Preakness Healthcare Center

A Legacy of Caring since 1929

Greetings!

Thank you for your interest in volunteering at Preakness Healthcare Center.

Kindly fill out the attached application and required forms.

Before your volunteer experience can begin, the following steps must be in place.

- Completion of an Application
- Medical clearance for signed by your physician.
  - Please provide proof of required influenza vaccination.
  - Please provide a copy of your Covid -19 vaccine card if applicable.
- Background check completed (NO CHARGE - you may do this online, or we can do for you.)
- Character Reference
- Interview
- Orientation (Date to be determined)

If you have any questions, please feel free to contact me at 973-585-2161 or smcevoy@passaiccountynj.org

We look forward to your service to our residents in the near future!

Sincerely,

Suzanne McEvoy, CTRS

Suzanne McEvoy, CTRS

Director of Volunteers and Community Outreach

Preakness Healthcare Center

A Legacy of Caring since 1929

Director of Volunteers: Suzanne McEvoy, CTRS
(973) 585-2161 / smcevoy@passaiccountynj.org

ADULT VOLUNTEER APPLICATION *(18yrs +)*

PLEASE PRINT CLEARLY

Date of Application:_____

Last Name: _____ **First Name:** _____

Address:

_____

City:_____ **State:** _____ **Zip:** _____

Telephone

_____

If a cell #, can we reach you via text? _____ yes _____ no

E-mail:

_____

How did you hear about Preakness Healthcare Center?

_____

_____

Emergency Contact information:

Name:_____ **Phone:** _____
Relationship:

_____

Education and Employment:
(High School/ College/ Degree/currently attending)

_____

_____

Other
Education:_____

Employer / Title:

_____

Special Skills/ Experience / Areas of Interest:

Hobbies/Talents/Interests: _____

_____

Are you fluent in a language other than English? If so, what language(s):

_____

Previous or Current Volunteer Experience:

_____

_____

Please select areas of interest (you may choose more than one):

___ **Pastoral Care/Spiritual Support**
___ **Therapeutic Recreation /Activities**
___ **Wheelchair Transport (*Therapeutic Recreation & Hair Salon*)**
___ **1:1 visits**
___ **Seasonal Opportunities (gardening, gift wrapping, caroling, etc.)**
___ **Preakness Hospital Auxiliary (Resident Store, Fundraising)**
___ **Special Events**
___ **Off site projects to benefit our residents (completing greeting cards, collection drives, etc.)**

Other: _____

_____

Service Commitment and Availability:

As part of the Volunteer Application Process, the following testing and documents are required: (1) a Certification of Good Health from a licensed physician; (2) proof of tuberculosis (TB) test; (3) COVID-19 vaccination and/or testing in accordance with regulatory requirements; (4) an Influenza Vaccine during the fall and winter months; (5) an interview; (6) orientation; and (7) reference letters. Are you willing to undergo mandatory screening and provide the required documents? The process may take up to four (4) weeks to complete.

_____ **Yes** _____ **No**

Volunteers are expected to provide volunteer services four (4) hours per month for a minimum of six (6) months. Are you able to complete the required volunteer hours? _____ **Yes** _____ **No**

Availability:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning (9:30 –Noon)							
Afternoon (1:30 – 4pm)							
Evening (6 – 8pm)							

Criminal History

Have you ever been convicted of or pled guilty to a crime or criminal offense, other than a minor traffic violation which has not been expunged or sealed by a court of law?

_____ Yes _____ No

If yes, please explain: _____

_____

_____

_____

PLEASE BE ADVISED THAT A CRIMINAL BACKGROUND CHECK IS REQUIRED FOR ALL ADULT VOLUNTEERS AS WELL AS A VALID SOCIAL SECURITY NUMBER.

I certify I have provided true and accurate information. I understand I will not be compensated for any volunteer services provided to Preakness Healthcare Center. I am aware that if I do not meet the guidelines associated with the Preakness Healthcare Center's Volunteer Program, I may be asked to discontinue my services.

_____ _____

Applicant's Signature **Date**

passaic COUNTY NEW JERSEY

Preakness Healthcare Center

A Legacy of Caring

Director of Volunteers: Suzanne McEvoy, CTRS: (973) 585-2161 / smcevoy@passaiccountynj.org

REFERENCE REQUEST - Preakness Healthcare Center Volunteer Program

Name of Volunteer Applicant: _____

I hereby authorize the person listed below to provide a reference for me including any information pertinent to past performance and character.

_____

Applicants Signature **Date**

Name of Reference: **Telephone #:**

_____

Address **City** **Zip Code**

E-mail Address: _____

Dear Sir or Madam:
Your name has been provided as a reference for the above-named individual who is applying to the Preakness Healthcare Center Volunteer program.

A prompt reply is appreciated. ALL INFORMATION WILL BE REGARDED AS CONFIDENTIAL.

1. How long have you know the applicant? _____
2. What is your relationship to the applicant? _____

Please rate the applicant in the following areas:

	Excellent	Good	Average	Below Average
Dependable				
Respectful				
Independent				
Outgoing				
Responsible				

Any additional information you would like to share: _____

_____

_____

_____

_____

Signature of Reference/Title **Date**

Telephone Reference? ___Yes ___No

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Physical Examination Attestation Form for Volunteers

Section 1:

To be completed by the Volunteer

Name:	**Email:**
Mailing Address:	**Phone #:**

Section 2:

To be completed by a Licensed Physician

Name and Credentials:	**Email:**
Office Mailing Address:	**Phone #:**

Attestation	I have conducted a physical examination on the above-named individual ***within the past 12 months.*** Based on the results of the exam, this individual is free of any condition that would prevent them from participating in a volunteer experience with Preakness Healthcare Center. **Date of examination**: _____

***Signature of Provider:** _____

***Date:** _____

Internal Use Only: *Application date:* _____ *Next exam due:* _____	_____ Date of TB Test _____ Date of last influenza vaccine _____ Covid-19 Vaccinations (attach copy of vaccine card)

7/17/23 SM

Preakness Healthcare Center

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Attestation of Influenza Vaccination

I,_____, understand that Preakness Healthcare Center is a mandatory Influenza Vaccination Facility and have received and reviewed a copy of the Influenza policy.

I attest that I have been provided with education about the importance of receiving an Influenza vaccination and that I have been provided with a vaccination information sheet (VIS) outlining the benefits and risks of Influenza vaccination and have had the opportunity to ask questions and provided with answers prior to vaccination.

I attest that I have been informed of the symptoms of Influenza and my responsibility to inform my supervisor or the Infection Preventionist should I develop any signs or symptoms consistent with Influenza. I have been instructed about actions to take, including, but not limited to: staying home, notifying my supervisor immediately if symptoms develop at work, seeing my healthcare professional and seeking treatment.

I understand Preakness Healthcare Center is required to provide a copy of this attestation to the New Jersey State Department of Health (P.L. 2019, c.330) and I authorize Preakness Healthcare Center to provide all required information to the NJDOH as required by law.

I attest that I have received the required Influenza Vaccine at (Name & address of Location):

_____

On (date): _____. I have provided proof of administration of the Influenza vaccination to my employer for inclusion in health file.

Administration of Influenza Vaccine

		L / R Deltoid
_____	_____	_____
Vial Batch #	**Exp. Date**	**Site of Inoculation**

_____ _____

Signature Date

TrionAid
ASSOCIATES INC.
616 WASHINGTON ST., TOMS RIVER NJ 08753
PH : 732-998-8406

Disclosure and Authorization Release Form

Preakness Healthcare Center (Volunteers)

Please Print Clearly!!!

Applicant's Full Name: _____ _____ _____ _____
Last First Middle Suffix (Sr., Jr.)

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ _____ _____
Month Day Year

Current Address: _____
Street Address (Apt.)

_____ _____ _____
City State Zip Code

Phone# _____

Email: _____

By signing below, I authorize Trionaid Associated, Inc. (TAI) and its agents to obtain a Investigative Report on me as part of Preakness Healthcare Center Volunteer hiring process. I understand that this report is limited to records containing criminal/sex offender information. I hereby release and discharge TAI, its affiliates, and its agents from any liabilities, expenses, losses, damages for this investigative process to include the accuracy or timeliness of information obtained from other sources.

I certify that the information provided is true and complete. Any false statement on this form, the application, and/or on my resume shall be considered sufficient cause for termination at any time.

Signature: _____ **Date:** _____

****Background check application also available ON-LINE:****

https://bit.ly/PreaknessHC

A Summary of Your Rights Under FCRA

The FACRA act promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.**
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the file which is under ("file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

  *You are the victim of identity theft and place a fraud alert in your file
  *Your file contains inaccurate information as a result of fraud

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need.Usually to consider an application with an employer, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights. For more** information, visit www.ftc.gov

Para information en espanol, visite www.ftc.gov escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.