Palisades Medical Center

New York Presbyterian Healthcare System

Date: _____

VOLUNTEER SERVICE APPLICATION

Last Name_____ First Name_____
Address_____ Home Phone_____
City/State/Zip_____
E-Mail_____ Cell Phone: _____
Date of Birth_____ Social Security No._____
Mo./Day/Yr

EMPLOYER:
Name: _____
Address_____
Phone_____
City/State/Zip_____

College/University Student
Name of School_____
Campus: _____

In Case of Emergency/Illness
Contact: _____
Relationship: _____

Phone:
Cell _____
Home:_____
Business: _____

Why are you interested in our volunteer program?

_____
_____
_____
_____

Please list any prior volunteer experience:

_____
_____
_____

EDUCATION: Last year completed, degree: _____

LANGUAGES: What languages do you speak? _____

VOLUNTEER PREFERENCES:

Patient care services	Yes_____	No_____
Office Services	Yes_____	No_____

Other Interests: Please List

_____
_____

References: Two references are required: (One personal, one business, not family member)

Please have references sent to:
Denise Whitley
Coordinator of Volunteer Services
7600 River Road
North Bergen, NJ 07047

Have you ever been convicted of a crime? _____ If yes, explain when, where and disposition of case_____
_____

Availability: Please note hours available in appropriate spaces.

	Sunday	Monday	Tuesday	Wednes	Thurs.	Friday	Sat.
Time Available							

(Actual commitment time will be determined during interview with the Coordinator of Volunteer Services)

I agree to abide by the requirements and regulations of Palisades Medical Center and the service to which I am assigned. I will serve a minimum of eighty (80) hours after participating in required training. Letters of recommendation will not be issued prior to completion of 80 hours of volunteer time.

Signature: _____ Date: _____

For Office Use Only: ID # _____ Orientation Date: _____

Assignment: _____ Start Date: _____

Day(s) & Times Assigned:
Mon. _____ Tues. _____ Wednes. _____ Thurs._____ Fri. _____
Sat. _____ Sun. _____

Uniform Issued _____ Badge Issued _____
Deposit Received_____

Exit Interview:

_____
_____
_____
_____

Deposit Returned: _____
Volunteer Signature

Palisades Medical Center

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VOLUNTEER SERVICES DEPARTMENT
PHYSICIAN'S CONSENT FORM

Dear Dr. _____:

_____ is interested in becoming a volunteer at Palisades Medical Center.

Are there any limitations (physical or mental) that would prohibit this service?
Yes_____ No_____ if yes, please explain limitations.

_____

_____

_____

DOCTOR PLEASE DOCUMENT HISTORY OF DISEASE OR VACCINES RECEIVED if patient was born in 1957 or later.

Immunizations:

Mumps_____
Measles (Rubeola) _____
German Measles (Rubella) _____
Chickenpox (Varicella) _____

_____
Physician's Signature (Please attach Professional Card or Stamp)

Please return to:
Palisades Medical Center
Coordinator of Volunteer Services
7600 River Road
North Bergen, NJ 07047

Sincerely,

Denise Whitley
Coordinator Volunteer Services

I have given permission for the release of the information requested.

_____
Volunteer's Signature