



Thank you for your interest in the Adult Volunteer Program at Shore Medical Center.

Volunteers help support the organization and its mission to provide the highest quality of care to our community, and promote a safe and compassionate environment for our patients, their families, and one another.

We offer a variety of roles tailored to each volunteer's area of interest in both patient contact and non-patient contact areas in the Medical Center and our Auxiliary Thrift Shops.

As part of the application process, applicants are required to:

- Complete an application
- Provide two personal references
- Meet with the Volunteer Director or Coordinator for a personal interview
- Attend hospital orientation
- Undergo a TB Gold test for tuberculosis
- Submit a form for a required background check

You may scan and submit your completed application and supporting documents to:

Lisa DiTroia, Volunteer Director at [lditroia@shoremedicalcenter.org](mailto:lditroia@shoremedicalcenter.org)

Or, you may mail your application to:

Shore Medical Center  
ATTN: Volunteer Office  
100 Medical Center Way  
Somers Point, NJ 08244

If you have any questions about the volunteer application process, please feel free to contact the Volunteer Office at 609-653-3543.

Thank you again for your interest!



Acknowledgement	_____
TB Gold	_____
Orientation date	_____
Background Check	_____

Application for Volunteer Service

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Birthdate: mm/dd/yyyy \_\_\_\_\_

Do you have any special training or skills, or are you certified in any integrative therapies?

\_\_\_\_\_

Please list any languages that you can speak (other than English) and your level of familiarity:

\_\_\_\_\_

Please indicate your schedule preferences below:

( ) Morning ( ) Afternoon ( ) Evening

( ) Monday ( ) Tuesday ( ) Wednesday ( ) Thursday ( ) Friday ( ) Saturday ( ) Sunday

Year-Round: ( ) Yes ( ) No Seasonal: ( ) Yes ( ) No

Type of Volunteer work preferred:

Patient Contact: ( ) Non-patient Contact : ( )

Please list any previous volunteer experience or other related experience below :

\_\_\_\_\_

Please list two people (not related to you) whom we may contact for a reference :

Name : \_\_\_\_\_ Relationship : \_\_\_\_\_

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

Name : \_\_\_\_\_ Relationship : \_\_\_\_\_

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

In case of emergency, contact :

Name : \_\_\_\_\_ Phone : \_\_\_\_\_

Relationship : \_\_\_\_\_

How did you hear about Shore Medical Center's Volunteer Program ?

Friend (  ) Hospital Volunteer (  ) School (  ) Newspaper (  ) Other(  ) \_\_\_\_\_  
*Please specify*

Is there any additional information you would like us to know in considering your application ?

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I hereby grant the right to use such recordings, audio tapes, video tapes and photographs, including reproduction thereof, in connection with the advertising program of Shore Medical Center, its successors and assigns, in any or all means to media, the right to copyright same and the right to License said program to other hospitals.

Yes \_\_\_ No \_\_\_ Signature \_\_\_\_\_

*I understand I am applying for a position as an unpaid volunteer at Shore Medical Center. I understand that placement in the program is not guaranteed.*

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)

**Please return completed application with:**

**Signed confidentiality agreement, background check consent, and media consent and release.**

**Applications can be emailed to: [lditroia@shoremedicalcenter.org](mailto:lditroia@shoremedicalcenter.org) or mailed to Shore Medical Center Attn: Volunteer Office 100 Medical Center Way, Somers Point, NJ 08244**



Volunteer Services  
Authorization for Background Check

In connection with your application for volunteer service, Shore Medical Center will perform a background check on all adult applicants. This will include a Social Security number confirmation and a criminal check. Your credit history will not be accessed. Background check will be conducted in compliance with the Fair Credit Reporting Act. If you are denied volunteer service because of the information obtained in this report, you may contact the vendor for clarification.

The vendor is: Verified First  
1550 South Tech Lane  
Suite 110  
Meridian, ID 83642  
844-709-2708

By your signature below, you authorize us to obtain this report in order to consider you for volunteer services.

Please print:

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

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

City/State/Zip: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Date completed: \_\_\_\_\_ approved \_\_\_\_\_ denied \_\_\_\_\_

After completion, SSN is erased, and form is attached to profile. If denied, form is returned to applicant.

**CONFIDENTIALITY AGREEMENT**

By virtue of your relationship with Shore Medical Center you will have access to information with various levels of sensitivity. It is your responsibility to understand the classification of information and to follow organizational policy regarding collection, access, and dissemination of information.

It is the policy of Shore Medical Center that all users of information shall recognize and uphold the confidentiality and privacy of patient, personnel, and enterprise wide information. Unauthorized collection, access, modification, or dissemination of information will constitute grounds for corrective action up to and including termination of employment or contractual relationship and/or pursuit of civil/criminal action or other legal remedy.

**CLASSIFICATION OF INFORMATION**

**Patient Records:** All medical, demographic and financial information related to a patient in the Shore Medical Center is considered confidential and may not be discussed, disclosed or accessed unless such discussion, disclosure or access is to provide direct or indirect patient care activities and/or has been authorized by the patient, his/her legal representative, or organizational protocols.

**Personnel Records:** All information related to personnel records of those employed or contracted through Shore Medical Center is considered confidential and may not be discussed, disclosed, or accessed unless such discussion, disclosure or access is authorized by the employee/contractee or organizational protocols.

**Enterprise Wide Information:** Defined by the administrative/management staff and includes information used in the strategic operation of the facility including but not limited to accounting records, vendor records, committee minutes, professional credentialing files etc. It is the responsibility of the administrative and management staff to educate personnel as to what level of sensitivity or confidentiality specific types of information should be classified to and communicate it accordingly.

**EXAMPLES OF VIOLATION**

Examples of violation include but are not limited to the following:

- Accessing information that is not within the scope of your responsibilities
- Disclosing your password or using another persons password
- Attempting to gain or gaining access to a secured application without proper authorization
- Unauthorized access, discussion, disclosure or altering of confidential patient/personnel information

**IMPORTANT: PLEASE READ THE ENTIRE CONFIDENTIALITY AGREEMENT. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THIS AGREEMENT, PLEASE ASK YOUR IMMEDIATE SUPERVISOR, PERSONNEL REPRESENTATIVE OR AN INFORMATION SECURITY OFFICER.**

I, \_\_\_\_\_ have read, understand and agree to comply with the above confidentiality agreement.  
Print Name

Relationship to SMC:  Board Member  Employee  Medical Staff Member  Contractor  
 Volunteer  Other: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## SMC Employee TB Screening Tool

Name: \_\_\_\_\_ Dept.: \_\_\_\_\_

DOB: \_\_\_\_\_

**Please answer the following TB Risk Assessment. If a “Yes” is answered for any question-symptom screening questions are to be completed.**

1. Have you been to a foreign country for  $\geq 1$  month visit with a high TB rate (ex: any country other than Australia, Canada, New Zealand, USA, and those in western or northern Europe)?  **Yes**  **No**
2. Currently or planned immunosuppression, including HIV infection, organ transplant Recipient, treatment with TNF-alpha antagonist, chronic steroids ( $\geq 1$  month), or other immunosuppressive medication.  **Yes**  **No**
3. Are you aware of having close contact with someone who has or had infectious TB Disease since the last TB Test?  **Yes**  **No**

**If a “Yes” was answered to the above Risk Assessment questions complete the symptom questions below.**

1. Have you had an unexplained fever within the last 24 hours or chills?  **Yes**  **No**
2. Are you currently having unexplained night sweats?  **Yes**  **No**
3. Have had a greater than 15lb weight lose without dieting-or no appetite?  **Yes**  **No**
4. Do you have an excessive cough; or coughing up bloody sputum?  **Yes**  **No**
5. Are you persistently experiencing unexplained weakness or fatigue?  **Yes**  **No**
6. Are you experiencing unexplained chest pain?  **Yes**  **No**

**Contact Employee Health if answer “YES” to any symptom questions for further screening or if you have any questions: (609) 653-3668**

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