



Dear Friend:

Thank you for inquiring about our Meadowlands Hospital Volunteer Program. Enclosed are a Release Authorization form and an Application for you to fill out and return in the enclosed envelope.

To ensure the safety of our patients, staff and volunteers, Liberty Health requires a background screening be completed before an application may be considered. Once all requirements have been satisfied, you will be contacted for an interview.

The interview consists of a tour of the hospital and a general orientation to Meadowlands Hospital Medical Center and our Volunteer Program. At that time, a uniform will be provided at a cost of \$20.00 and a work schedule will be set.

Volunteers at our facility perform countless valuable services, working directly with patients or helping staff members in various departments. It is our mission to achieve the hospital's continuing goal to provide the best possible health care to the communities we serve.

We welcome you to join us!

Sincerely,

Georgine Gallo

Georgine Gallo  
Director Community Services

# **MEADOWLANDS HOSPITAL** **VOLUNTEER APPLICATION**

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

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: MO. \_\_\_\_\_ DAY \_\_\_\_\_

E-Mail: \_\_\_\_\_ Personal Physician \_\_\_\_\_

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

Address: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

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

In case of Illness, Notify (Name) \_\_\_\_\_ Phone: \_\_\_\_\_

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Education (last year attended, degree awarded): \_\_\_\_\_

Special Training (specify): \_\_\_\_\_

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

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Please list two references (friend, physician, clergy, employer) who we may contact:

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

Telephone: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Have you ever been convicted of a felony or serious crime? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain. (The existence of a conviction does not constitute an automatic bar to volunteering.)

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Why are you interested in volunteering? \_\_\_\_\_

Are you interested in direct involvement with patients? Yes ( ) No ( )

Please circle any of the following in which you are skilled:

NURSING    TYPING    COMPUTER    LIBRARY SCIENCES

Hobbies (specify) \_\_\_\_\_ Foreign Language (specify) \_\_\_\_\_

	<u>A.M.</u>	<u>P.M.</u>	<u>EVENING</u>
<b>MONDAY</b>			
<b>TUESDAY</b>			
<b>WEDNESDAY</b>			
<b>THURSDAY</b>			
<b>FRIDAY</b>			
<b>SATURDAY</b>			
<b>SUNDAY</b>			

(Actual commitment time will be determined during the interview and orientation.)

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I understand that any misleading or false statements, or subsequently discovered material omissions would be cause for immediate dismissal after starting volunteering. I understand that my volunteering is contingent upon receipt by this organization of satisfactory references. I will notify Volunteer Services if I an unable to keep my volunteer assignment. I agree to abide by the requirements and regulations of Meadowlands Hospital.Campus and the service to which I am assigned. I will be punctual, courteous, dependable, and keep in confidence all information I may hear concerning a patient, doctor, employee, or volunteer.

SIGNATURE

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**Please return to:  
Meadowlands Hospital Medical Center  
Volunteer Office  
55 Meadowlands Parkway  
Secaucus, NJ 07094**

**FOR VOLUNTEER OFFICE USE**

Reference Forms Sent: \_\_\_\_\_ Returned: \_\_\_\_\_

Dr. Release Sent: \_\_\_\_\_ Returned: \_\_\_\_\_

Interview Date: \_\_\_\_\_ By: \_\_\_\_\_

New Volunteer Orientation: \_\_\_\_\_ Uniform given: \_\_\_\_\_

Health Form Given: \_\_\_\_\_ Safety Film Reviewed: \_\_\_\_\_

Start Date: \_\_\_\_\_ Department Notified: \_\_\_\_\_

Permanent Placement: \_\_\_\_\_

## RELEASE AUTHORIZATION FOR BACKGROUND CHECKING

This is to notify you that in connection with your application for volunteering at Meadowlands Hospital, we may procure a background check on you as part of the process of considering your application. In the event that information from the report is an adverse decision, you will be provided with a copy of this report.

By signing below, I hereby authorize Sterling Testing Systems to follow through with a background check.

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

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

Full name (print) \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Current Residence Address: \_\_\_\_\_

\* Date of Birth & Social Security Number is required for background investigation purposes only, and will be used for no other purposes.