RWJBarnabas HEALTH | Trinitas Regional Medical Center

Thank you for your interest in Trinitas Regional Medical Center.

WINTER Collegiate Medical Mentor Program 1/2/2025-1/14/2025

Please be advised that each participant in the Collegiate Medical Mentor Program must complete the following requirements:

- Submit to criminal background check subject to a fee once accepted
- Include a copy of your immunization record
- Include documentation of your FLU VACCINE
- Include a brief essay describing why you want to be a part of this program and what you hope to gain. Please limit your essay to one page, double spaced.
- Include a copy of your resume and copy of transcript.

APPLICATION DEADLINE: NOVEMBER 30, 2024

Please print out the application and return it along with the necessary documents to the following address:

TCMM
Trinitas Regional Medical Center
225 Williamson Street
Elizabeth, NJ 07207
Attn: Lisa Liss

If you have any questions, please send an email to: *lisa.liss@rwjbh.org*

NOTE: INCOMPLETE OR LATE APPICATIONS *WILL NOT* BE CONSIDERED

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TRINITAS REGIONAL MEDICAL CENTER 2025 COLLEGIATE MEDICAL MENTOR PROGRAM CHECKLIST

I have enclosed:

- Completed Application.
- **DOCUMENTATION OF FLU VACCINE.**
- Documentation of Covid vaccine if available.
- Copy of Immunization Record.
- Documentation of a NEGATIVE PPD Test performed within the past year (if available).
- $50 PROCESSING FEE (refundable if not accepted – NO CASH).
- $100 FEE TO HOLD MY SEAT (refundable with no more than one absence – NO CASH).

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APPLICATION FOR WINTER COLLEGIATE MEDICAL MENTOR PROGRAM

1/2/25-1/14/25

PLEASE PRINT CLEARLY

NAME: _____ _____
Last **First**

HOME PHONE: _____

ADDRESS:_____ **CELL PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

E-MAIL: _____ **LAST FOUR OF SS#**_____

REFERENCES: **1.**_____
Name **Relationship to you** **Phone no.**
2._____
Name **Relationship to you** **Phone no.**

LEVEL OF EDUCATION January 2025: _____

DECLARED MAJOR: _____

Have you participated in the TRMC Collegiate Medical Mentor program before? _____Y _____N

PERSON TO BE CONTACTED IN AN EMERGENCY:

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **PHONE:** _____

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Have you ever been employed or are currently employed by Trinitas Regional Medical Center or any of its affiliated organizations before? If so, please to list your former position and dates of employment.

Yes _____ No _____ If Yes, please list the department and dates below

Department	**From**	**To**
_____	_____	_____
_____	_____	_____

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 give Trinitas Regional Medical Center ("TRMC"), Elizabeth, NJ, my consent to photograph, record, or film/videotape me/my child ("photograph"), or to interview me/my child. I also give TRMC my consent to use those photographs or interviews and other information about me/my child in any publication or advertising materials (printed or electronic) or for any lawful purpose. I understand and agree that TRMC may distribute my/my child's photograph and/or interview information to other organizations for use in promoting volunteer services. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or name or my child's photograph and/or name.

I understand that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Volunteer Services Department at Trinitas Regional Medical Center, 225 Williamson Street, Elizabeth, NJ 07207. I understand that my revocation will not apply to information that has already been released in response to this authorization. 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

_____ _____

Signature **Date**

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IF ACCEPTED INTO THE COLLEGIATE MEDICAL MENTOR PROGRAM I AGREE THAT:

1. **I shall at all times uphold the mission, vision and values of Trinitas Regional Medical Center.**

2. **I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.**

3. **I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, physicians or staff, and not seek to obtain confidential information from a patient.**

4. **I shall attempt to resolve any problems related to my activities with my supervisor, and or, Director of Volunteer Services.**

5. **I shall not sell or attempt to sell goods or services, request contributions, or to solicit persons to sign or distribute political petitions on hospital premises, unless I receive the express authorization of the Director of Volunteer Services to engage in these activities.**

6. **I agree to sign a release of medical information form so that my doctor(s) may furnish Trinitas Regional Medical Center information concerning my health.**

8. **I understand that the Volunteer Services Department reserves the right to terminate my status as a result of: (a) failure to comply with Medical Center policies, rules and regulations; (b) absences without notifications; (c) unsatisfactory attitude, work or appearance; or (d) any other circumstances which, in the judgment of the Director of Volunteer Services, would make my continued service contrary to the best interests of the Medical Center.**

I have read each of the above conditions and I agree to be bound by them.

_____ _____

Student Signature **Date**

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I have been informed that the flu vaccination is part of the medical requirement to participate in the Collegiate Medical Mentor program at Trinitas Regional Medical Center/RWJBH. If I apply and am accepted to become a volunteer, I am required to provide documentation that I have received a current flu vaccination, or provide documentation that I am declining the flu vaccination due to medical or religious reasons (documentation must come from your physician or clergy on letterhead). I understand that failure to provide documentation will jeopardize my volunteer status.

I understand I must wear a face covering when interacting with patients at Trinitas Regional Medical Center/RWJBH. I must self-screen to determine if sneezing, coughing, running a fever and stay home.

Name: _____
Please Print

Signature: _____

Date: _____

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TRINITAS REGIONALMEDICALCENTER
CONFIDENTIALITY AGREEMENT

I, the undersigned, acknowledge that during the course of my voluntary participation in the_____ at Trinitas Regional Medical Center hereby referred to as"facility," that I may receive access to confidential information of the facility that is prohibited from disclosure to others.

"Confidential Information" means information provided by the facility that is not commonly available to the general public, or is required by law or regulation to be protected from disclosure to third parties not considered part of the facility's "workforce" as that term is defined by federal and state health information privacy regulations such as the Health Information Portability and Accountability Act. Confidential Information includes information contained in patient medical records and any other health information which identifies a patient, such as information concerning the facility's employees, services or business operations. Such information can be acquired by any means and in any form, written, spoken, virtually or electronic.

I agree not to share, disclose or discuss Confidential Information with anyone who does not have a legitimate interest in such information. I will abide by Trinitas Regional Medical Center's policies and procedures concerning Confidential Information and I will contact a facility representative if I have any questions regarding these policies and procedures.

I will maintain and protect the privacy of the facility's employees, medical staff and patients and will not misuse or be careless with such information.

I understand that any violation of this Agreement or the facility's policies related to access, use or disclosure of Confidential Information may result in significant legal ramifications for which I will be held solely responsible with respect to this Agreement.

I acknowledge that I have reviewed all of the information above. I understand that compliance with the principles, policies and procedures expressed above is a condition of my virtual participation at the facility.

_____ _____

Name (please print) Date

_____

Signature

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HIPAA/CONFIDENTIALITY AGREEMENT

I, an employee or agent of Trinitas Regional Medical Center (TRMC), acknowledge the confidentiality of patient health care information ("Confidential Patient Information") that I may receive or have access to in the course of providing patient care or other services at any TRMC Facilities at which I am assigned. Patient and personnel information including medical, financial, social and spiritual information from any source and in any form, including oral communication, audio recording, written and electronic display, is strictly confidential. Access to confidential patient and personnel information is permitted only on a need-to-know basis. It is the policy of TRMC that all users respect and preserve this right to privacy and confidentiality. Violations of this policy include, but are not limited to:

- Accessing information that is not within the scope of your job;
- Disclosing, misusing without proper authorization, or altering patient or personnel information;
- Disclosing your sign-on code and password or using another person's sign-on code and password for accessing electronic or computerized records;
- Accessing the information of a colleague or co-worker who is not assigned to your care or treatment;
- Leaving a secured application unattended while logged on; and
- Attempting to access a secured application without proper authorization;
- Patient information is the patient's private property lent to the Hospital and its staff for a specific and mutually agreed upon purpose;
- All information about a patient is to be kept confidential at all times. Remember; do not discuss patient information in the elevator, lobby or cafeteria. Be careful when utilizing the speakerphone that patient information is not broadcasted for everyone in the surrounding area to hear, breaking patient confidentiality. Do not post patients' names publicly, for example on walls, doors, bulletin boards, etc;
- Except when required by law, patient information is not to be released to any person or department not directly involved in the delivery of patient care, without expressed written permission by the patient or legally authorized representative;
- Family access to a patient's record may be permitted **only** with patient consent;
- All patients are legally entitled to confidentiality regardless of race, gender, religion, age and socioeconomic or criminal status; and
- An employee, physician, volunteer or trustee admitted to Trinitas Regional Medical Center as a patient also has the same right to confidential treatment of their personal information. **DO NOT SHARE THEIR ADMISSION** unless requested to do so by the patient.

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I have read the above statements and understand and agree to my role in Patient Confidentiality at Trinitas Regional Medical Center.

Violations of this policy may constitute grounds for disciplinary action up to and including termination of employment or loss of hospital privileges in accordance with Hospital procedures and/or federal or state law, and/or legal action. I shall maintain the confidentiality of Confidential Patient Information, and in doing so shall comply with all applicable state and federal laws and regulations, including without limitation, the privacy provisions under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the policies and procedures of each TRMC facility where I am assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with TRMC.

HIPAA ACKNOWLEDGEMENT & EMPLOYEE CONFIDENTIALITY

_____ _____

Signature Date

_____ _____

Name (Print) Department

YOU MUST CHECK ONE

_____ EMPLOYEE **_____ CONTRACTOR/OUTSOURCED STAFF** **_____ STUDENT**