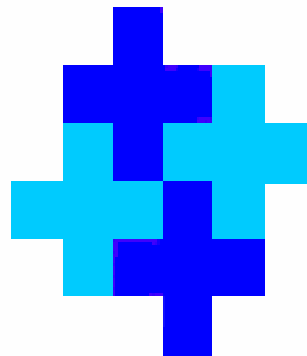


Volunteer Application



**Newton
Memorial
Hospital**

R's Your Life, Live R Well



**175 High Street
Newton, NJ 07860
Volunteer Services Department
973-579-8370**

Personal Information

Last Name		First	M.I.	Social Security Number	
Address		Street & Number	City	State	Zip Code
Telephone Number (Home)		Telephone Number (Work)		Name of Spouse	
Emergency Contact Name, Address, & Relationship			Telephone Number (H)	Telephone Number (W)	
Have you been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give exact details of convictions, offenses, where committed, sentencing court, date of sentence, and nature of sentence on separate sheet. Convictions are not an automatic bar to volunteering.			Do you wish to declare yourself handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Indicate any allergies, health conditions or disabilities that may interfere with your ability to perform volunteer work.					
In the past 3 years, have you knowingly used narcotics, amphetamines, or barbiturates that were not prescribed for you by a licensed physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.				Have you previously served as a volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital/Agency _____ Area of Service _____	

General Information and Availability for Work

Include preference in assignment: <input type="checkbox"/> Patient <input type="checkbox"/> Non-Patient <input type="checkbox"/> Clerical					
Are you available year-round? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when are you away?			Why are you interested in becoming a volunteer at NMH?		
How did you learn about the volunteer program at Newton Memorial Hospital?			Are you currently seeking paid employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type?		
Please check all that you are a member of: <input type="checkbox"/> NMH Auxiliary Member <input type="checkbox"/> Retired Senior Volunteer Program			To the best of your knowledge, will you be available to volunteer for at least twelve months from this date? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you be available to volunteer a minimum of 4 hours a week? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Days available to work (check all that apply)					
	Morning 8 am – 12 pm	Afternoon 12 pm – 4 pm	Evening 4 pm – 8 pm		
<input type="checkbox"/> Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Work Experience

Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Occupation
Employer Name and Address		Supervisor's Name	Telephone Number

Volunteer Agency (Name, Address, City, State, Zip)	Supervisor's Name	Telephone Number
Volunteer Agency (Name, Address, City, State, Zip)	Supervisor's Name	Telephone Number

References (Please exclude relatives)

Personal/Professional Reference (Name, Address, City, State, Zip)	Telephone Number
Personal/Professional Reference (Name, Address, City, State, Zip)	Telephone Number
Physician (Name, Address, City, State, Zip)	Telephone Number

High School Student Applicants Only

Name of Parent or Legal Guardian	Telephone Number (Home)
Address Street & Number City State Zip Code	Telephone Number (Work)
Are you receiving school credit for your volunteer work? <input type="checkbox"/> Yes <input type="checkbox"/> No How many hours do you need to complete?	
Name of School Counselor	Telephone Number (Office)
High School Year of Graduation	Telephone Number (School)

College Internship Applicants Only

College	Advisor	Telephone Number
Student's College Address Street & Number City State Zip Code	Telephone Number	
Major/Minor	Cumulative Average	Science Average
Internship Field of Interest	Year of Graduation	Dates of Internship From _____ To _____
Extracurricular Activities	Are you receiving school credit for your volunteer work? <input type="checkbox"/> Yes <input type="checkbox"/> No How many credits will you receive? How many hours do you need to complete?	

Interest/Skills (Please indicate with a check mark)

Clerical Skills:	<input type="checkbox"/> Typing	<input type="checkbox"/> Librarian	<input type="checkbox"/> Mailings
	<input type="checkbox"/> Filing	<input type="checkbox"/> Record updating	<input type="checkbox"/> Alphabetizing
	<input type="checkbox"/> Phone receptionist	<input type="checkbox"/> Numerical updating	<input type="checkbox"/> Cash register
	<input type="checkbox"/> Using copiers	<input type="checkbox"/> Computer	<input type="checkbox"/> Other (specify) _____

Other Skills:	<input type="checkbox"/> Public speaking	<input type="checkbox"/> Research	<input type="checkbox"/> Foreign Language
	<input type="checkbox"/> Journalism	<input type="checkbox"/> Photography	<input type="checkbox"/> Graphic Arts
	<input type="checkbox"/> Public relations	<input type="checkbox"/> Calligraphy	<input type="checkbox"/> Other (specify) _____
Patient Care Services:	<input type="checkbox"/> Messenger services	<input type="checkbox"/> Read to patients	<input type="checkbox"/> Visiting/listening
	<input type="checkbox"/> Transporting	<input type="checkbox"/> Feeding patients	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> Pastoral Care		
Additional Skills/Comments:			

Certification

AFTER COMPLETING APPLICATION, PLEASE READ CAREFULLY AND SIGN

We appreciate your interest in our hospital. A clear understanding of your background and work history will aid us in considering you for the volunteer position that best meets your qualifications and interests.

1. I give permission to Newton Memorial Hospital to investigate any and all information concerning my application in order to determine my qualifications. This includes but is not limited to medical clearance, criminal background checks, employment and personal reference checks and educational or certification verification. I understand that any misrepresentation of facts contained in this application may be cause for my rejection or dismissal.
2. I agree to abide by all hospital rules and regulations. I understand that if placed, my placement will be subject to the conditions of any applicable introductory period established by hospital policies. I understand that this application and any other hospital documents are not contracts of employment, and that any volunteer who is placed may voluntarily leave under proper notice, and may be terminated by the hospital at any time and for any reason.
3. In the event of resignation or termination, I agree to return all hospital property loaned to me such as identification badges, uniforms, etc.

My signature below indicates that I have read, understood, and consented to the above statements. This authorization or photocopy shall serve as consent for the hospital to request any information concerning my application.

Signature

Date

Parent's Signature (Required if the volunteer is under 18 years of age)

Date

Please Return Application To:

Kathe Brannon, Director of Volunteer Services, Newton Memorial Hospital, 175 High Street, Newton, NJ 07860