



Dear Prospective Volunteer:

Thank you for inquiring about volunteer opportunities at the AtlantiCare Regional Medical Center. Volunteers are essential members of our healthcare team because they help us make the Medical Center a more pleasant place for our patients, their families, visitors and our employees. We are happy to hear you are interested in joining our VIP (Volunteers In Partnership) ranks.

Enclosed, please find an application for the AtlantiCare Regional Medical Center's Department of Volunteer Services. Please complete this form and return it to us by mail or you may return it to our office between the hours of 8:30am – 4:00pm. There are several steps to becoming a hospital volunteer:

- Please complete and return to our office the enclosed volunteer application. Be sure that ALL sections of the application are completed in full and signed, **INCLUDING PHYSICIAN'S RELEASE FORM**, as missing information/signature prolongs the background check process.
- **The background check process can take from 4 to 5 weeks.** Once your background check is complete we will contact you to schedule an interview to discuss the opportunities available to you.
- All new volunteers must receive a PPD (TB) test and a blood test which determines measles and rubella immunity prior to beginning a volunteer assignment. We will make arrangements for these tests for you once your background & reference check are completed. There is no charge to the volunteers for this test.
- You must attend a volunteer orientation prior to beginning your assignment, which we will schedule for you after the completion of the above mentioned background check, interview, PPD (TB) & blood test. **Orientation, interview, PPD (TB) test & blood test could take 4-6 hours.**

I am sure you will find volunteering a worthwhile and rewarding experience and look forward to meeting you. If you have any questions, please do not hesitate to call us at the numbers listed below.

Sincerely,

Cigi Serrano  
Manager  
Volunteer Services  
Mainland & City Campus  
Phone: (609) 652-3499 Fax: (609) 748-4031  
Karen Adams  
Volunteer Office Assistant



**VOLUNTEER APPLICATION**

All applicants will be given equal consideration regardless of race, color, age, religion, gender, national origin or marital status. We solicit and encourage qualified disabled persons and veterans to apply. All answers to questions on this form will not be used to discriminate against any applicant.

**Instructions:** Please complete **all** items on this application. The information will be held CONFIDENTIAL and used to facilitate a positive experience with ARMC. Please contact the Volunteer office at the numbers listed on the previous page if you have any questions. Thank you for your interest in becoming a volunteer.

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Month & Day – Year is Optional)

Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact:

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

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

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**AtlantiCare location where you are interested in volunteering:** *(Check all that apply)*

- ARMC Mainland
- ARMC City
- \_\_\_\_\_
- ARMC Hammonton (Kessler)
- ARMC Cancer Center
- ARMC Life Center

Please indicate the type(s) of volunteer work in which you are interested: *(Check all that apply)*

**Please choose any of the areas that interest you:**

- Fundraising
- Pharmacy
- Information Desks
- Dietary
- Special Events
- Other
- Ambassador Services
- Gift Shop/Hospitality Cart
- ICCU
- Outpatient Registration
- Patient/Nursing Assistance
- Same Day Surgery
- Emergency Room
- Office/Clerical

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Days available (*please circle*):

Monday      Tuesday      Wednesday      Thursday      Friday      Saturday      Sunday

Hours available (*suggested*) (*please circle*): 9 a.m. to 1 p.m.      1 p.m. to 4 p.m. (other) \_\_\_\_\_

Will you be willing to fill in at other times, if needed? \_\_\_\_\_

The intended duration of your volunteer service will be: (please check one)

1-3 months       3-6 months       6 months-1 year       1 year or more

Do you speak another language? \_\_\_\_\_ If yes, list language(s) \_\_\_\_\_

Have you ever been convicted of, or pleaded guilty to a crime?  Yes       No

If yes, please explain: \_\_\_\_\_

Please indicate any special skills or abilities that you have (*check all that apply*):

Public Speaking

Music

Writing

Fundraising

Computer

Other (*please specify*): \_\_\_\_\_

Please describe any previous volunteer experience. Include type of work and dates of involvement:

\_\_\_\_\_  
\_\_\_\_\_

Please provide information about employment experience, beginning with most recent/present experience:

Employer Name & Mailing Address	Employer Phone	Position and Responsibilities	Dates Employed (From/To)

Please list any professional and/or community organizations to which you belong:

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References – Not related to you (please list three):

Name	Mailing Address	Phone	Relationship	Years Acquainted

I hereby give ARMC permission to contact my references:

\_\_\_\_\_

**Print Name**

\_\_\_\_\_

**Prospective Volunteer Signature**

**Date**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please sign, attesting that all the information you have provided here is accurate.

Office Use Only	
Logged:	
Letter:	
Index Card:	
Time Card:	
A & E:	
Health Form Sent:	Received:
Reference Sent:	Received:
Assignment:	
Lab:	



**PHYSICIAN'S RELEASE FORM - Confidential Medical Information**

**\*\*IMPORTANT! This form must be completed by your physician. If this form is not complete, we cannot process your application. No exceptions can be made.\*\***

Volunteer's Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Dear Healthcare Provider,

1. The above person has applied for a volunteer position within our organization. Knowledge of a prospective Volunteer's medical background is necessary for making a suitable assignment, not only for the applicant's protection but also for the protection of our patients. Prompt completion of this form is greatly appreciated.
2. How long has the prospective volunteer been your patient?
3. When was the prospective volunteer's last visit to your office?
4. Can the prospective volunteer perform the essential functions of the position? (example: walking, pushing wheel chairs, standing, etc...)
5. To my knowledge this applicant:

Is free from contagious disease and capable of performing volunteer assignments at AtlantiCare Regional Medical Center.

YES \_\_\_\_\_

NO \_\_\_\_\_

6. Has the following physical and/or emotional condition requiring restrictions and/or precautions to be observed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Has no restrictions: (check here) \_\_\_\_\_

8. Would you recommend the applicant for volunteer work?

Physician's Printed Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**CONFIDENTIALITY STATEMENT**

If accepted as a hospital volunteer, I agree that:

1. I shall not reveal the names of patients that I visit or come into contact with.
2. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, other volunteers, or personnel and not seek to obtain confidential information from a patient.
3. My services are given to a patient with humanitarian reasons, regardless of religious or race differences.

**I HAVE READ EACH OF THE ABOVE CONDITIONS AND I AGREE TO BE BOUND BY THEM.**

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Volunteer Signature

Date

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Volunteer Printed Name

## **AUTHORIZATION FOR CONSENT AND RELEASE FROM LIABILITY**

In connection with my application for employment at or engagement with AtlantiCare Health System, Inc., AtlantiCare Health Services, Inc., Atlantic City Medical Center, AtlantiCare Foundation, AtlantiCare Surgery Center, LLC, AtlantiCare Health Plans, or InfoShare (hereinafter collectively referred to as "AtlantiCare"), I hereby authorize AtlantiCare to conduct a background investigation on me. I understand that such an investigation could include, but is not limited to the use of a credit check and criminal background check, a motor vehicle records check, and a military personnel records check. I understand that AtlantiCare may gather information which could include information from any present or former employer, reference provided by me, any school, law enforcement agency, local or county record office, licensing agency or other persons having personal knowledge about me, my character, my work history, reputation, personal characteristics and mode of living. I hereby authorize such an investigation and release AtlantiCare, its officers, directors, trustees, employees or agents from any and all liability arising from conducting the investigation, and preparing any reports relating thereto. This authorization for the release of information includes, but is not limited to, matters of opinion related to my character, abilities and past conduct. I authorize and request all persons, schools, businesses, credit bureaus, courts, law enforcement officers and agencies, motor vehicle agency, custodian of military records and licensing agencies to release such information without reservation, restriction or qualification. I understand that, if I am employed, any false statements made by me will be considered as cause for dismissal. I understand that my employment, in part, is contingent upon the satisfactory results of a complete background investigation and drug screening, as may be required. I hereby authorize AtlantiCare or its agents to conduct a background investigation. I hereby release AtlantiCare, its officers, directors, or any person and agency providing such information from any and all claims and damages connected with the release of any requested information. I agree that any copy of this document is as valid as the original and shall remain valid during the term of my employment unless revoked by me in writing.

## **AUTHORIZATION FOR CREDIT REPORT AND CRIMINAL BACKGROUND INVESTIGATION**

I understand that as part of your procedure for processing my employment application, you may obtain a credit report and criminal background check containing information about me. I hereby authorize you to obtain a credit check and a criminal background check on me which may be used in evaluating me for promotion, reassignment or retention, as appropriate, during the tenure of my employment. I further understand that AtlantiCare complies with the Fair Credit Reporting ("Act"). In the event that information from a credit report or criminal background check is used, in whole or in part, in making decision that is adverse to me, AtlantiCare will provide me with a copy of the credit check and criminal background check and my rights under the Act.

## **DRUG TESTING**

I understand that AtlantiCare has a policy against the possession, use, sale or transfer of illegal drugs by applicants being considered for employment or engagement by AtlantiCare as well as by those already employed or engaged by AtlantiCare. I further understand that AtlantiCare is committed to a drug free workforce and has adopted a drug testing program to assist in implementing and enforcing that policy. I hereby consent to the taking of a urine sample by AtlantiCare or its designated agent for the purpose of drug testing for cocaine, marijuana, opiates, methamphetamine and phencyclidine (PCP). I hereby consent to the release of any reports of such samples from the laboratory to AtlantiCare and release

**AtlantiCare, its officers, directors, trustees, employees and agents from any and all liabilities arising from the authorized release or use of the information derived from or contained in my test results. I understand that any offer of employment extended to me by AtlantiCare is based on the condition that I successfully pass the drug test. I understand that if I refuse to participate or if my results are positive, my offer of employment will be revoked and my application will be rejected.**

**Print Name:** \_\_\_\_\_

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

**Signature:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security No.:** \_\_\_\_\_

**Driver's License: State:** \_\_\_\_\_ **No.:** \_\_\_\_\_

**Parent's Name (if under 18 years of age):** \_\_\_\_\_

**Parent's Signature (if under 18 years of age):** \_\_\_\_\_

**Former Name, if name changed through marriage or otherwise:** \_\_\_\_\_

**ATLANTICARE REGIONAL MEDICAL CENTER  
MANTOUX SKIN TEST**

**ARMC requires that all staff and volunteers be tested for tuberculosis by the Mantoux Skin Test. Our Occupational Health Nurse will perform this test free of charge.**

**This test must be done BEFORE you begin work with us as a volunteer. You will be given a copy of the monthly calendar listing when Occupational Health will be at the Mainland Campus. Their office is located on the ground level, follow the directional signs for the Human Resources Office, and their office is located in the back of this department. Present this instruction sheet to the Occupational Health Nurse to make him/her aware you are a new volunteer.**

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**RUBELLA SCREENING: MEASLES IMMUNITY**

**\_\_\_\_\_ is required to have a Rubella test/Measles Immunity in order to perform volunteer work at ARMC. Results are to be forwarded to the Volunteer Office. All charges should be directed to Occupational Health.**

**Please register in the Outpatient Registration Department, located on the main level.**