Maimonides
Medical Center

## DEPARTMENT OF VOLUNTEER AND STUDENT SERVICES

# Please read carefully before filling out application!

Dear Prospective Volunteer and/or Student:

Thank you for your interest in volunteering and/or completing your internship/clinical rotation at Maimonides Medical Center. Please complete and return the enclosed application and questionnaire. We will call you to schedule an interview when it appears likely that appropriate placements will be available. Due to the large volume of applicants, we cannot guarantee volunteer placement in your preferred area at any given time.

When filling out the forms, please print legibly. On the application card, complete the front side only. Under "**Personal References**," please supply **the full mailing address and phone number of two people** to whom we can mail a brief reference form. These should not be family members, but others who know you as a friend, neighbor, teacher, co-worker, etc. Under "**Employment**," check the box that most accurately reflects your primary status. Under "**Languages Spoken**," list only those in which you are fluent. Under "**Education**," give the highest level you have completed, e.g. high school graduate, two years of college, certificate program, etc. If you are currently a student, give the school and the grade you are in now.

**Prior to beginning volunteer service or internship/clinical rotation**, volunteers and students must be scheduled for an **interview**, have a criminal background check completed (if 18 years old and over), and attend a mandatory **orientation** that is conducted by the Department of Volunteer and Student Services.

All volunteers and students will require medical clearance prior their start date. **Medical forms are required to be completed by the applicant's private physician upon acceptance to the program.** Completed medical forms will be submitted to Employee Health Services and clearance may take five to ten business days.

Although most volunteers serve more, the minimum time commitment is two four-hour shifts per week. Volunteers interested in the Interpreter or Companion program must commit to a minimum of a one eight-hour shift per week. We consider consistency more important than quantity of hours. We are coordinating the schedules of many volunteers; therefore, we must be able to depend on your attendance.

For those whose ultimate goal is to seek employment, please be aware that, while it can be a valuable experience, **volunteer service at the hospital does not lead to paid employment at Maimonides Medical Center.** We are happy to provide references for volunteers whose service has been satisfactory, and **we require at least 150 hours of service** before we can do a letter of recommendation. Of course, we hope that you will serve far more than 150 hours and join the ranks of dedicated volunteers who remain with us for many years.

As individuals, our volunteers have varied skills, interests and preferences, which we try to accommodate. Our primary goal is to meet the needs of the patients who depend on the hospital for their well-being. As a volunteer, your greatest satisfaction will come from knowing that you are helping others in the community.

Maimonides Medical Center

# APPLICATION FOR VOLUNTEER AND STUDENT SERVICES

DATE: _____

| LAST NAME, FIRST NAME | Phone Numbers | E-mail Address | Date of Birth |
|---|---|---|---|
| | Home | | |
| | Work | | |
| | Cell | | |

| Address (Include Apartment Number) | City | State | Zip Code |
|---|---|---|---|
| | | | |

| | Name | Phone Number | Address (Street, City, State, Zip) | Relationship |
|---|---|---|---|---|
| Emergency Notification | | Home | | |
| | | Work | | |
| | | Cell | | |

Are You a U.S. Citizen? □ Yes □ No □ Green Card □ Visa – Type: _____

□ Female □ Male

| | | | |
|---|---|---|---|
| Employment | □ Employed full time<br>□ Employed part time<br>□ Retired<br>□ Workfare | □ Student<br>□ Homemaker<br>□ Seeking work<br>□ Unemployed | Languages Spoken (other than English) |
| Education | Current or Last School Attended | Level of Education Completed | Interests/ Skills / Major |
| | | | |

Previous Volunteer Work / Community Service: _____

_____

Maimonides
Medical Center

4802 Tenth Avenue
Brooklyn, NY 11219
Tel: 718-283-3980
www.maimonidesmed.org

# Volunteer / Student Enrollment Agreement

I, the undersigned, an applicant for volunteer service or clinical rotation at Maimonides Medical Center ("Medical Center"), do hereby give my personal authorization to release information of both an oral and written nature, regarding my past employment, school attendance, past volunteer service or affiliations with entities mentioned on the application and criminal background. I understand that the information received from the individuals or institutions by the Medical Center will be held in confidence.

If accepted for volunteer service or clinical rotation, I hereby agree to abide by all rules and regulations of Maimonides Medical Center. I understand that I am obligated to maintain an accurate record of my hours of service in my assigned department as a volunteer or student at the Medical Center. My failure to maintain such record and/or to abide by any of the Medical Center's policies and procedures may result in the immediate termination of my volunteer duties or clinical rotation at the Medical Center.

I understand that in the course of my volunteer duties or clinical rotation I might learn privileged information of a medical, financial, or personal nature, and that all such information must be treated as strictly confidential. I agree not to disclose any information I learn about patients or their family members to anyone except a staff member. I also agree that any conversations I may have with staff about patients or their families in the course of my duties will be held in private where they cannot be overheard. I understand that unauthorized disclosure of confidential information will be grounds for immediate termination of volunteer service or clinical rotation.

_____ _____

Signature Date

_____

Please print name

Maimonides
Medical Center

**DEPARTMENT OF VOLUNTEER AND STUDENT SERVICES**

# VOLUNTEER / STUDENT QUESTIONNAIRE

***Name*** _____ ***Date*** _____

***Telephone number where you can be reached during the day:***

_____

***Were you referred to us by an individual or organization? Please provide the name:***

_____

***Briefly explain your reasons for wishing to volunteer and/or do internship at Maimonides Medical Center:***

_____

***What type of volunteer assignment are you interested in?*** (You may check more than one)

- ❒ Direct Patient Care (please specify) →
  - ❒ Child Life
  - ❒ Companion (over 18 years old)
  - ❒ Feeder
  - ❒ Cuddler (21-75 years old)
  - ❒ Emergency Department
  - ❒ Hospitality
- ❒ Office/Clerical
- ❒ Ladies Auxiliary (Patient Library)
- ❒ Research
- ❒ Other (please specify) _____
- ❒ Support Services (please specify) →
  - ❒ Food & Nutrition
  - ❒ Laundry
  - ❒ Refreshment Cart
  - ❒ Patient Transport

_____

***Please list areas of training and/or experience and specific skills you have.*** (e.g., degree or certification, types of jobs you have had, typing, computer skills, etc.)

_____

***What days and hours would you wish to serve on a regular basis?*** (Please note that most office assignments are limited to Monday – Friday, 9:00 a.m. to 5:00 p.m.; patient care assignments may be available early evenings and weekends.)

_____

***What special qualities can you contribute*** *that will help Maimonides Medical Center fulfill its mission of providing high quality patient care and servicing the needs of the community?*

_____

Maimonides
Medical Center

**VOLUNTEER AND STUDENT SERVICES**

# Dress Code

*All MMC volunteers, students, and Summer Youth Program participants are required to abide by the Medical Center's dress code. Please note the following:*

## Allowed

***Professional Attire:***

Button-down Collar Shirts (tucked in)
Polo Shirts (tucked in)
Slacks
Blouses (with sleeves)
Skirts (to the knee with pantyhose)
Dresses (to the knee with pantyhose)
Shoes (must be totally closed)
Black Sneakers (only if allowed by Dept. Head or Program)

## Not Allowed

Provocative Clothing
T-Shirts
Tank or Crop Tops
Baggy or Cargo Pants
Tight Pants
Mini Skirts or Skorts
Jeans, Leggings or Jeggings
Sweatpants or Sweatshirts
Shorts or Capris
Sandals, Slippers or Crocs
Open-toed Shoes
Sneakers or Converse
Baseball Caps or Durags
Large or Excessive Jewelry
Excessive Facial Piercings
Artificial or Long Nails
Excessive Perfume or Cologne

**All clothes must fit and cannot be worn improperly**

**PLEASE SIGN, PRINT YOUR NAME, AND DATE:**

**I understand Maimonides Medical Center's dress code and acknowledge that I will not be allowed to report to work if I am not dressed appropriately.**

**Therefore, I agree to abide by Maimonides Medical Center's Dress Code.**

_____ _____

**Signature** **Date**

_____

**Please Print First & Last Name**

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**VOLUNTEER AND STUDENT SERVICES**

# Volunteer Program
# Parent Permission Form

Date: _____

I, the undersigned parent/ legal guardian of _____,
**Minor's First and Last Name**

request and authorize the enrollment of my son/daughter/ward in the Maimonides Medical Center Volunteer Program.

If my son/daughter/ward sustains an injury or accident, which requires emergency medical treatment while he/she is performing volunteer duties in the program, I give my consent for such medical treatment to be given at the Maimonides Medical Center Emergency Room or the closest emergency center.

_____
Signature

_____
Please print name

_____
Number Street

_____
City State

_____
Telephone Number

_____
Relationship

Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, NY 11219
Tel: 718-283-3980
FAX: 718-635-6145
www.maimonidesmed.org

**VOLUNTEER AND STUDENT SERVICES**

# *School Counselor/Teacher's Confidential Evaluation and Recommendation*

Your student _____ has applied for volunteer service at
**Student's First and Last Name**

Maimonides Medical Center. We would appreciate your time filling in the following information. Thank you for your cooperation.

| | Excellent | Good | Fair | Poor |
|---|---|---|---|---|
| School attendance and punctuality | | | | |
| Alertness | | | | |
| Maturity | | | | |
| Ability to follow directions | | | | |
| Cooperation with authority | | | | |
| Personal appearance and demeanor | | | | |
| Academic performance | | | | |

Is the student passing all major subjects? ☐ Yes ☐ No

What type of volunteer assignment would you consider most appropriate for this student?

- ☐ Patient Care (Nursing Unit)
- ☐ Clerical / Office
- ☐ Service Occupation (Food & Nutrition, Laundry, Warehouse)

I recommend this student for volunteer service: ☐ Yes ☐ No ☐ With Reservations

_____ School

_____ Signature

_____ Address

_____ Print Name and Title

_____ Telephone Number

_____ Date

# CONSENT FOR PARTICIPATING IN MAIMONIDES MEDICAL CENTER PUBLIC RELATIONS PROJECT

1. I, the undersigned, a participant in the Maimonides Medical Center's public relations project (or the parent or legal guardian of such participant), hereby consent to the interview, taking of any and all still photographs, motion pictures, television and/or video tapes, voice recordings, and/or other recordings ("Recordings") of my/his/her person at the Maimonides Medical Center (the "Hospital") or another location during the course of my/his/her participation in _____ ("Demonstration") and agree to the use of these materials as follows:

   For educational and/or training purposes at the Hospital or at another location; for publicity and/or soliciting of contributions, in any medium whatsoever, by the Hospital and/or by any person or persons the Hospital may name; and/or for any broadcast or other public viewing. Such recording may be used as described here in above, in full or edited form or may be incorporated into other recording or formats and may be copied for multiple distribution and/or broadcast.

2. I agree that I will receive no compensation or other remuneration for the taking, production, use, broadcast and/or distribution of such recordings or for my participation in any manner in such Demonstration, and I specifically release the Hospital and all others from any liability or other obligation arising from the taking, production, use broadcast and/or distribution of such Recordings and from my participation in the Demonstration.

Date:_____ _____
(SIGNATURE OF PARTICIPANT)

_____
(PRINT NAME)

Address_____

Date: _____ _____
(SIGNATURE OF PARENT OR LEGAL GUARDIAN)

_____
(PRINT NAME AND RELATIONSHIP TO PARTICIPANT)

WITNESS_____

Address_____

Note: If the participant is under (18) years, the permission of the participant's parent or legal guardian must be obtained, unless the participant can give consent in accordance the Hospital's policies and procedures pertaining to consent by minors.

**COMPLETED ORIGINAL FORM MUST BE RETURNED TO THE PUBLIC AFFAIRS DEPARTMENT, MAIMONIDES MEDICAL CENTER, 4802 TENTH AVENUE, BROOKLYN, NY 11219.**