



Volunteer / Internship

Thank you for your interest and taking your time out to become a volunteer. We appreciate your dedication to help the community we serve. These are the following criteria you must complete in order to become an active volunteer.

(1) Fill out an application

- *Application needs two letters of recommendation (one personal, one professional)*
- *If applicant is a student they can get recommendation from a teacher to count as their professional recommendation*

(2) Schedule an interview with Ms. Allison Smith (call 718-963-7345)

(3) Complete Medical Evaluation: ~ (Drug screening, must be done at Wyckoff)

~ (Medical Physical, your responsibility)

(4) Need a Criminal Background Check, conducted at the Human Resources Department.

(5) Attend Orientation (Mandatory in order to obtain a Wyckoff ID Badge)

(6) Receive ID Badge

(7) Placement in Department

Adult

WYCKOFF HEIGHTS MEDICAL CENTER

VOLUNTEER APPLICATION

Please print.

Date _____

Name _____
Last First

Phone Home () _____ Cell _____

Address _____ Apt# _____

City/State/Zip _____ Email Address _____

Date of Birth _____ Social Security # _____

Emergency Contact _____ Relationship _____

Emergency Contact's Phone () _____ Male _____ Female _____

School currently attending _____

Highest grade completed _____ Most recent academic average _____

Educational/Career Goal _____

Are you volunteering at WHMC through a school program? Yes No

If yes: Program _____ Coordinator _____

Languages (other than English, spoken fluently) _____

Any work experiences: _____

Any volunteer experiences: _____

List the name of one teacher and your guidance counselor as a reference:

Teacher _____ Subject _____

Guidance Counselor _____

AVAILABILITY

Please write the times under the corresponding days you are available to volunteer.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

We realize our volunteers are often motivated by the desire to help others. How do you feel this experience will benefit you? (i.e. skills, preparation for future career goals, experiential learning)

I hereby affirm that all information I have provided on this application is true and may be verified by WHMC.

Signature: _____ Date: _____

DEPARTMENT USE ONLY

Date: _____ Interviewer: _____

Comments:

Area assigned _____

TO WHOM IT MAY CONCERN:

Miss/Ms./Mr. _____ would like to be a volunteer in this hospital and has given your name as a personal reference. Your prompt reply to the following questions will be appreciated and will be confidential. Please return this form to us as soon as possible.

How long have you know the applicant? _____

In what capacity? _____

Do you believe the applicant would be a serious, responsible, and reliable Volunteer?

_____ if yes please explain: _____
(Yes/No)

In your opinion, would the applicant work well with and be helpful to the patients and Staff?

Additional Comments: _____

Thank you for your cooperation.

Respectfully,
Allison Smith
Volunteer's Services Coordinator

Signature

Please Print

Tele. No.: _____

Address: _____

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Please Print

Tele. No.: _____

Address: _____

WYCKOFF HEIGHTS MEDICAL CENTER HUMAN RESOURCES DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION VOLUNTEER SERVICES

In connection with my application for Volunteering at Wyckoff Heights Medical Center, I hereby authorize the Medical Center to investigate any and all information I have provided therein **and to contact my past employers, verify my references and conduct a criminal background check.**

I hereby release from any and all liabilities all representatives, staff, employees, and Board of Trustees of the Wyckoff Heights Medical Center for acts performed in good faith and without malice in connection with evaluating my Application for Employment, my credentials and qualifications.

I also hereby release from any and all liabilities any and all individuals and organizations who provide information to the Wyckoff Heights Medical Center or its staff; in good faith and without malice, concerning my competence, character and other qualification, and thereby consent to the release of such information.

(PRINT NAME)

Social Security Number

Date of Birth

Current Address: _____

Date

(SIGNATURE)

WYCKOFF HEIGHTS MEDICAL CENTER

Confidentiality and Safeguarding of Information

Every attempt must be made to safeguard the confidentiality of patient information. Care must also be taken to guard against invading the privacy of our employees. Access to information regarding individuals should be limited to those persons with a need to know the information. Any employee or agent of the hospital who engages in unauthorized access to or disclosure of information in violation of the privacy rights of our patients may be subject to discipline, up to and including immediate termination, in addition to possible civil or criminal sanctions. Special confidentiality rules apply to medical information pertaining to mental health, substance abuse and HIV/AIDS. Reading or discussion of a patient or employee record for other than job-related reasons is prohibited.

Hospital business information also must be safeguarded. No employee shall use Hospital business information for his or her own benefit or the benefit of others during the term of his or her employment or thereafter. This information includes the hospital's methods, processes, techniques, computer software or passwords, copyrights, research data, clinical information in possession of the Hospital which has not been published or disclosed to the general public.

Many of the Hospital's records serve as a basis for treatment decisions for its patients, or as documentation for billing purposes. Consequently, the proper and timely creation of accurate and complete records is a duty of each member of the Hospital community.

The Hospital is required to maintain certain types of medical and business documents for specific periods of time. Employees are expected to comply with the records retention and destruction schedules for their departments.

I acknowledge that I have received and read Wyckoff Heights Medical Center's policy on confidentiality and safeguarding information.

Signature

Date

Print Name

Wyckoff Heights Medical Center Dress Code

Attention All Volunteers

The Dress Code is business casual for all volunteers/interns at Wyckoff Heights Medical Center.

*Examples of Business Casual attire are:
Slacks, trousers, dressy pants, casual skirts, button down/polo shirts*

When volunteering at Wyckoff please adhere to the dress code, including the following:

- 1. No shorts or skirts above your knees;*
- 2. No jeans, sweatpants, or leggings;*
- 3. No sneakers, flip flops, sandals, or open toed shoes;*
- 4. No halter tops, tank tops, or shirts with oversized logos;*
- 5. No caps, hats, or sunglasses;*
- 6. No skin-tight, body-hugging, or revealing clothing;*
- 7. No Ipods or CD players;*
- 8. No chewing gum;*
- 9. No smoking;*
- 10. No extremely long nails (1" from basic cuticle);*

*We appreciate your cooperation.
Volunteers/Interns who are not appropriately attired will be sent home.*

YOUR APPEARANCE IS VERY IMPORTANT!!!!!!

Name ----- Signature-----