



**PARENTAL or GUARDIAN
PERMISSION and RELEASE for TEEN-AGE VOLUNTEERS**

To All Parents or Guardians:

Your child has shown an interest in volunteering his/her services to University Hospital. Since she/he is a minor, you must give Parental or Guardian permission by signing the statement below and returning it to the Volunteer Office before the child starts his/her volunteer work.

I, _____ hereby give permission for my child/ward _____ to give volunteer services at University Hospital, and to receive the Physical Examination required for everyone who works in the hospital in any capacity, as well as for Emergency Treatment if necessary. I agree not to hold University Hospital responsible for any illnesses or injuries that might be sustained as a result of my child doing volunteer work.

Has your child been under the care of a Physician within the past two years? _____

If yes, for what ailment, and for what length of time? _____

Name of Physician: _____

Has your child ever been treated for any of the following:

Excessive cough, expectoration, difficulty of breathing or palpitation? _____

Disease of the heart or blood vessels? _____

Rupture? _____

Any form of mental illness? _____

What operations(s) has she/he had? _____

Please submit this completed form to:

Deirdre Watley
Manager of Volunteer Services, Room C-431
University Hospital
150 Bergen Street
Newark, NJ 07103

So that the hospital may run on schedule, we ask you to see that your child is here at the appointed time, and that only an emergency keeps him/her from being here. If something really important is going to keep him/her away, please telephone the Volunteer Office (973) 972-4064 and let us know, so that we can have someone take his/her place that day.



UNIVERSITY HOSPITAL

Newark, New Jersey

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 ___



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



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 it is 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

CONFIDENTIALITY STATEMENT FOR INFORMATION SECURITY

In recognition of the confidential nature of patient records and/or employee data to which I may have access, either as part of my duties at University Hospital, or because of other reasons. I, _____ understand and will comply with the following:

- I will not misuse or disclose any information without proper authorization, nor alter patient or personnel records. I will not discuss patient or employee information except as it relates to my job.
- I will not permit any other individual to use my information systems password to gain access to the above-mentioned information. I am responsible for any information entered into the computer system under my user ID and password. I will report problems related to my password/system access to my supervisor. I will request modification to my system password immediately if I suspect that someone has gained access to my sign-on password.
- I will file written/printed information in a secure place and/or dispose of it with proper regard for privacy and confidentiality.
- I will not access, report on or extract information that is not consistent with my normal job functions and responsibilities.
- I will not leave a secured computer application unattended while signed-on.

I recognize that a violation of the above conditions may constitute grounds for disciplinary action, up to and including termination of volunteer assignment.

Signature

Social Security #

Date

Department

TERMINATION OF A VOLUNTEER ASSIGNMENT

I understand and agree that as 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 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: _____

Volunteer Medical Form

To be completed by volunteer's Physician prior to commencing service at University Hospital

Name: _____

Date of Birth: _____ SSN: _____

	<u>Date Given</u>	<u>Date Read & Results</u>
Physical Exam:	_____	_____
Mantoux Two Step/ Tuberculin Skin Test	_____	_____
	1 st	
Chest X-Ray- (Required if PPD + And no prior history)	_____	_____
Serologic Tests:		
Hepatitis B Ab:	_____	Susceptible/Immune _____
*Measles (Immunity or Vaccination Required)	_____	Susceptible/Immune _____
*Rubella (Immunity or Vaccination Required)	_____	Susceptible/Immune _____
*Varicella (Immunity or Vaccination Required)	_____	Susceptible/Immune _____
Other	_____	

***Must be reported if cleared for any assignment.**

Immunization Provided:

- Hepatitis B #1 _____
- Hepatitis B #2 _____
- Hepatitis B #3 _____
- MMR #1 _____
- MMR #2 _____
- Polio, Oral _____
- Tetanus _____
- Varicella _____
- Other _____

- Patient has no communicable disease and
- Cleared for any position
- Cleared for Limited assignment

Other Comments:

Physician's Signature Date

Name (Please Print) Title NJ License #