VOLUNTEER APPLICATION

Name: ____

DOB: ____/____/______ Primary Phone Number: ______________________

Street Address: ____

City: ______________________ State: ______ Zip Code: ____________

E-mail Address: ____

Are you a licensed MD, DO, PA, NT? Yes ☐ No ☐

Are you a licensed RN, LVN, CAN, EMT? Yes ☐ No ☐

Specialty: ____

Are you a student? Yes ☐ No ☐ Major/Area of Study: ____________________

Please list an emergency contact:

Name: __________________________ Phone: ____________________

In the table below, fill in the time(s) you are available to volunteer:

	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**Saturday**
8:00-9:00						
9:00-10:00						
10:00-11:00						
11:00-12:00						
12:00-1:00						
1:00-2:00						
2:00-3:00						
3:00-4:00						
4:00-5:00						
Other (Please specify)						

Available start date:__________________ Length of Commitment:______________________

Do you speak any language other than English? ☐ Yes ☐ No

If yes, please list: ____

Please indicate the position(s) for which you are interested in volunteering:

☐ Medical Professional ☐ Clinical Records Assistant ☐ Back Office Clerk

☐ Receptionist/Intake Clerk ☐ Eligibility Assistant ☐ Pharmacy Assistant

☐ Education ☐ Physical Fitness

List any special skills/training: ____

____

____

What do you hope to gain from your volunteer experience?

____

____

____

How did you hear about Health For All?

____

____

HIPAA RELEASE FORM

CONFIDENTIALITY

The privilege of being a volunteer carries with it the responsibility of being loyal to Health For All patients and staff. It is ABSOLUTELY ESSENTIAL and MANDATORY that all information pertaining to the individuals we serve be held in the strictest confidence. Violation of this policy can result in immediate dismissal of a volunteer.

Health For All adheres to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As such, I understand that as a volunteer of Health For All, I will have access to the medical records of patients of the clinic. I agree to keep all information about the patients STRICTLY CONFIDENTIAL. This means I will not discuss anything I learn about a patient – either through medical records or through direct contact with the patient – with anyone other than the appropriate Health For All staff.

____________________________________ ____________________

Signature Date

MEDICAL PROVIDER

Consent and Release

As a medical professional providing service at the Health For All Clinic, I agree to provide true and accurate data regarding my medical credentials.

In addition, I specifically authorize Health For All and its authorized representatives to consult with any third party who may have information, including the National Practitioner Data Bank, and including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics behavior or any other matter bearing on my satisfaction of the criteria for initial or continued appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of said third parties relating to such questions to include conducting a criminal background check. I also specifically authorize said third parties to release said information to Health For All and its authorized representatives upon request.

I acknowledge that I have the responsibility to keep this application current by informing Health For All of any change in the areas of inquiry contained herein.

______________________________________ ______________________
Signature Date

______________________________________ ______________________
Print Name