ADULT VOLUNTEER APPLICATION

Dear Applicant:

Thank you for your interest in volunteer opportunities at The Valley Hospital. Kindly complete and return the enclosed Volunteer Application and Volunteer Verification Disclosure & Authorization forms.

Minimal requirements of all volunteers include:
- Ability to understand and communicate clearly.
- Ability to maintain confidentiality.
- Ability to give and follow direction.
- Ability to satisfactorily meet the requirements of the position.
- Ability to participate in annual TB screenings/education and complete post-tests.
- Ability to respond promptly and appropriately to customer requests.
- Ability to respond effectively in an emergency and offer assistance as necessary.
- Ability to project a positive outlook and willingness to help as needed.
- Ability to work independently with minimal supervision.
- Ability to commit for at least six months of service.

Your completed volunteer application will be reviewed over the next few weeks. If you do not hear from us, it means that we do not have an open assignment that matches your availability, interest and skills.

Upon receipt of favorable references, applicants will be invited to an informational interview session. Those accepted into our program must pass a criminal background check, fulfill mandatory health requirements, and complete a self-learning module.

We take great pride in our program and our volunteers. "Volunteers are the heart of Valley," and their contribution of time and service to our patients, families, guests and staff is immeasurable. If you have any questions, please do not hesitate to call us at (201) 447-8135.

Sincerely,

Liz Tortorella, CAVS
Director, Volunteer Resources
Please Print Clearly.

Name _______________________________________________ 
Last __________ First __________ M.I. __________

Address ________________________________________________________________
Street __________ City __________ State __________ Zip __________

E-Mail Address _______________________________ 
Cell Phone _______________________________

Home Phone ______________________________ Work Phone ______________________________

In case of EMERGENCY, please contact ______________________________ ______________________________ ______________________________

Relationship __________ Home Phone ______________________________ Cell Phone ______________________________ Work Phone ______________________________

Physician (Optional) ______________________________ MD Phone ______________________________

Are you a member of the VH Auxiliary? □ No □ Yes/Branch ________

Do you volunteer for Valley Home Care/Hospice? □ No □ Yes

Have you previously volunteered at Valley Hospital? If so, when? ____________________

How did you learn of volunteer opportunities at Valley Hospital?
□ Brochure □ Bulletin Board □ Website □ Newspaper □ Community Presentation □ Volunteer Office
□ Referred by: ______________________ Specify if VH Empl/Vol/Auxilian________
□ Other ______________________________

Please include three personal/professional references, excluding relatives. 
Provide complete addresses otherwise your application will not be processed. Please print clearly.

1. Name ______________________________ Company ______________________________
Street ______________________________ City __________________ State _____ Zip ________
Phone ______________________________ Email ______________________________

2. Name ______________________________ Company ______________________________
Street ______________________________ City __________________ State _____ Zip ________
Phone ______________________________ Email ______________________________

3. Name ______________________________ Company ______________________________
Street ______________________________ City __________________ State _____ Zip ________
Phone ______________________________ Email ______________________________
Please explain why you choose to volunteer at Valley Hospital

Volunteer Experience

Occupation/Work History

If working, please list current employer/address

Education

Current College Students:

School ____________________________ Year of graduation ________ Course of Study________________________

Foreign Languages Spoken

If you are unable to perform specific job functions or duties, please describe those functions or duties.

Hobbies/Interests

Are there special skills, experiences or qualifications which you feel would enhance your volunteer assignment?

If you were able to choose/design an assignment, what would it be?

Availability – please list all days/times you are available to volunteer.

Days: □ Sun □ Mon □ Tues □ Wed □ Thurs □ Fri □ Sat Available to start ____________

Times: □ Early AM (6-9AM) □ Morning □ Afternoon □ Evenings Specify hours ____________________

Are you available throughout the year? ______ If no, when are you not available?______________
Most volunteer assignments require a regular commitment. The list below represents assignments that are or may become available. We ask that you make selections thoughtfully, as careful consideration is given in matching ability, interest and skills with the needs of our organization. Please check all that interest you.

Enhancing the Patient and Family Experience
- Transporting patients in wheelchairs
- Greeting/directing/escorting guests
- Serving in the Emergency Department
- Providing Pet Therapy Visits
- Reception/Waiting Area services
- Delivering flowers
- Delivering mail/newspapers
- Dispensing good cheer and comfort gifts
- Serving customers in Kurth Gift Shop
- Assisting staff/patients on units
- Working with seriously-ill patients
- Making pastoral care visits
- Working with the elderly
- Bringing “early bird coffee” 7AM to patients
- Serving customers in Kurth Cafe
- Offering refreshments in waiting areas
- Working with patients in a rehab facility
- Providing Information Systems support

Providing Office Support Services
- Assisting with mailings
- Photocopying, scanning, faxing
- Data entry
- Computerized billing
- Providing phone coverage
- Filing/collating
- General clerical tasks

Opportunities at Valley Home Care

- Visiting Patients in Their Homes
  - Assist special-needs families – respite, emotional support, friendly visits, errands
  - Terminally-ill adults/children (Hospice)
  - Homebound elderly
  - Infants/Children

College Career Development Programs
- Physician Shadowing
- Physician Assistant Shadowing
- Nurse Shadowing
- Administration Shadowing
- Clinical Research
- Laboratory
- Pharmacy
- Cardiac Cath Lab
- Valley Dining/Dietary
- Cardiac Rehabilitation
- Physical Therapy, Occupational Therapy, Speech Therapy and Audiology

Off-Site Environments
- 505 Goffle Road – Ridgewood
- 579 Franklin Turnpike – Ridgewood
- Luckow Pavilion – Paramus
- Kraft Center – Paramus

I would prefer an assignment:
- Mostly Walking
- Mostly Sitting
- Working with Others
- Working Independently

The Valley Hospital Auxiliary
- Interested in learning more about opportunities to get involved.
The Valley Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at The Valley Hospital, I may come into the possession of confidential patient information, even though I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence while I serve as a volunteer and after I terminate or conclude my relationship with The Valley Hospital. As a condition of my assignment, I hereby agree that I will not at any time during or after my assignments with The Valley Hospital disclose any patient information whatsoever.

When patient information must be discussed with any health care practitioners during the course of my volunteer work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient’s care.

I understand that any misrepresentation of information on this application will cause my name to be withdrawn from consideration as a volunteer. If I am accepted as a volunteer, I agree to abide by The Valley Hospital’s policies and procedures and work within the boundaries as defined by the Volunteer Resources Department.

By signing below, I acknowledge that I have read the above and accept the responsibility associated with these statements. I understand that violation of this agreement may be cause for immediate termination of my association with The Valley Hospital.

____________________________
Volunteer Name (Print)

____________________________
Volunteer Signature

________________________________
Date

Revised: 10/14: 8/15
The Valley Health System
Volunteer Background Verification Disclosure & Authorization

In connection with your application for volunteer service with the Valley Health System, a consumer report or investigative consumer report, as defined by the Fair Credit Report Act (FCRA), may be obtained from a consumer-reporting agency. Please complete this form and return with your application.

Information to be completed by Volunteer Applicant:

Applicant’s Name ____________________________________________
(Please Print)

Social Security #________________________       Date of Birth _______________
Month/Day/Year

Address _______________________________________________________

City/State/Zip _________________________________________________

Phone ________________________________________________________

AUTHORIZATION

During the application process and at any time during the tenure of my volunteer service, I hereby authorize the Valley Health System to obtain a consumer report or investigative consumer report on me that I understand may include information regarding my character, general reputation, or personal characteristics. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification, to the extent that such investigation includes information bearing on my character, general reputation, or personal characteristics. This authorization does not include the release of my medical information or financial records.

Signature _____________________________________    Date ___________________