Thank you for your interest in becoming a part of our dynamic team of volunteers who enhance the patient experience 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:

- Acting as a liaison between hospital staff and family members
- Greeting patients and visitors at the information desk
- Serving customers in the Atrium Gift Shop or at one of the Auxiliary's thrift shops located in Marmora and Somers Point

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 two-step PPD skin test for tuberculosis
- Provide documentation of the following blood titers within the past 5 years: MMR, Varicella, and Hepatitis B (for certain positions)
- Submit a form for a required background check
- Volunteer a minimum of four hours per week for at least six months

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

Lisa DiTroia, Volunteer Director at 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.

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

Acknowledgement	_____
PPD	_____
COVID	_____
Orientation date	_____
Background Check	_____

Application for Volunteer Service

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

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Birthday: *(month and day only):* _____

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 ?

_____
_____
_____

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 application with:

Signed confidentiality agreement
Proof of COVID vaccination

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