Thank you for your interest in the Junior Volunteer program at Shore Medical Center.

Volunteers help support the organization and its mission of patient-centered care in a number of capacities including, but not limited to:

- Assisting nursing staff with patient needs
- Clerical positions
- Errands throughout the hospital
- Gift and/or thrift shop
- Assisting patients and visitors to their destinations throughout the hospital

The following requirements are necessary for consideration:

- **Must be at least 16 years of age**
- Provide a copy of your birth certificate
- Provide a written recommendation from a school teacher or advisor
- Meet with the Volunteer Director for a personal interview
- Attend hospital orientation
- Undergo a two-step PPD test for tuberculosis
- Abide by uniform and dress code standards
- Make a commitment of one volunteer shift per weekly from July 1st – August 21st

You may scan and submit your completed application to:
lditroia@shoremedicalcenter.org

Or, you may mail your application to:

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

Please include your **completed** Junior Volunteer application (signed by a parent or guardian), a copy of your birth certificate, and letter of recommendation. There are a limited number of spots available for the summer program.

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.

SHORE MEDICAL CENTER℠

Junior Volunteer Application
Summer 2026

Name: _____
(Last) (First) (Middle)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate _____E-Mail Address: _____

In case of emergency, please contact: Name: _____

Phone Number: _____ Relationship: _____

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

_____

What school do you currently attend: _____ Grade: _____

Do you have an interest in the medical field? YES ( ) NO ( )

Field of interest: _____

Please indicate your schedule preferences below:

( ) Morning ( ) Afternoon ( ) Evening

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

Type of volunteer work preferred: **Summer Only**

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

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

_____
_____
_____

Do you have summer vacation and/or any summer camps planned ? YES ( ) NO ( ) If yes, what dates would you be absent from volunteer service ?

_____

Are you currently working a paid job? YES ( ) NO ( )

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 ?

_____
_____
_____

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 Student) (Date)

PARENT/GUARDIAN

Your child has expressed an interest in becoming a Junior Volunteer at Shore Medical Center. Please review the enclosed materials and sign below to indicate your approval.

I have read through the application materials provided, and I give permission for my child, _____ (if selected to the Junior Volunteer Program) to volunteer at Shore Medical Center.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Telephone: _____

Please note the following:

- Students must be available to attend hospital orientation
- Commit to a weekly assignment from July 1 – August 21st
- Spots are limited for the summer program so only complete applications are accepted and students will be interviewed in the order their applications are received by the volunteer office

Dear Parent or Guardian,

As part of a state regulation, we are required to administer a two-step PPD (tuberculosis skin test) to all new volunteers at Shore Medical Center.

The hospital will provide this test free of charge, or you can choose to have your family physician administer the test and provide the Volunteer office with documentation of the results.

If your child has already been given the two-step PPD by your physician, you can submit a copy of the results to the Volunteer Office.

The PPD is administered under the skin, and must be checked for any reaction within 48 – 72 hours. The second step is administered one week later, and checked for reaction in the same time period as the first step.

Please sign below giving the Shore Medical Center Employee Health Nurse permission to administer the PPD.

By signing below, I am giving Shore Medical Center permission to administer a two-step PPD test to my child, _____.

_____ _____

Parent/Guardian Signature Date

If you have any questions regarding this test, please contact the Volunteer Office at 609-653-3543, or the hospital's Employee Health Nurse at 609-653-3668.

Shore Medical Center
Junior Volunteer Service Standards

Please read the following service standards for Junior Volunteers at Shore Medical Center.

- Good attendance and cooperation with the rules and regulations of the program are mandatory. Please be aware that excessive lateness and or/absenteeism will cause suspension from the program.

- Please be on time for volunteering on your scheduled day. Please provide as much notice as possible if you are unable to report as scheduled by calling the Volunteer Office at 609-653-3543 or email lditroia@shoremedicalcenter.org. You may leave a message any time.

- Volunteers **must be** in uniform at all times while in the hospital. Long pants and clean sneakers are required to be worn with a volunteer shirt. No jeans, shorts, capri pants, sandals, clogs, or backless shoes are allowed. Your hospital-issued badge must be worn above the waist and visible at all times. As a representative of the hospital, you are required to maintain a neat and clean appearance at all times. If you are dressed inappropriately, you will be asked to contact your parent or guardian to be picked up from the hospital.

- Fingernails must be your own natural nails and may be no longer than ¼ inch above fingertips. Fake nails, overlays, or tips are not permitted.

- Perfumes, heavily fragrant lotions or facial piercings are not permitted.

- Professional conduct is expected at all times. Junior volunteers will be counseled if they demonstrate negative conduct including, but not limited to, falling asleep on the job, excessive complaining, use of foul language, being disrespectful, or leaving the area in which they are assigned.

- Please limit personal items or valuables brought to the hospital. Junior volunteers are not permitted to be on their cell phone while on assignment. You may check messages, etc. while on one of your breaks. If family members need to reach you, they can call the Volunteer Office at 609-653-3543, Monday to Friday if necessary.

- A Junior Volunteer **may not under any circumstances** give out personal contact information to other volunteers, patients, or hospital employees. This includes, but is not limited to, cell phone numbers, email addresses, or home addresses.

- **Do not** discuss personal problems with members of the medical staff. You should never discuss any patient information with visitors, other volunteers, or a member of the staff (unless it directly involves the patient's care).

- Gum chewing is not permitted while volunteering.

- You may not leave the hospital campus during your scheduled shift unless you have received permission from the Volunteer Office.

- Smoking is prohibited on the hospital campus.

- Although we appreciate your dedication, please do not volunteer when you have any symptoms of an upper respiratory infection, gastrointestinal symptoms, skin rashes, lesions, or conjunctivitis.

If I am accepted as a Shore Medical Center Junior Volunteer, I agree to adhere to the guidelines, rules, and regulations of the hospital. I understand that if I am in violation of any program rules, my parents/guardian will be notified and I may be subject to disciplinary action up to and including termination from the program.

_____ _____

SIGNATURE DATE

I agree to support Shore Medical Center's guidelines, rules, and regulations for the Junior Volunteer program by assuring that my child is appropriately dressed, on time for their assignment, and notifying the Volunteer Office of any absences. I have read, understand, and fully support the above service standards.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

Shore Medical Center
Consent and Release for Multimedia Reproduction – Under 18 years of age

I, being the parent of _____, who is under 18 years of age, hereby grant to Shore Medical Center, its successors and assigns, without consideration, the right to use information given verbally or in writing about the hospital stay and experience of the above named minor. I hereby grant the right to use such information, in connection with the advertising program of Shore Medical Center, its successors and assigns, in any or all means or media, the right to copyright same and the right to License said program to other hospitals. I release Shore medical Center, their successors, assigns, and licensees, from any and all liability arising out of the exercise of the rights hereby granted.

_____
Subject's Parent/Guardian Signature

_____
Address

_____
City, State, Zip

_____
Date

Shore Medical Center, Public Relations Department
100 Medical Center Way, Somers Point, NJ 08244-2387

609-653-3679

SHORE MEDICAL CENTER
Somers Point, NJ 08244

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 credentialling 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