



2009

Dear Student,

Thank you for your interest in our free program this summer, **NURSING CAMP** at Trinitas Regional Medical Center.

Attached you will find the application you requested. Please complete it and return it in its entirety along with a copy of your immunization record that you may obtain from your school nurse along with your completed physical. Please indicate your week of preference. Note, you must include a letter from your guidance counselor recommending you for this wonderful program. Please be certain you qualify for this program by reviewing the enclosed fact sheet.

You may return the necessary documents to:

Volunteer Department  
Trinitas Regional Medical Center  
225 Williamson Street  
Elizabeth, NJ 07207  
Attn: Nursing Camp

Space is limited, so you must return the materials **NO LATER THAN MAY 15, 2009.** Incomplete applications and applications received after MAY 15, 2009 will NOT be considered. Selection is based upon letter of recommendation, academic standing and order in which we receive your application. We will contact you with our decision.

Thank you again for your interest.

Sincerely,

Lisa Liss  
Director - Volunteer Services



Nursing Camp 2009

FACT SHEET

- Student must be entering 11<sup>th</sup> or 12<sup>th</sup> grade in September 2009
- Student must submit immunization record (can be obtained from school nurse)
- All students must have a PPD current as of 4/1/09. Trinitas Regional Medical Center will perform this test for the student at no cost if documentation cannot be produced.
- Applications will not be considered if incomplete
- Applications for all sessions must be returned by May 15, 2009
- Student must be a resident of Union County
- Student must be in good academic standing
- Student must commit for 5 FULL DAYS
- Students will be accepted on a “First Come First Served” basis (program is very popular and fills quickly)



**TRINITAS**  
Regional Medical Center  
225 Williamson Street  
Elizabeth, NJ 07207



**APPLICATION FOR NURSING CAMP 2009**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **E-mail** \_\_\_\_\_

**Parent or Guardian's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Name of School:** \_\_\_\_\_

**Address of School:** \_\_\_\_\_

**Grade in September 2009:** \_\_\_\_\_

**Previous Volunteer Experience:** \_\_\_\_\_

**Please indicate size for scrubs:**

**Tops:** \_\_\_\_\_XS \_\_\_\_\_S \_\_\_\_\_M \_\_\_\_\_L \_\_\_\_\_XL \_\_\_\_\_Other

**Bottoms:** \_\_\_\_\_XS \_\_\_\_\_S \_\_\_\_\_M \_\_\_\_\_L \_\_\_\_\_XL \_\_\_\_\_Other

**Please check the box next to the week you would like to be considered for:**

**Week #1 6/29-7/3**

**Week #2 7/6-7/10**

**Week #3 7/13-7/17**

**Week #4 8/10-8/14**

**PERSON TO BE CONTACTED IN AN EMERGENCY:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City & State** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Career Planned:** \_\_\_\_\_

**Why do you want to participate in Nursing Camp?**

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**References:**

1.	_____	_____	_____
	<b>Name</b>	<b>Relationship to you</b>	<b>Phone No.</b>
2.	_____	_____	_____
	<b>Name</b>	<b>Relationship to you</b>	<b>Phone No.</b>

***Please read the following carefully before signing this application***

I understand that this is an application for and not a commitment or promise of volunteer opportunity.

I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with Trinitas Regional Medical Center that is true, correct and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for a volunteer position with Trinitas Regional Medical Center or my termination as a volunteer. I hereby authorize that I may be interviewed, photographed or videotaped by a photographer or videographer authorized by Trinitas Regional Medical Center. I understand that such interview, photograph or video may be used in print and electronic communications. I further understand that this consent is expressly intended to release all personnel of Trinitas Regional Medical Center, as well as the attending physician and consultants, from any claim arising out of the use of such interviews, photographs and/or videotape

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**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE NOTE: Application is not complete and will not be considered if not returned in its entirety by MAY 15, 2009.**

**STUDENT MUST BE A RESIDENT OF UNION COUNTY**

**VOLUNTEER SERVICES DEPARTMENT**

**THIS HEALTH CERTIFICATE MUST BE COMPLETED BY A PHYSICIAN BEFORE APPLICANT MAY VOLUNTEER AT TRINITAS REGIONAL MEDICAL CENTER.**

**VOLUNTEER APPLICANT:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**1. TO MY KNOWLEDGE THIS APPLICANT:**

**IS FREE FROM CONTAGIOUS DISEASE AND CAPABLE OF PERFORMING VOLUNTEER ASSIGNMENTS AT TRINITAS REGIONAL MEDICAL CENTER.**

**YES** \_\_\_\_\_

**NO** \_\_\_\_\_

**2. HAS THE FOLLOWING PHYSICAL AND/OR EMOTIONAL CONDITION REQUIRING RESTRICTIONS AND/OR PRECAUTIONS TO BE OBSERVED:**

**PLEASE NOTE RESTRICTIONS AND/OR PRECAUTION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAS NO RESTRICTIONS:**

\_\_\_\_\_  
**PHYSICIAN'S NAME (PLEASE PRINT)      PHYSICIAN'S SIGNATURE**

\_\_\_\_\_  
**PHYSICIAN'S ADDRESS**

\_\_\_\_\_  
**DATE**

**PLEASE RETURN COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.**

**form: VOL-7**

**rev.4/09**

**healthcertificate**

**TO GUIDANCE COUNSELOR**

**Mr./Miss \_\_\_\_\_ has expressed an interest in becoming a participant in our Nursing Camp part of our Teen Volunteer Program at Trinitas Regional Medical Center.**

In order to insure the selection of the most eligible applicants, we would appreciate your cooperation by completing the following questionnaire. If you have any questions, please feel free to contact Lisa Liss, Director of Volunteer Services at (908) 994-5164.

Thank you for your assistance.

**1. Scholastically, the applicant is considered:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

**2. The applicant is cooperative and accepting of authority:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

**3. The applicant is conscientious:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

**4. The applicant is willing and able to follow directions:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

**5. The applicant's attendance and tardy record is:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

**6. The applicant is in good health:**

Excellent\_\_\_\_\_ Good\_\_\_\_\_ Fair\_\_\_\_\_

I recommend the applicant for Trinitas Regional Medical Center Nursing Camp:

With enthusiasm\_\_\_\_\_ I would not recommend\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School

**TRINITAS REGIONAL MEDICAL CENTER**

**Dear Parent or Guardian:**

**Your permission is necessary for \_\_\_\_\_ to have a Mantoux Test for TB. If the Mantoux Test for TB is positive, it will be necessary to have a chest x-ray performed and a urine test for pregnancy if positive will be required for all females prior to having a chest x-ray. Please sign below to indicate your approval.**

**PLEASE SUBMIT A COPY OF YOUR CHILD'S IMMUNIZATION RECORD ALONG WITH THIS APPLICATION. THIS CAN BE OBTAINED FROM YOUR CHILD'S PHYSICIAN OR SCHOOL NURSE.**

**Sincerely,**

**Lisa E. Liss  
Director - Volunteer Services**

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**I give permission to the staff of Trinitas Regional Medical Center to complete all hospital requirements for pre-placement tests.**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship**  
tbtest  
rev.4/4/09

**form:vol-6T**

Dear Parent or Guardian:

**PLEASE READ THE FOLLOWING CAREFULLY**

Your son/daughter has expressed an interest in participating in Nursing Camp at Trinitas Regional Medical Center. We would be very happy to accept him/her as a member of the Trinitas Nursing Camp Program, if this meets with your approval.

We would appreciate it if you would sign the consent form below and have your son/daughter return it to us as soon as possible since it becomes part of their permanent record.

The form assures Trinitas Hospital that:

1. Your son/daughter is 14 years of age or older.
2. He/she volunteers with your approval.
3. Both you and he/she realize that volunteering is now his/her responsibility and should be taken very seriously. He/she agrees to complete a week of instruction, from 7:30am to 3:00pm. He/she must follow all rules and regulations established and be regular in attendance. Should a volunteer be negligent of his/her duties, it may be cause for dismissal from the program.
4. He/she is not to be at the Medical Center on any other days or times than those assigned except when visiting a patient.
5. He/she is at the Medical Center as part of our Volunteer Program. Excessive socializing on the premises may result in termination.
6. It is the duty of the parent/guardian to assume responsibility for transportation to and from the Medical Center.
7. Unless there is an emergency, Volunteers may not make or receive phone calls. Please arrange transportation ahead of time.
8. Uniforms are required. A uniform will be provided for your child. Uniforms must be worn at all times and it is the responsibility of the Volunteer to keep their uniform neat and clean.

Director - Volunteer Services  
Trinitas Regional Medical Center

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**TO: DIRECTOR OF VOLUNTEER SERVICES**

My son/daughter \_\_\_\_\_ is 14 years of age or older and has my consent to become a participant in NURSING CAMP at Trinitas Medical Center on the day/days for which he/she is scheduled and to adhere to the rules and regulations of the Volunteer Program.

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Signature

Date

Please check one: Parent \_\_\_\_\_ Guardian \_\_\_\_\_



**STOP**

**DID YOU?**

- **Complete the application in its entirety?**
- **Include a copy of your immunization record including recent PPD testing?**
- **Have your physician complete the HEALTH CERTIFICATE?**
- **CHECK OFF YOUR UNIFORM SIZE?**
- **CHOOSE A WEEK?**