_ If so, when? \_\_\_\_\_

What was the nature of the crime? \_\_\_\_\_

**Please Note:** Solaris will verify criminal history record pursuant to N.J.A.C. 13:59-1.2(a)(2). A conviction will not necessarily disqualify you for the volunteer position for which you have applied. Factors such as age and time of offense, seriousness and nature of the violation and rehabilitation will be taken into account. You may omit convictions, which have been expunged or sealed by the court.

Should I be accepted as a JFK Medical Center volunteer:

- (1) I understand that this acceptance is totally separate and distinct from any employment agreement now or in the future.
- (2) I promise to abide by all medical center rules and regulation. Failure to comply with policy and confidentiality is understood to be grounds for termination of volunteer services.

Signature and Date \_\_\_\_\_



**MEDICAL CENTER**

\_\_\_\_\_  
(Print last name, first name)

**VOLUNTEER SERVICES DEPARTMENT  
MEDICAL INFORMATION FORM**

**Personal Physician:**

Name: \_\_\_\_\_

(print last, first)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Do you have any special needs that require accommodation? \_\_\_\_\_

**In an Emergency, please notify:**

Name: \_\_\_\_\_

(print last, first)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Please check one: Junior Volunteer \_\_\_\_\_

Adult Volunteer \_\_\_\_\_

Date \_\_\_\_\_

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**VOLUNTEER SERVICES**  
**HEALTH QUESTIONNAIRE**

Volunteer's Name \_\_\_\_\_  
(Print last, first)  
Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**All Adults:**

Need to provide proof of 2 vaccinations or a blood titer proving immunity for:  
Varicella (Chicken Pox)

**AND**

**Adults born after 12/31/56:**

Also need to provide proof of the following vaccinations or a blood titer proving immunity for:

- 2 Rubeola (Measles)
- 1 Mumps
- 1 Rubella (German Measles)

**Juniors** are required to provide proof of the following vaccines or a blood titer showing immunity to the following:

- 2 MMR (Rubeloa (Measles), Mumps, Rubella (German Measles))
- 2 Varicella (Chicken Pox)

It is recommended, but not required, that anyone who wants patient contact and could potentially have contact with blood, body fluids or body substances should have the Hepatitis Vaccine. If you had the vaccine, please provide a copy for your file:

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(Please print Volunteer's last name, first name)

### VOLUNTEER SERVICES DEPARTMENT DOCTOR REFERENCE FORM CONFIDENTIAL

TO: Dr. \_\_\_\_\_  
( please print)

Date: \_\_\_\_\_

Your patient has applied to do volunteer service, not requiring medical training, at JFK Medical Center. I would appreciate you filling out this form in order to provide necessary information regarding this individual. A prompt reply would be helpful in our processing this application. This form can be faxed to 732.744.5808.

1. How long have you known this applicant? \_\_\_\_\_
2. Would you recommend the applicant for volunteer assignment at this hospital?  
\_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Doctor's Address

Thank you for your cooperation.

Christine Ann Piferski, MA  
Director, Volunteer Services

