VOLUNTEER APPLICATION

Valley Home Care and Valley Hospice
15 Essex Road, Suite 301
Paramus, NJ 07652
(201) 291-6000

DATE:_____
NAME:_____ HOME PHONE:_____
ADDRESS:_____ WORK PHONE:_____
CELL PHONE: _____
E-MAIL ADDRESS _____
CITY AND STATE:_____
BIRTHDAY - Month _____ Day_____

EDUCATION HISTORY

Name & Location Course Majored In/Degree # of Years Did you graduate?
High School

_____

College

_____

Graduate School

_____

Other Schooling

_____

Do you have any special training?
No If Yes, Explain:

_____

Do you speak a language other than English?

_____

What licenses or certificates do you possess?

_____

Certificate Number, date of expiration and state valid in

_____

Military Experience -

_____

Past/Current Volunteer Experience(s):

_____

_____

PHYSICAL INFORMATION

Do you have any limitations which would prevent you from performing the duties of the position for which you are applying?
No_____ If Yes, Explain:_____
Do you drive? Yes_____ No_____

Do you have a valid driver's license? Yes_____ No_____
Driver's License Number_____Plate Number_____

Have you ever been convicted of or pleaded guilty to a crime? No_____ Yes_____
(Do not include those convictions which have been expunged or sealed by a court.)
If yes, please explain. Convictions are not an absolute bar to volunteering, but will be considered in relation to the position sought._____
_____
_____

EMPLOYMENT RECORD
(Give most recent position first)
Name, Address, Phone Date Employed Job Title Reason for Leaving
From/To
_____
_____
_____
_____

IN CASE OF AN EMERGENCY, NOTIFY:
Name:_____Phone:_____
Address:_____

INTERESTS, HOBBIES, SPECIAL SKILLS:
_____
_____
_____

How did you find out about these volunteer programs?_____
_____

Types of activities preferred and volunteer required volunteer hours:
_____Clerical Work (1-2 hours a week/ 3 hours month)
_____Visiting Patients on Hospice Services (Required 1 hour a week)
_____ Visiting Patients on Home Care Services (Requires 1 hour a week)
_____ End of Life Doula Services for Hospice (Requires 2-6 hour vigil shifts)
_____ Visiting Butterflies Pediatric Home Care and Hospice Services (Requires 1- 2 hour visits)
_____ Supporting parents on Maternal Child Health Services (Required 2 hour visits)
_____ Fundraising/Events: Teddy Bear Party (March) or to support Memorial Services

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I am available ____ hours per week. Please circle best dates to volunteer
Mon. Tues. Wed. Thurs. Fri.
Sat and Sun (hours are not available for clerical office hours.)

(Circle days available)
_____Mornings _____Evenings
_____Afternoons _____Weekends for only patient visits and vigils

<u>EOLD VOLUNTEER SERVICE ONLY</u>: Would you be able to do a shift between 8 PM – 6 AM?

1. Yes, I am open to doing those hours as needed or once a month. Of those hours above, I would prefer ____PM to _____ PM/AM.

2. No, I am sorry, I am not open to doing those hours because, _____
   _____

Valley Home Care and Hospice provides health care and hospice patients and families residing in the Bergen and Passaic communities. Please complete one of the questions below;

1. I am willing to volunteer to see patients in these towns only: (please indicate):_____

2. I am willing to go where ever there is a need.

If you were in the military would you be interested to join our "We Honor Veteran's Volunteer program?

1. Yes, I am open to visiting <u>all</u> patients that were in the armed services
2. Yes, I am only interested in visiting Home Care patient's in the armed services
3. No, I am not so interested to visit patients, but I would be open to provide social and bereavement support their wives and families while they on Valley Home Care and Hospice.

<u>For Hospice Volunteers - Please complete the following section</u> -
Has anyone close to you died or been diagnosed with a terminal illness? Have you had any personal losses (deaths, divorce) within the last 12-18 months? If so, please explain when, how they related to you, and how you have adjusted:

_____
_____
_____
_____
_____

Reasons for wanting to be a part of the Valley Hospice Volunteer Training Program:

_____
_____
_____
_____

If you are interested to become an End of Life Doula Volunteer, what calls you to provide this sort of service?

_____
_____

For Butterflies Pediatric Services, Maternal Child Health and Valley Health Affiliates Volunteers - Please complete the following section -

Please explain why you would like to participate as a volunteer:_____

_____

_____

_____

_____

REFERENCES:

Please submit three (3) names and full address (name, street, apartment, town, state, zip code for non-family references. **No emails or phone number please**. Applications without full information will delay your time to start volunteering. So, please fill out completely.

1. _____
2._____
3._____

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1. If I am accepted, I agree to abide by and observe all rules and regulations of Valley Home and Community Health Care.

2. I understand that if I misrepresent any information on this application I will not be Considered.

Signed:_____

Please mail your application to the address above to the attention of Leslie Galioto, Volunteer Coordinator. Thank you!

Valley Health System
Employee Statement of Confidentiality

As a condition of my employment, I understand that the information that I will access through all Valley Health Information Systems (The Valley Hospital, Valley Home Care, Valley Medical Group) and manually generated records include sensitive and confidential patient information. I understand that it is my responsibility to maintain confidentiality of all information, both clinical or financial, that is entrusted to me. This obligation shall exist while I am employed and shall continue after my employment or termination regardless of the reason.

I specifically understand that information regarding patients, employees, and individuals affiliated with Valley Health System is to be disseminated only to those individuals who have a need to know. I also understand that all documents bearing the Valley Health System logo or form number, all computer programs, all operating manuals, policies and procedures, and methods of doing business developed by Valley Health System are of a confidential or trade secret nature and shall remain the property of Valley Health System.

I agree to access patient information only as necessary to accomplish the purpose of my job description.

I understand the user ID/password assigned for access to any Valley Health System computer system is unique to me and for my use only. This code identifies me in the computer system. I am accountable for system access and entries performed with my personal security code.

If issued a password, I agree not to release it to anyone else. I will not post, share, or otherwise distribute my password. I will contact the Information Systems Department immediately if I have a reason to believe the confidentiality of my password has been broken. I will be required to create a new password.

By signing below, I acknowledge that I have read the above and accept the responsibilities associated with these statements. I understand that I will be subject to disciplinary action, suspension, and/or possible immediate termination if I violate any of the above agreed-upon statements.

_____ _____

Employee Name (Printed) Date

_____

Employee Signature

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 _____

Revised: 5/06