|  |
| --- |
| **Well of Healing Mobile Medical Clinic** **Volunteer Application** |

## Contact Information

|  |  |
| --- | --- |
| Name |  |
| Street Address |  |
| City, St, Zip Code |  |
| Home Phone |  |
| Work Phone |  |
| E-Mail Address |  |

## Availability

### During which hours are you available for volunteer assignments?

|  |  |  |  |
| --- | --- | --- | --- |
|  [ ]  Weekday mornings |  [ ]  Weekend mornings |  [ ]  Mon |  [ ]  Thurs |
|  [ ]  Weekday afternoons |  [ ]  Weekend afternoons |  [ ]  Tues |  [ ]  Fri |
|  [ ]  Weekday evenings |  [ ]  Weekend evenings |  [ ]  Wed |  [ ]  Sat [ ]  Sun |

## Interests

### Pease check ALL areas which you are interested in volunteering.

|  |  |  |
| --- | --- | --- |
|  [ ]  Medical Doctor |  [ ]  Paramedic |  [ ]  Administration |
|  [ ]  Nurse Practitioner |  [ ]  College Student |  [ ]  Events |
|  [ ]  Physician Assistant  |  [ ]  Phlebotomy  |  [ ]  Volunteer coordination |
|  [ ]  Registered Nurse |  [ ]  Driver |  [ ]  Fundraising |
|  [ ]  License Vocational Nurse |  [ ]  Pharmacist |  [ ]  Grant Writing |
|  [ ]  Medical Assistant |  [ ]  Education |  [ ]  Clerical |
|  [ ]  Certified Nurse Aide |  [ ]  Dental |  [ ]  Clinic Manager |
|  [ ]  EMT |  [ ]  Ministry Team  |  [ ]  Other  |

## Special Skills or Qualifications

### Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including special licenses and certifications. If licensed provider (MD, RN, PA, etc.), please provide the specifics. From the Federal Tort Claims Act (FTCA) qualification for liability coverage for the following is requested.

|  |
| --- |
| Primary Source Verification: Relevant Education, Training, or Experience |
|  |
| Name of Medical School Attended: |  |
| Residency: |  |
| Please provide copies of any licenses |  |
| Vaccine Status: Please provide a copy of HEB B and TB Skin Test Record or Waiver |

## Previous Volunteer Experience/Information (please summarize)

|  |
| --- |
| **Why are you volunteering to work with the Well of Healing Mobile Medical Clinic (WOHMMC)?**  |
|  |
| **What are your unique gifts and how might they serve this particular setting?** |
|  |
| **What special training have you received that could be useful to WOHMMC?** |
|  |
| **How did you hear about us?** |
| **Do you have previous volunteer experience?** [ ]  Yes (please explain) [ ]  No |
|  |
| **Our ministry vision comes from the Bible verse “for the poor will never cease to be in the land; therefore, I command you, saying, ‘You shall freely open your hand to your brother, to your needy and poor in your land.’” Deuteronomy 15:11. How do you feel about this scripture?** |
|  |
| **Work Experience:** List the past two (2) employers or voluntary roles beginning with the most recent  |
| Name and Address of Employer:  |
|  |
| Date employed month/year: From: To: |
| Position(s) held/title: |
|  |
| Briefly describe your regular duties:  |
|  |
| Reason for leaving: |
|  |
| Name and Address of Employer:  |
|  |
| Date employed month/year: From: To: |
| Position(s) held/title: |
|  |
| Briefly describe your regular duties:  |
|  |
| Reason for leaving: |
|  |

## Personal Information

### Do you have any physical limitations? [ ]  Yes (please explain) [ ]  No

|  |
| --- |
|  |

|  |
| --- |
| If applicable, list ALL professional licenses and/or certifications you hold: |
| Professional license:  |  |
| Professional license:  |  |
| Professional license:  |  |
| Professional license:  |  |
| Certification: |  |
| Certification: |  |
| Certification: |  |
| Certification: |  |

|  |
| --- |
| Do you carry Malpractice insurance**:** [ ]  Yes [ ]  No |
| Carrier: Policy Number: Exp. Date:  |
| Are you a licensed driver? [ ]  Yes [ ]  No Basic method of transportation:  |
| Are you presently attending a faith community? [ ]  Yes [ ]  No |
| If yes, what is the name? |
| What is the name of your Pastor, Priest, Rabbi, or Minister?  |
|  |
| Are you involved in your faith community in any capacity? [ ]  Yes [ ]  No If yes, please explain:  |
|  |

## Person to Notify in Case of Emergency

|  |  |
| --- | --- |
| Name |  |
| Street Address |  |
| City ST ZIP Code |  |
| Home Phone |  |
| Work Phone |  |
| E-Mail Address |  |

## Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. It is understood and agreed upon by the Well of Healing Mobile Medical Clinic and the undersigned that the relationship being entered into is a volunteer position and not employment. Both parties agree there will be no payment or fringe benefits which may be enjoyed by regular employees, and that either party may terminate the volunteer services at any time, without cause and without notice.

By signing below you acknowledge that you understand you will practice only within the scope of practice your license allows, ***if applicable***. And, you are aware that during the course of your volunteer work, photographs and/or video footage may be taken and used in promotional and/or educational settings. You freely authorize photographs and/or videos that you are in to be used at the discretion of the Organization.

|  |  |
| --- | --- |
| Name (print) |  |
| Signature |  |
| Date |  |

## Our Policy

### It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

### **THANK YOU** for completing this application form and for your interest in volunteering with us!

## OFFICE USE ONLY

|  |  |
| --- | --- |
| Interviewed By: |  |
| Date Interviewed: |  |
| Orientation Date: |  |
| Assignment: |  |
| Start Date:  |  |
| Required Documents:  | [ ]  Copy of Vaccine Records Received [ ]  Copy of Licenses Received [ ]  Copy of BLS |

**HEPATITIS B IMMUNIZATION CONSENT/WAIVER FORM**

By law, the Hepatitis B vaccine series will be made available to employees within 10 days of initial assignment to a position presenting occupational exposure and completion of required training unless the employee has previously received the complete Hepatitis B series, antibody testing reveals the employee is immune, or the vaccine is contraindicated for medical reasons.

|  |  |
| --- | --- |
| Employee Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Position: |  | Site: |  |

|  |  |  |
| --- | --- | --- |
| On (date) |  | I [ ]  attended a blood borne pathogen education and training class, or |

|  |
| --- |
| [ ]  viewed a blood borne pathogen education and training videotape or webinar. |

I understand that as part of my job, I may become exposed to blood or other potentially infectious items or materials that put me at risk for acquiring the Hepatitis B virus (HBV). Therefore, at no charge to myself, I have been offered the Hepatitis B vaccine, which is intended to render me immune to the HBV. At least three separate intramuscular injections are necessary to produce the desired immunity (sometimes additional injections are necessary to reach immunity), and all three doses are necessary in order for the vaccine to be effective. After the initial dose is given, repeat doses are given one month and six months later. There is a strong likelihood the vaccine will be successful if I receive all three doses, but there is a potential that even when administered properly the vaccine will not result in the desired immunity, such that there is a chance I may become infected with HBV even if I complete the full series.

All medicines may cause side effects, but most recipients of the vaccine have few or no side effects. The most commonly reported side effects include diarrhea, dizziness, fatigue, a general feeling of discomfort, headache, irritability, loss of appetite, mild fever or sore throat, nausea, pain, swelling, or redness at the injection site, runny nose, tiredness, weakness. In rare cases, more severe side effects may occur, including rash, hives, itching, difficulty breathing, tightness in the chest, swelling of the mouth, face, lips, or tongue, unusual hoarseness, fainting, fast or irregular heartbeat, red, swollen, blistered, or peeling skin, severe or persistent dizziness, unusual bruising or bleeding. In case of such reactions, seek immediate medical care or attention.

If the vaccine does not lead to the desired immunity (because I do not complete the three-dose series, or I choose not to receive supplemental injections if the first series does not develop immunity), or if I choose not to receive the vaccine at this time, I understand that I will need post-exposure treatment if I have a direct contact with blood, other body fluids, or other actually or potentially infected items, in order to address potential exposure concerns.

[ ]  I have read and understand the above information and wish to receive the hepatitis B vaccine series (three doses). I have no known sensitivity to yeast and I am unaware of any reason why the vaccine may cause me harm or lead to an adverse reaction.

[ ]  I have read and understand the information above. I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

|  |  |  |
| --- | --- | --- |
|  |  |  |

Signature Date

|  |
| --- |
| **HEPATITIS-B VACCINATION RECORD** |
| **1st Dose:**  | **2nd Dose:**  | **3rd Dose:**  |
| **Adm. By**:  | **Adm. By**:  | **Adm. By:**  |

**Health Evaluation Questionnaire and Tuberculosis Screening**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **Date of Birth:** |  |
| **Phone Number:** |  |
| **Work Title or Description:** |  |

**Please complete this form even if you have had a prior abnormal (positive) tuberculosis (TB) skin test.**

**Do not** repeat a skin test however if you have had a prior abnormal (positive) test.

1. [ ] Yes [ ] No Have you had any new problem, which is infectious or would prevent you from performing your assigned duties?
2. [ ] Yes [ ] No Have you had an unexplained weight loss in the last year?
3. [ ] Yes [ ] No Do you have a cough that has lasted 3 or more weeks?
4. [ ] Yes [ ] No Do you cough up blood?
5. [ ] Yes [ ] No Do you have unexplained fevers or night sweats?
6. [ ] Yes [ ] No Do you have any of the following conditions which may damage your immune system and affect your response to a tuberculosis skin test? Note: You do not need to indicate which condition: Cancer, chemotherapy, sarcoidosis, HIV/AIDS, treatment with steroids or take medications for managing an organ transplant.
7. [ ] Yes [ ] No Have you completed a TB skin test in the last 12 months? If yes, please provide a copy of your skin test with this form.
8. [ ] Yes [ ] No Have you ever had a positive TB skin test? If so, did you have a chest x-ray to evaluate your abnormal skin test? [ ] Yes [ ] No Date of x-ray: Click here to enter text.
9. [ ] Yes [ ] No Have you completed the vaccine series for Hepatitis B?

**Volunteer Sign and Date**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature: |  |  | Date: |  |

**PPD-5TU**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date Given: |  | Given By:  |  |  | Site:  |  |
| Date Read:  |  | Induration:  |  | mm | Read By:  |  |

**Must be read within 48 – 72 hours; Record no skin reaction as zero mm induration and not as “negative”.**

**Please use this section for annual PPD skin testing done with Well of Healing Mobile Medical Clinic. Do not test any volunteer with a history of a prior PPD positive**

**For Reviewing Well of Healing Mobile Medical Licensed Personnel**

The volunteer [ ]  is [ ]  is not able to perform assigned duties based on assessed absence of a health condition that would create a hazard for the volunteer or staff or to patients.

|  |  |
| --- | --- |
| Name and Title: (print) |  |
|  |  |  |

Signature Date Reviewed

# Confidentiality Agreement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Privacy Policy

Confidential information is defined as any information found in a patient’s medical record, personal information, and work-related information (including salary information). All information relating to a patient’s care, treatment, or condition constitutes confidential information.

* Employees shall never discuss a patient’s medical condition with any non-employee of the Practice, friends, or family members. Confidential matters involving patients will not be discussed in areas where they might be overheard by other patients or other non-employees of the Practice. Staff members are to be aware at all times that conversations regarding patients are not to be overheard by others and take appropriate steps to ensure this confidentiality.
* Any unauthorized disclosure of confidential information by employees could render the clinic liable for damages. Any employee who violates the confidentiality of clinic, medical- or employee-related information is subject to disciplinary action up to and including termination from employment.

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have received a copy of, read, understand, and agree to uphold this written policy on matters of confidential information.**

**I also understand that in my daily job duties, I will have access to confidential clinic operations and any violation of confidentiality, in whole or in part could result in disciplinary action up to and including termination and/or legal action.**

**I recognize that this signed document of my agreement to uphold the provisions of this policy will be kept on file in my personnel file.**

|  |  |  |
| --- | --- | --- |
|

|  |  |
| --- | --- |
| Date: |  |

 |

|  |  |
| --- | --- |
| Volunteer/Employee: |  |

|  |  |
| --- | --- |
| Practice Representative Witness:  |  |

**Well of Healing Mobile Medical Clinic**

**Abuse Policy**

**Abuse Policy Form Acknowledgement**

As part of the orientation process for participation in the Well of Healing Mobile Medical Clinic, I hereby acknowledge receipt of the policy and procedures as it regards to abuse and abuse reporting. I understand that reporting of child abuse or elder or dependent adult abuse may be reported by anyone; however certain individuals including medically licensed providers are mandated reporters. The following information from the California Department of Social Services web page lists specific professions or positions found in the California Penal Code Section 11165.7: (<http://mandatedreporterca.com/faq/faq.htm>).

|  |  |  |
| --- | --- | --- |
|  |  |  |

Name of Volunteer/Employee Signature

**HIPPA and Infection Control Compliance (BBP)**

**How to Register for Stericycle**

Every volunteer must complete the HIPPA and Infection Control Compliance (BBP) videos annually.  Please go to the website: [MyStericycle.com](https://mystericycle.com/) and using the WOHMMC account ID#: 6078008 and Zip Code: 92336 complete the necessary compliance.

After you have completed the videos, please print and sign your Certificates of Completion and return them to the Office for your file by scanning and emailing a copy with this application.