Catch the New Jersey WAVE
WONDERFUL ADOLESCENT VENTILATOR EXCURSION

VOLUNTEER APPLICATION

ALL INFORMATION COLLECTED WILL
REMAIN PERSONAL AND CONFIDENTIAL

GENERAL INFORMATION

Are you a camper or a volunteer staff member? ☐ Camper ☐ Staff Member

Last/First Name: _____ D.O.B.: _____ Sex: M☐ F☐

Address: _____ City: _____ State: _____ Zip: _____

Best Way To Reach You: ☐ Mobile ☐ Home ☐ Email ☐ Text

Phone #: _____ Email: _____

Emergency Contact #: _____ Relationship: _____

EDUCATION HISTORY

Highscool ☐ 9 ☐ 10 ☐ 11 ☐ 12 College ☐ 1 ☐ 2 ☐ 3 ☐ 4 Post -Grad ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name of High School _____ City/State _____

Major _____ Degree/License/Certification _____

Major _____ Degree/License/Certification _____

Current School _____ City/State _____ Year _____

DISCIPLINE OF INTEREST

☐ Speech Therapy (ST) ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

☐ Therapeutic Recreation (TR) ☐ Other: _____

Are you pursuing an opportunity with Wave to satisfy a course/program requirement?

☐ Yes ☐ No

Professional Credentials or Area of Study (If applicable)

_____

_____

Have you ever been convicted of a law violation (excluding traffic violations)?

☐ Yes If yes, please explain: _____

☐ No

AVAILABILITY

Day 1 ☐ Morning ☐ Afternoon ☐ Evening Day 2 ☐ Morning ☐ Afternoon ☐ Evening

Day 3 ☐ Morning ☐ Afternoon ☐ Evening Day 4 ☐ Morning ☐ Afternoon

Are you fluent in any languages besides English (including American Sign Language)? If so, please list:

_____

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ADDITIONAL QUESTIONS

Interest and Hobbies:

Special Skills (ex. music, art, sports, clerical skills, ect)

Volunteer Experience

To photograph, interview, videotape, record and publish information, statement or images.
I authorize and permit representatives of Wave to photograph, record, conduct media interviews and/or publish my statements, images of myself.

I agree to the use and reproduction of pictures, statements and images of myself or my child for advertising, publicity, newspapers, television and/or radio broadcasts; books, brochure, magazines and newsletters; and videotapes or motion pictures.

Signature of Applicant

Date

Signature of Parent/Gaurdian

Phone Number

I certify that the statements herein are true to the best of my knowledge. I understand that in the event any statement made by me is found to be false, my application will become void and my volunteer status will be terminated. Furthermore I agree that I shall complete all assigned activities in a responsible and professional manner and will uphold and respect the confidentiality of every patient.

Signature of Applicant

Date

Signature of Parent/Gaurdian

Date

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VOLUNTEER MEDICAL QUESTIONS

Last/First Name: _____

Do you have or have you ever had:	Details:
☐ A back injury?	
☐ A herniated disk in your back?	
☐ Back survery for removal of a disc?	
☐ A neck injury?	
☐ A herniated disc in your neck?	
☐ Neck surgey for the removal of disc?	
☐ Knee injury? Which knee? _____	
☐ Knee injury? Which knee? _____	
☐ Shoulder injury? Which shoulder? _____	
☐ Shoulder surgery? Which shoulder? _____	
☐ Elbow injury? Which elbow? _____	
☐ Elbow surgery? Which elbow? _____	
☐ Wrist injury? Which wrist? _____	
☐ Wrist surgey? Which wrist? _____	
☐ A hernia? Which side? _____ Surgery? _____	
☐ Arthritis or Rheumatism?	
☐ Amputation of a digit or extremity?	
☐ Epilepsy?	
☐ Diabetes?	
☐ Cardiac disease/high blood pressure?	
☐ Respiratory Problems?	
☐ Tuberculosis?	
☐ Total loss of sight in one or both eyes or a partial loss of corrected vision of more than 75% bilaterally? Which eye? _____	
☐ Residual disability from poliomyelitis (polio)?	
☐ Cerebral Palsy?	
☐ Multiple Sclerosis?	
☐ Parkinson's Disease?	
☐ A vascular disorder?	

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VOLUNTEER MEDICAL QUESTIONS

Do you have or have you ever had:	Details:
☐ Hospitalization for any mental disability for a period of six months or more?	
☐ Hemophilia?	
☐ Chronic osteomyelitis?	
☐ Surgical or spontaneous fusion of a major weight-bearing joint?	
☐ Muscular dystrophy?	
☐ Thrombophlebitis?	
☐ Total deafness?_Which eye? _____	
☐ Any permanent physical condition which constitutes a 20% impairment of a part of or of the body as a whole?	
☐ Head injury?	
☐ Allergy to products containing latex?	
☐ Other allergies or asthma?	
☐ A back injury or disease process of the back resulting in disability over a total of 120 days?	
☐ Any injury, operation, or any disability not covered in the above questions?	
☐ Is there any question you did not understand?	
Which Question?	

All statements and information given in this questionnaire are true, to the best of my knowledge and belief.

Volunteer Name (Print) _____

Signature: _____ Date: _____

Parent/Legal Guardian (Print) _____

Signature: _____ Date: _____

Relationship: _____

Disclosure and Release - 18 & Older Only

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VOORHEES PEDIATRIC FACILITY (on behalf of NJ WAVE) , may obtain information about you from a consumer reporting agency for volunteering purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources. These reports may be obtained at any time after receipt of your authorization and, if you are accepted as a volunteer, throughout your volunteering service. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for volunteering is an investigation into your criminal history, education and/or employment history conducted by Accutrace, Inc. P.O. Box 624, Bryn Mawr, PA 19010 or by contacting us at 1-888-54 -TRACE or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing NJ WAVE to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are accepted as a volunteer, throughout the course of your volunteering service is limited to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or volunteers only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am accepted as a volunteer, throughout my volunteering service. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Accutrace, Inc. or another outside organization acting on behalf of NJ WAVE, and/or NJ WAVE itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or volunteers only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. □

California applicants or volunteers only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. □

< Please Print Clearly >

Applicant's Name: _____ _____
First Middle Initial Last Email

Maiden Name(s) Used:_____Nickname(s) Used:_____

Signature: _____ **Date:** _____mm/_____dd/_____ yyyy

		-			-									-			-				

Date of Birth (mm/dd/yyyy) Social Security No

Driver's License Number State

PROFESSIONAL LICENSE/CERTIFICATE NUMBER STATE PROFESSION

SCHOOL/UNIVERSITY NAME DEGREE/DIPLOMA TYPE DATE RECEIVED

Current Address City State Zip
No. of Years at Current Address: _____ Phone Number _____
Previous Addresses within the Past 7 Years (Use back if additional space is needed)

Address City State Zip

Address City State Zip