Health & Hope

Health and Hope Medical Outreach
Volunteer Application

Name: Last: First: Middle:
Dr ( ) Mr ( ) Mrs ( ) Miss ( ) Ms ( ) (required)
Nickname:

Mailing Address: City, State, Zip

Phone: Home: Work: Cell:

Email Address:

Date of Birth: Sex: M ( ) F ( )

Driver's license number: Expiration Date:

Category of Volunteer: Provider ( ) Medical Personnel ( ) Spiritual Care ( )
Clinic Volunteer ( ) Other ( ) _____
Church Affiliation:

EMERGENCY CONTACT INFORMATION:

Name: Relationship:

Phone:

EDUCATION:
Institute: Degree: Date:

Certifications (BLS required for healthcare workers):

Other:

WORK EXPERIENCE: (Begin with most current)

1. Employer: Address: Phone:

   Position held: Dates worked: From: To:

2. Employer: Address: Phone:

   Position held: Dates worked: From: To:

Health & Hope

Volunteer Application Continued

MEDICAL VOLUNTEERS:
License: License number: Expiration date:
Professional Skills: MD/DO ( ) PA ( ) ARNP ( ) RN ( ) LPN ( ) CNA ( )
MA ( ) Lab Tech ( ) Pharmacist ( ) Pharmacy Tech ( )

Service Preference:
Bi-weekly ( ) Monthly ( ) Quarterly ( )
1st Tuesday ( ) 2nd Tuesday ( ) 3rd Tuesday ( ) 4th Tuesday ( ) 5th Tuesday ( )

Assignment Preference:
Medical Provider( ) Nurse( ) Registration Clerk( ) Greeter( ) Intake Interviewer( )
Resource Coordinator( ) Credentialing Coordinator( ) Waiting Room Host( ) General Clerical( )
Communications Committee( )

Have you ever been convicted of any criminal offense including, but not limited to, drugs, theft or inflicting bodily, sexual or emotional injury? Yes ( ) No ( )

If so, what are the details and outcome?

CV or Resume attached?(optional) Yes ( ) No ( )

I hereby certify that the above is true and complete to the best of my knowledge.

By submitting this application, I authorize HHMO and its representatives to investigate and verify any and all of the information in this volunteer application, including a criminal background check, education verification, license verification and National Provider Data Base check.

HHMO EOE Policy
It is the policy of HHMO to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual orientation, age, or disability.

Thank you for completing this application form and for your interest in volunteering at HHMO.

Signature: _____ Date: _____

DATE DRAFTED:
DATE BOARD APPROVED: 9/5/12
BOARD CHAIR SIGNATURE:
REVISIONS:12/10/12

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Health and Hope Medical Outreach
Volunteer Agreement

Thank you for your interest in volunteering at HHMO. Before being placed in a volunteer position there are some important guidelines of which you need to be aware. Volunteering is a fun and rewarding experience, but it requires a commitment since patients, staff and other volunteers are relying on you.

All volunteers are expected to honor the following statements. Please review them carefully prior to your volunteer orientation and feel free to ask any questions that you may have at that time.

As a volunteer at Health and Hope Medical Outreach I agree to:

- Report on time for my scheduled shift.
- Notify the Executive Director at least one week in advance of any cancellations or changes to my volunteer schedule. (We understand that illness and family emergencies are unavoidable but please call the clinic as soon as you know that you cannot work a scheduled shift.)
- Comply with all HHMO policies, protocols, procedures, and objectives.
- Respect all HHMO staff and fellow volunteers.
- Respect and maintain confidentiality in regard to all personal and medical information of patients at HHMO.
- Provide health care services with courtesy and respect to all patients and their family members.
- Report any incidents, concerns, or disputes to the proper HHMO staff.

Health and Hope Medical Outreach agrees to:

- Provide orientation, training, and support to all new volunteers.
- Respect, support, and recognize the efforts of all volunteers.

HHMO reserves the right to terminate the relationship between itself and the volunteer if at any time service is found to be unsatisfactory or in the event that the provided services are no longer needed.

Name (please print): _____

Signature: _____

Date: _____

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Health and Hope Medical Outreach
Volunteer Confidentiality Agreement

I, _____, understand:

That all information I am exposed to regarding patients, program participants, volunteers, family members of patients/volunteers, customers, and/or employees of HHMO, and their partners/collaborators may be governed or protected by federal, state and/or local regulations and, where privileged, is to be held in the strictest confidence.

☐ No privileged information will be discussed with family, friends, or any other unauthorized person;

☐ I may release only information that is duly authorized for release and for which I have training and authorization to release;

☐ Unauthorized disclosure is cause for termination of volunteer services as well as possible civil and/or criminal sanctions.

Furthermore, I hereby agree to:

☐ Release only that information that is duly authorized for release;

☐ Resist any effort or request for information that is protected by relevant federal, state, and/or local regulations;

☐ Not divulge, publish, or otherwise make known to unauthorized persons or the public any confidential information obtained in the course of my employment or participation with clinic activities; institute or comply with appropriate procedure for safeguarding such information and will hold discussions only in places which assure privacy, and only on a need to know basis.

Signed: _____

Printed Name: _____

Date: _____

Witness: _____