Hackensack Meridian
Pascack Valley Medical Center

Department of Volunteer Services

Junior Volunteer Application

Dear Prospective Volunteer:

Please read this letter ***carefully*** for the requirements of becoming a volunteer at Pascack Valley Medical Center.

Requirements:

- Minimum age is 17 years old.
- Must be able to participate in a 2-hour training session.
- ***Must have one (1) letter of reference from a teacher or guidance counselor.***
- **Must be able to devote a minimum of 75 hours and three to five months consecutive service in a calendar year to be entitled to a letter confirming hours volunteered.**
- **Proof of Covid vaccination required.**

Contact Information:

- Luisa Rivas
  Community Health Outreach & Volunteer Coordinator
  Email: Volunteers@hackensackumcpv.com
  Phone: 201-781-1118

Possible duties performed by junior volunteers include patient transport, errand running, clerical duties, filling water pitchers, greeting and escorting visitors.

If your availability matches our needs you will be contacted to schedule an interview to discuss the role you can take on as a Pascack Valley Medical Center Volunteer, as well as what volunteer positions are currently available. At this time you will receive the health forms to be completed by your physician.

IMPORTANT NOTE: Application and the letter of recommendation from a teacher or guidance counselor must be submitted together to be reviewed by our office.

Sincerely,

Luisa Rivas
Community Health Outreach & Volunteer Coordinator
Email: Volunteers@hackensackumcpv.com
Phone: 201-781-1118

JUNIOR VOLUNTEER APPLICATION

Date: _____ **Miss** _____ **Mr.**_____ **Mx.** _____

Name: _____ **Nickname, if any:** _____

Address:_____

Date of Birth: _____ **Social Security #:** _____

Phone Number: _____ **School Grade:** _____

Cell Number: _____ **Email:**_____

Name of School you attend/address:

_____

Do you have past experience as a volunteer? (If yes, please explain):

Please circle the type(s) of volunteer tasks that interest you.

Clerical/non-typing	Filing	Filling water pitchers	Collating Paperwork
Transporting patients	Answering phones	Directing visitors	Delivering items

Days and hours that you are available to volunteer:

_____

Emergency Contact:

(Name)_____**(Number)**_____

Physician's name, address and phone number:

_____

_____

_____

Do you have a family member who presently works Pascack Valley Medical Center?

_____

If yes, please list name, their relationship to you and their location:

Applicant's Signature: _____ **Date:**_____

Guardian Consent:

My child, _____ is at least 16 years of age or older and has my consent to serve as a junior volunteer at Pascack Valley Medical Center. He/she is in good health and upon completion of the required training course, will be responsible to complete their volunteer assignment. The Director of Volunteer Services will determine the volunteer assignment during an interview.

Guardian Signature_____ **Date**_____

Relationship _____**Cell Phone #**_____