UNIVERSITY HOSPITAL
Newark, New Jersey

University Hospital
An Affirmative Action/Equal Opportunity Employer
VOLUNTEER INFORMATION SHEET

Name: _____ **Social Security #** _____
(Last Name) (First Name) (MI)
Phone # (Home): _____ **Cell:** _____
Address: _____ **Apt #** ____**City:** _____ **State:** ___ **Zip Code:** _____

EDUCATION
HIGH SCHOOL NAME: _____ **ADDRESS:** _____
Last Year Completed: _____ **Did you graduate?** ☐ **YES** ☐ **NO**
☐ **Diploma** ☐ **Equivalent**
COLLEGE/UNIVERSITY: _____ **ADDRESS:** _____
Major/Specialization: _____
Last Year Completed: _____ **Did you graduate?** ☐ **YES** ☐ **NO**
Diploma/Degree received: _____
TRADE/BUSINESS SCHOOL: _____ **ADDRESS:** _____
Did you graduate? ☐ **YES** ☐ **NO**
Diploma/Degree received: _____
Driver's License #: _____ **State Where Issued:** _____ **Exp. Date:** _____

PROFESSIONAL CERTIFICATION/LICENSE
License/Document No. : _____
Type of Document: _____ **Date Issued:** _____ **Exp. Date:** _____
LIST ADDITIONAL SKILLS:
_____
_____
_____
_____

Do you have the legal right to reside in the U.S.? ☐ **YES** ☐ **NO**
Alien Registration No. : _____ **Visa:** _____ **Exp. Date:** _____
Naturalization No. _____ **Date:** _____ **Place:** _____

Have you been convicted of a crime or found guilty of disorderly person's offense or misdemeanor (exclude any minor motor vehicle offenses)? ☐ **YES** ☐ **NO**
If yes, explain on a separate sheet and attach to application. Include any crimes, misdemeanors, or disorderly convictions.

Why do you want to volunteer?
_____
_____
_____
_____

VOLUNTEER & EMPLOYMENT HISTORY (List last three, starting with most recent)
From: _____________ **To:** _____________ **Employer:** ____________________________________ **Phone No.:** _______________________ **Address:** _________________________ **City:** _________________ **State:** ________ **Zip Code:** ________ **Job Title:** _______________ **Responsibilities:** ____ ____ **Reason for leaving:** ____ **Immediate Supervisor:** _______________________ **Phone No.** _________________________ **If currently employed, may we contact your employer?** ☐ **YES** ☐ **NO**
From: _____________ **To:** _____________ **Employer:** ____________________________________ **Phone No.:** _______________________ **Address:** _________________________ **City:** _________________ **State:** ________ **Zip Code:** ________ **Job Title:** _______________ **Responsibilities:** ____ ____ **Reason for leaving:** ____ **Immediate Supervisor:** _______________________ **Phone No.** _________________________ **If currently employed, may we contact your employer?** ☐ **YES** ☐ **NO**
From: _____________ **To:** _____________ **Employer:** ____________________________________ **Phone No.:** _______________________ **Address:** _________________________ **City:** _________________ **State:** ________ **Zip Code:** ________ **Job Title:** _______________ **Responsibilities:** ____ ____ **Reason for leaving:** ____ **Immediate Supervisor:** _______________________ **Phone No.** _________________________ **If currently employed, may we contact your employer?** ☐ **YES** ☐ **NO**

I hereby release from liability all persons; corporations, or other organizations furnishing information. I am aware that my *volunteer status* with Hospital is conditional depending on the results of verification of references, license, educational background, criminal background check, and if required, a physical examination. It is understood and agreed that any misrepresentation, to the best of my knowledge and belief in this application will be sufficient cause for cancellation of the *application for a volunteer position, and/or termination of my volunteer services.* I hereby give University Hospital permission to investigate all references and to secure any additional information that may be required.

In accordance with Federal Law UH will not employ or enter into contracts with any individual or entity that is currently excluded by the Office of the Inspector General (OIG) and/or the General Services Administration (GSA) from participating in Federal programs.
I have read the above statement and I do certify that I am not currently excluded by the OIG and/or the GSA from participating in Federal healthcare programs.

Signature: _________________________________ **Date:** _____________________________

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UH BACKGROUND CHECK
Regular and Volunteer Staff

_____ _____ ____ _____ _____
First Name Last Name MI Social Security No. Date of Birth

_____ _____ _____
Other Name(s) used Telephone No. Email

Please List all addresses for the past Ten years. If more than three, Please use the reverse side of this form.

1. _____ _____
Full Street Address, City, State From To
2. _____ _____
Full Street Address, City, State From To
3. _____ _____
Full Street Address, City, State From To

Current/Previous Employment Please list employment starting with the most current.

1. _____ _____ _____
Employer Full Street Address, City, State Phone Number

_____ _____ _____
Your Title Supervisor's Name & Phone Number Dates Employed: From To

2. _____ _____ _____
Employer Full Street Address, City, State Phone Number

_____ _____ _____
Your Title Supervisor's Name & Phone Number Dates Employed: From To

3. _____ _____ _____
Employer Full Street Address, City, State Phone Number

_____ _____ _____
Your Title Supervisor's Name & Phone Number Dates Employed: From To

MAY WE CONTACT YOUR CURRENT EMPLOYER? ☐ **YES** ☐ **NO**

Complete only if applying for a position which requires a valid license: _____ _____
Driver's License Number State Issued

Please list the highest education complete:

_____ _____
Name of School or University Address

_____ _____ _____
Degree or Diploma Date Awarded Name Attended Under

Professional License or Certificate:

_____ _____ _____ _____
License/Certificate Number State Issued Type of License/Certificate Expiration Date

_____ _____ _____ _____
License/Certificate Number State Issued Type of License/Certificate Expiration Date

APPLICANT SIGNATURE: _____ **Date:** _____

HUMAN RESOURCES USE ONLY ***Select report type and screening level by placing a check in the appropriate box.***

470 Regular Staff **3130 Volunteer Staff**	**471 Regular Staff** **480 Volunteer Staff**	**472 Regular Staff** **481 Volunteer Staff**
☐ **Level I** ☐ **Level II**	☐ **Level III**	☐ **Level IV**

Comments:

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DISCLOSURE AND AUTHORIZATION FORM

(Faculty, Staff, Housestaff, Volunteers)

In connection with my application for employment or volunteer services with UH, I understand that a consumer report or investigative consumer report, as those are defined in the Federal Fair Credit Reporting Act as amended (FCRA), 15 USC 1681 et seq., may be obtained by UH from a consumer reporting agency. I understand that the report may include but not be limited to my consumer credit history, education, professional licensing, professional liability claims history, criminal history, driving history, personal character abilities, work habits, charges of research misconduct, mode of living, residency, immigration status, general reputation, performance, experience and other termination of past employments. I further understand that the consumer reporting agency may not give out information about me to UH without my written consent.

I understand that I am entitled to be informed if an offer of employment or volunteer assignment is withheld because of information obtained from the consumer reporting agency: and in that event, I have sixty (60) days within which to submit a written request to the consumer reporting agency which will provide me with a copy of my file and a "Summary of your Rights Under the Fair Credit Reporting Act."

I hereby authorize UH where I will be expected to work to obtain consumer reports in connection with my application for employment or volunteer service with UH. I authorize all former employers, listed references, schools, law enforcement agencies and courts, to release to UH and/ or their representative's information pertaining to me.

Note: The phrases and wording contained in this authorization are required under the FCRA. UH will not run a credit check on an applicant as part of the investigation unless the position or volunteer assignment for which applied requires financial information on a prospective candidate. The candidate will be notified if a credit check is required.

Please Print

Name: _____ **SS#:** _____

Other name(s) used: _____

Applicant Signature: _____ **Date:** ___/ __/___

UH – University Hospital

CONFIDENTIAL

Replacement Health Questionnaire
To be completed by the Volunteer

Name (please print) _____
Last **First** **Middle**

Mailing Address _____
Street **Apt. #**

_____
City **State** **Zip Code**

Home Telephone Number: _____

Social Security Number: _____-_____-_____

Date of Birth: _____ **Age:** _____ **Birthplace:** _____

Height _____ **Weight:** _____ **Sex: Female** ____ **Male** ____

Marital Status: Married ____ **Widowed** _____ **Divorced** _____ **Single/Never Married** _____

Person to Contact in Emergency: _____ **Relationship:** _____

Address: _____

Emergency Telephone Number: _____

Primary Personal Physician: _____ **Telephone No.** _____

Have you ever been hospitalized or treated at University Hospital? Yes _____ **No** _____

Current Employer: _____ **Company Insurance:** _____

Volunteer Position Applied for (if know): _____

Department: _____ **Work location:** _____ **Work Number:** _____

How would you describe your health? Excellent _____ **Good** ____ **Fair** _____ **Poor** _____

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VOLUNTEER PLEDGE

Believing University Hospital-UH has a real need of my service while working through the Volunteer Program.

I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously

I will wear my uniform at all times while on duty at the hospital. This includes lunch hour and walking to and from my assignment. I will be careful to always wear a clean uniform and to present a neat appearance.

I will consider as confidential all information which I may hear or see directly or indirectly in the hospital.

I will report to the supervisor in the area to which I am assigned and be sure she/he knows my name, the hours and days I will be working with her/him. I will not leave my assignment without telling her/him how long I will be gone.

I understand my hours are _____ If I find I must change them, I will discuss it with the Manager of Volunteer Services.

I understand that meal vouchers or parking validation are benefits given to those volunteers who donate four hours or more on the day they volunteer

I will take my problems, criticisms or suggestions to the Manager of Volunteer Services.

If I find I cannot continue my volunteer work temporarily or permanently, I will so inform the Volunteer Office.

I will up-hold the traditions and high standards of the Hospital and the Volunteer Program.

_____ _____

(**Volunteer Signature**) **Date**

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NEW JERSEY WORKERS' COMPENSATION ACT

I, _____ understand and agree with the following conditions concerning services performed by me as a volunteer worker.

It is understood that Volunteer Workers are not covered by the New Jersey Workers Compensation Act. (This does not apply to statutory exception for volunteer ambulance drivers).

It is understood that if a Volunteer Worker is uninsured while performing services on UH premises the Hospital will provide at the time of injury reasonable emergency medical treatment for the injury without charge, regardless of apparent fault and that is it also understood that the provision of emergency medical services does not constitute an admission of liability on the part of University Hospital.

_____
Signature of Volunteer Worker

_____
Date

CONFIDENTIALITY AGREEMENT
VOLUNTEER SERVICES DEPARTMENT

I UNDERSTAND AND AGREE THAT IN THE PERFORMANCE OF MY DUTIES AS A VOLUNTEER OF UNIVERSITY HOSPITAL, I MUST HOLD MEDICAL INFORMATION IN CONFIDENCE. FURTHER, I UNDERSTAND THAT INTENTIONAL OR INVOLUNTARY VIOLATION OF UNIVERSITY HOSPITAL'S CONFIDENTIALITY MAY RESULT IN TERMINATION OF MY SERVICES AS A VOLUNTEER.

SIGNATURE **DATE**

_____ _____

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TERMINATION OF A VOLUNTEER ASSIGNMENT

I understand and agree that as The University Hospital appreciates my contributions of service time to the hospital.

I _____ agree to perform only the volunteer duties that are listed in the position description that I signed when commencing my volunteer assignment. I understand that any assistance I provide will not include any duties that require hands on contact with the patients.

I understand that The University Hospital is not obligated to have volunteer assistance but has decided to have assistance at its own discretion and has the right to terminate a volunteer's assignment at anytime as it may see necessary.

I have read the above information and am in full understanding.

Volunteer Name (Print) _____

Volunteer's Name (Sign) _____

Date: _____