AtlantiCare

A MEMBER OF GEISINGER HEALTH SYSTEM

Thank you for your interest in volunteering at AtlantiCare. Volunteers are an important part of our team, providing support in the Medical Centers and satellite offices to help deliver exceptional services to the communities we serve. We are grateful that you will share your talents with us, and want your experience as a volunteer to be a rewarding one.

Enclosed are the documents which must be completed in full. **Incomplete applications cannot be processed.**

- **AtlantiCare Volunteer Application – Confidentiality Statement** – Please PRINT LEGIBLY the names and phone numbers of three references whom are *not related to you*. All references are contacted by phone and we ask that you alert your references about receiving a phone call on your behalf.
- **AtlantiCare Physician Medical Certification Form-Confidential Medical Information – Page 8** This form must be completed by *your* personal physician and **brought with you to your Occupational Medicine Appointment** (explained on page 7 of the application) ** If you do not have a personal physician, you are welcome to contact the AtlantiCare Access Center at 1-888-569-1000 for assistance. *AtlantiCare does not cover any cost associated with the completion of the Physician Medical Certification Form*.

Please return the completed Volunteer Application to:

Volunteer Services
65 W. Jimmie Leeds Road
Pomona, NJ 08240

609 404-7477

Upon receipt of your completed application, you will be sent by e-mail (or by USPS if you do not have e-mail) an invitation to attend a Group Interview and Information Meeting. AtlantiCare conducts background checks on all employees and volunteers. **At the completion of the Group Interview/Information Meeting, you will be asked to complete a Criminal Background Check/Authorization for Consent and Release from Liability Form.** Your social security number and date of birth are required to run the background check. If you are interested in being a hospice volunteer, you will also need your driver's license information. At this meeting you will be photographed for your ID badge.

When your background and reference checks are complete, you will be sent by e-mail (or USPS if you do not have e-mail) an Adult Volunteer Authorization for Medical Services form which contains contact information for you to schedule an appointment for your health screening which is outlined on page 7 of this packet.

When medical clearance is received and an orientation completed, we will meet with you for your final interview at a mutually agreeable date/time to discuss volunteer opportunities.

All applicants must pass the background check and be medically cleared to be considered for our volunteer team. Volunteer opportunities are based on the needs of a department and qualifications of a volunteer to meet specific needs. If there is a suitable fit, we will arrange your volunteer schedule at the final interview.

To continue active as a volunteer, the following are required annually: education, TB testing, evaluation, and flu vaccine.

The average time to be processed as a volunteer is approximately six weeks. A recap of the steps:

- Submit completed application
- Arrange to have personal physician complete Physician Medical Certification Form-Confidential Medical Information
- Attend Group Interview/Information Meeting
- Schedule appointment with Occupational Medicine (you will need the completed Physician's Form for this appt.)
- Complete orientation
- Schedule final interview

Please call if you have any questions. We look forward to having you a part of our volunteer team! Thank you.

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VOLUNTEER APPLICATION

AtlantiCare is an Equal Opportunity Employer

Volunteer opportunities are based on the needs of a department and qualifications of a volunteer to meet specific needs. If there is a suitable fit, we will arrange your volunteer schedule at the final meeting.

Instructions: Please complete **ALL** parts on this application. **Incomplete applications cannot be processed.** Please call the Volunteer Office if you have any questions. Thank you.

Date: _____ Name: _____ _____
(First) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ E-mail Address: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Employer: _____

► **Have you ever been employed by the AtlantiCare Health System?** ❑ **No** ❑ **Yes**

If yes, when and which department? _____

Do you have any relatives who are employed or volunteer at AtlantiCare? ❑ No ❑ Yes, If yes, please list the name of the person, relationship to you, and the department they work in.

NAME	RELATIONSHIP TO YOU	DEPARTMENT

How did you hear about volunteering with AtlantiCare? _____

Please tell us why you would like to be an AtlantiCare Volunteer: ***(required)***

_____

_____

_____

_____

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How would you like to volunteer with AtlantiCare?
(**Volunteer opportunities are based on department needs and volunteer skills. Please check all areas of interest.)**

- ❑ Interacting with patients (e.g. visiting patient rooms, sitting with patients to offer companionship, hospitality cart)
- ❑ Interacting with the public (e.g. information desk, hospital greeter/guide, registration, dietary, accompanying musicians/pet visits throughout the hospital)
- ❑ No One Dies Alone – Provide companionship and support for patients dying in the hospital who have no family/friends locally, or family/friends who are not involved. Specialized training is required.
- ❑ Logistics (e.g. restocking, rotating inventory, delivering supplies)
- ❑ Clerical help (e.g. filing, computer data entry, assembling information packets, phone support, laminating, mailings)
- ❑ Creative Arts and Healing Program (e.g. musicians, licensed pet therapy, etc. to visit patients or perform in lobbies)
- ❑ Knitting and Crocheting – donations of new, handmade lap blankets or shawls for hospice patients.
- ❑ Pastoral – provides emotional and spiritual support to patients
- ❑ Auxiliary (fundraising/community representatives of the hospital, $15 annual dues)
- ❑ Gift Shop sales (e.g. pricing of items, stocking shelves, sales, cashier) must be able to use the cash register/charge machine and commit to a four hour shift weekly
- ❑ Heart Heroes – participate in fund raising activities to place automated external defibrillators in our community through a matching funds program
- ❑ Bumper "T" Caring Clowns (Interested volunteers complete a comprehensive clown training course offered by Bumper "T" Caring Clowns on the art of gentle humor. They use therapeutic clowning as a powerful tool to promote the healing process. From the moment they enter a hospital, the Caring Clowns consider themselves a positive, healing force. They pride themselves on being masters in the art of "reading" a room, listening, and using gentle humor to make true connections with the people who need them. www.bumpertcaringclowns.org for more information.
- ❑ Hospice ** helping patients and their families who are at end of life, either directly with the patients/families, or helping in the hospice office. PLEASE COMPLETE THE HOSPICE QUESTIONNAIRE form of the application if you may be interested in this area of volunteering. It is mandatory to attend a one-time specialized training which is held at the AtlantiCare Hospice and Palliative office in Egg Harbor Township. The training is held on a Saturday from 8:00 a.m. to approximately 4:30 p.m.
- ❑ Other interests for volunteering? Please explain:_____

_____

_____

Is your volunteering a short term commitment? ❑ No ❑ Unknown at this time ❑ Yes – If yes, please explain:_____

_____

ARE YOU A VETERAN? ❑ No ❑ YES – If yes, thank you for your service!

Please list branch of military: Branch:_____

DO YOU SPEAK ANOTHER LANGUAGE? ❑ No ❑ Yes – If yes, what languages?_____

_____

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Please list any hobbies or specialized talents you want to share (e.g. crafts, gardening, filing/clerical skills, musician, etc.): _____

_____

_____

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

_____

_____

_____

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

_____

_____

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

Employer Name, City and State: _____

Position & Responsibilities: _____

Employed From: _____ Employed To: _____

Employer Name & Address: _____

Position & Responsibilities: _____

Employed From: _____ Employed To: _____

Employer Name & Address: _____

Position & Responsibilities: _____

Employed From: _____ Employed To: _____

Do you hold any current licenses or certifications? ❑ No ❑ Yes, If yes, please complete table below and **INCLUDE A COPY OF THE LICENSE(S) / CERTIFICATION(S) WITH YOUR APPLICATION:**

LICENSE OR CERTIFICATION TITLE	ISSUING ORGANIZATION	ISSUANCE DATE	EXPIRATION DATE

PLEASE INCLUDE ANOTHER SHEET OF PAPER IF THERE ARE MORE LICENSES/CERTIFICATIONS

COMPLETE THIS PAGE **ONLY** IF YOU ARE INTERESTED IN HOSPICE

AtlantiCare HOSPICE
A MEMBER OF GEISINGER HEALTH SYSTEM

COMPLETE THIS PAGE **ONLY** IF YOU ARE INTERESTED IN HOSPICE

HOSPICE VOLUNTEER QUESTIONNAIRE

The AtlantiCare Hospice team includes doctors, nurses, social workers, clergy, home health aids and volunteers. The team works with patients and their families to provide palliative and hospice care to those facing life-limiting illnesses. The team also provides grief support to surviving family and friends. No one is turned away, regardless of their financial situation.

Volunteers are a valuable part of our team. Their involvement in a patient's care is refreshing as they go into a patient's home as a friend to the patient and their family. A Hospice Volunteer's schedule is flexible; therefore, PEOPLE WHO WORK FULL TIME, PART TIME, ARE RETIRED, LIVE LOCALLY YEAR-ROUND, SUMMER RESIDENTS, AND THOSE WHO TRAVEL are welcome to be a part of the team. There are a variety of ways of involvement in the program including visiting patients, delivering a handmade gift to the patients, working in the office, or providing telephone support to the bereaved. (If requested, a bereavement volunteer calls the bereaved once a month for up to 13 months following the death of their loved one. In addition to the hospice training, a separate training is held for anyone interested in becoming a bereavement volunteer.)

Hospice Volunteer Trainings are usually held twice a year on a Saturday at the AtlantiCare Hospice and Palliative Care office in the Airport Commerce Center, 6550 Delilah Road, Building 300, Suite 210 in Egg Harbor Township. The training runs from 8:00 a.m. to approximately 4:30 p.m. A continental breakfast, and lunch are served. Notification is sent approximately one month before the scheduled trainings to those who have expressed an interest.

PLEASE COMPLETE THIS FORM **ONLY** IF YOU ARE INTERESTED IN BECOMING AN ATLANTICARE HOSPICE VOLUNTEER.

Print Name:_____ Date:_____

Home Phone:_____ Cell Phone:_____

E-Mail_____

Would it be suitable to communicate with you by e-mail? ☐ Yes ☐ No

1. How did you become interested in becoming a Hospice Volunteer?_____

   _____

2. Have you lost anyone close to you in your lifetime? ☐ Yes ☐ No How recent was/were your loss(es)?_____

   What was/were your relationship(s) to the deceased?_____

   In what way(s), if any, has/have this/these loss(es) impacted your decision to become a Hospice Volunteer?

   _____

   _____

3. What work or life experiences are you bringing to the role of Hospice Volunteer?_____

   _____

4. In what areas are you interested in Volunteering?

   ☐ Direct Patient Care ☐ Bereavement Volunteer ☐ Office Help ☐ Computer Data Entry ☐ Fundraising

5. How far are you willing to travel to participate as a volunteer? _____miles _____minutes

6. Fear of animals? ☐ No ☐ Yes, If yes, what:_____

7. Please list any allergies:_____

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Photo Release/Release of Information to the Media

I hereby grant permission to AtlantiCare, its employees and assigns and/or outside media to photograph, videotape or interview me. The specific information to be released to the media or AtlantiCare includes:

☑ Photos ☑ Videos ☑ Interview ☑ Other, describe:

_____

_____

_____

I understand that the photographs, videotape or interview shall become the property of AtlantiCare and/or the outside media and that I shall not have any rights to the same. I also understand that I will not be compensated for participating in the taking of photographs, videotaping or interviewing and that I will not be entitled to compensation as a result of the broadcast or publication of the photographs, videotape or interview.

I understand that the photographs, videotape or interview may be used and redisclosed as a press release and shared with media for possible publication or broadcast. I also understand that the photographs, videotape or interview might be publicized or broadcast, or used in promotional materials that include, but are not limited to, brochures, billboards, advertisements, the AtlantiCare Internet site and the AtlantiCare Intranet site, Facebook and other media, publicity and marketing venues. I understand that the photographs, videotape or interview might be edited and I agree that AtlantiCare, its employees and/or agents shall have the right to, at any time, add to, edit, arrange, rearrange and/or revise such photographs, videotape or interview. I understand that AtlantiCare maintains the right to reuse the photograph, videotape, or interview for future purposes without additional authorization or release.

I release AtlantiCare, its employees and agents from any and all claims and from all liability including, without limitation, claims for libel, invasion of privacy and/or misappropriation of likeness arising out of the interviewing, photographing or videotaping and subsequent publication or broadcasting of this material. I understand that I am not required to sign this authorization and that AtlantiCare will not condition treatment on my execution of this authorization. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with the request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations and that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA. This authorization will expire 12-31-2071.

☐ Employee	☑ Volunteer	☐ Patient	☐ Other Customer

Name (please print):_____

Home town:_____

Signature: _____

If Subject is a Minor:
Name of Parent or Guardian (please print):_____

Signature: _____

Office Use Only Description: _____

_____

_____

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CONFIDENTIALITY STATEMENT

If accepted as a hospital/hospice volunteer, I agree that I will attend a hospital/hospice orientation, at which I will learn about policies and laws impacting my duties in the hospital/hospice, including legal obligations relating to patient privacy, and:

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. I shall provide services solely for the benefit of patients and without regard to their race, age, religion, national origin, sex, disability, diagnosis, or ability pay and source of payment for services rendered by AtlantiCare.

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

Please print your name:_____ **Date:**_____

Your signature:_____

REFERENCES – Not related to you *(please list three)*: **IMPORTANT! – Please contact your references and inform them that you are using them as references.** Many people do not want to answer questions about others over the phone and refuse to provide a reference for that reason. Please provide a daytime and alternate phone number for your references. **If we are unable to obtain references, we cannot process your application.**

I, _____, hereby give ARMC permission to contact my references.
PLEASE PRINT YOUR NAME

Your Signature:_____ **Date**:_____

1) Name: _____ Years Acquainted:_____

Phone(s): _____ Relationship: _____

2) Name: _____ Years Acquainted:_____

Phone(s): _____ Relationship: _____

3) Name: _____ Years Acquainted:_____

Phone(s): _____ Relationship: _____

Please sign below, attesting that all the information you have provided in this application is accurate and true to the best of your knowledge.

Signature: _____ **Date**: _____

OCCUPATIONAL HEALTH
AtlantiCare
Physician Group
A MEMBER OF GEISINGER HEALTH SYSTEM

Guidelines for AtlantiCare Adult Volunteer Occupational Health Appointment

Soon you will be visiting us in Occupational Health for your Volunteer appointment. In preparation for this visit, below are a few details to help you come prepared. Your appointment may last up to an hour so you can schedule accordingly.

Please bring to your appointment the following:

1. **Two (2) forms of identification:** At least one must include a photo. Examples of acceptable documents are driver's license, passport, county ID, social security card, military ID or birth certificate. Credit cards are not acceptable.
2. **Vaccination and blood titer records you may have for Measles, Mumps, Rubella, Chickenpox, Hepatitis B , Tdap vaccine, Flu vaccine and TB skin test**
3. **Physician Medical Certification Form (completed by your personal physician). Page 8 of this packet.**
4. **AtlantiCare Adult Volunteer Authorization for Services**

For safety reasons, infants and young children should not be brought to the Occupational Health office.

Your visit will include the following:

- *Urine Drug Screen - Drink fluids and be prepared to submit a urine sample. .*
- *Review of Immunization Records for Measles, Mumps, Rubella ,Chickenpox, Hepatitis B , Tdap vaccine, Flu vaccine and TB skin test .*
- *Lab Draw - Non-fasting bloodwork will be drawn for the above titers not presented.*
- *The Tdap and Flu vaccine (during Flu season) may be administered. Please wear a short sleeve shirt for safe administration.*
- *A TB skin test will be placed if you have no history of a positive reaction to the TB skin test. A return visit in 2-3 days will be required for the read of this test . Bring your current chest x –ray report (within one year) if you do not receive the TB skin test due to a reaction. This TB test and read will be repeated in 7 days.*

We will consider any religious or medical exemptions you may have during your visit.

The AtlantiCare Occupational Health Team

DO NOT SEND THIS FORM WITH YOUR APPLICATION. YOU MUST HAVE THIS COMPLETED FORM WITH YOU WHEN YOU HAVE YOUR APPOINTMENT AT OCCUPATIONAL MEDICINE.

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Physician Medical Certification Form-Confidential Medical Information:

IMPORTANT: This form must be **completed by your physician prior to your scheduled appointment** at AtlantiCare Occupational Health. If this form is not completed, your appointment at AtlantiCare Occupational Health will be rescheduled.

Your Name:_____

Your Address:_____

Dear Physician:

The individual noted above has applied for a volunteer position with AtlantiCare. Please complete the medical certification below:

My signature below certifies that the individual noted is able to fulfill the requirements in the below Volunteer Role Description. AtlantiCare will be performing testing to determine the patient's immunity to Measles, Rubella, Mumps and Varicella. In the event the patient results with low/no immunity, an MMR and Varicella vaccine is required. In the event these vaccinations are necessitated, as the patient's primary physician, I find the above named individual medically cleared to receive the above mentioned vaccinations.

Physician's Printed Name:_____

Physician's Address:_____

Physician Signature:_____ **Date**:_____

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VOLUNTEER ROLE DESCRIPTION

POSITION SUMMARY

The Volunteer assists and supports hospital/hospice staff and management with patient care activities and administrative duties. Some hospital duties may include helping patients read letters, distributing reading material, transporting patients to and from therapy, and distributing gifts and flowers. Some hospice duties may include visiting patients to provide companionship, caregiver respite, or run errands for the families

This position supports organizational goals by providing quality customer service, participating in performance improvement efforts and demonstrating a commitment to teamwork and cooperation.

WORK ENVIRONMENT

Potential for exposure to the hazards and risk of the hospital environment, including exposure to infectious disease, hazardous substances, and potential injury. This position requires sitting, standing, walking, stooping and crouching a majority of the workday. Works with such equipment as computer terminal, fax machine, printer and copier.

The above statement reflect the general details considered necessary to describe the principle functions of the job as identified and shall not be considered as a detailed description of all work requirements that may be inherent in the position.