SALEM FREE MEDICAL CLINIC
1300 Broadway NE #104 Salem, OR 97301
Fax: 503-990-8774
SalemFreeMedClinic.org

# Volunteer Application – Primary Provider

(Doctor, Dentist, Chiropractor, Psychiatrist, Psychologist, Nurse Practitioner, etc.)

*The Salem Free Medical Clinic (SFMC) exists to provide quality health care at no cost to the poor, the uninsured, and the underinsured children and adults in our community as an expression of Christ's love.*

## GENERAL INFORMATION:

Name: ______________________________ Title/Licensure: ______________

Address: ____________________ City __________ State: ____ Zip: __________

Home Phone: ____________________ Cell Phone: ____________________

Email Address: __________________________________________

License #: ____________________ Date of Birth: ______________

Employer: ____________________ Address: ____________________

Job Title: ______________ Years Worked: ________ Work Phone: ____________

Job Duties: __________________________________________

## EMERGENCY CONTACT INFORMATION:

Spouse (if married): ____________________ Phone: ______________

Other Contact Name: ____________________ Relationship: ______________

(H): ______________ (C): ______________ (W): ______________

## VOLUNTEER AND BACKGROUND INFORMATION:

In what other organizations have you served as a volunteer?

Have you ever voluntarily left or been asked to leave a role within an organization due to unresolved concerns on either your part or that of the volunteer organization? ☐ No ☐ Yes

If yes, please explain:

Have you ever been convicted of a crime? ☐ No ☐ Yes

If yes, please explain:

## SFMC VOLUNTEER INFORMATION:

How did you hear about SFMC?

When can you serve? (Circle those that apply)

Weekly: ________ X's a week Monthly: ________ X's a month

Monday Tuesday Wednesday Thursday Friday Saturday

Mornings Afternoons Both AM & PM Evenings (e.g. 6-9 pm)

***Feel free to list any comments or when you can work in order of preference, etc. on the back.***

**CREDENTIALING INFORMATION:**

Do you have your own private mal-practice insurance? ☐ No ☐ Yes

Have you had any mal-practice claims against you in the past 10 years? ☐ No ☐ Yes

If yes, please explain:

School of Medicine: ______________________________

Date of Graduation: ____________________

Dates of Internship: From: ____________________ To: ____________________

Type of Internship: ____________________

Dates of Residency: From: ____________________ To: ____________________

Type of Residency: ____________________

Dates of Fellowship: From: ____________________ To: ____________________

Type of Fellowship: ____________________

Please attach copies of:

- ☐ License for area of expertise
- ☐ Drivers License or other government issued photo ID
- ☐ DEA
- ☐ BLS, ACLS, PAL's or other accreditation

NOTE: Processing your application through the Federal Tort Act Coverage of Free Clinic Volunteer Health Care Professionals may take up to three (3) months. Please be patient. We will let you know as soon as all the information has been returned to us. You can volunteer in other capacities, but cannot see patients alone until this credentialing process is completed if you do not have your own mal-practice insurance.

The information I have provided may be verified, if necessary, by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me, or by conducting a criminal background check. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to support Salem Free Medical Clinic's mission, values and policies and procedures. In signing this agreement I recognize that I am putting myself under the authority of the SFMC Board of Directors and leadership of the clinic.

Signature: ______________________________ Date: ________________

***Please do not submit this document electronically. Mail it to the address located at the top of the application or deliver in person to the clinic.***

# SALEM FREE MEDICAL CLINIC GUIDELINES

*Please review the following general guidelines followed each time the doors of SFMC are open whether it is a health or training clinic. It is expected that each volunteer adhere to these standards.*

**HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) STANDARDS:**
Confidentiality means protecting a patient's privacy and sharing clinic business only with those who have a need to know. The "need to know" is defined as the need to have information to perform your job as a volunteer. Confidential patient information includes, but is not limited to, patient's presence, medical, financial, quality assurance/quality improvement/performance improvement, and risk management data. By signing below you are agreeing to maintain absolute confidentiality of all Salem Free Medical Clinic information. This expectation pertains to patient as well as family member (including children, parents, spouses, siblings) and business arrangement information. Any breach of confidentiality is grounds for corrective action.

*I understand that this means that I will not discuss confidential patient information with others or access this information, including electronic, unless it is required in the performance of my job duties and is the minimum necessary.*

**DRESS CODE:**
SFMC does not have a "dress code" in the sense of mandated attire. We do ask that you dress neat, clean, and with modesty (no short shorts, short skirts or tank tops). One way to judge the appropriateness of your attire is to ask yourself if you can bend, kneel, and move around with easily and with modesty. We require that all volunteers wear a name badge so that everyone can distinguish between our volunteers and patients when there are questions, etc.

**DEPENDABILITY:**
When you sign up to work at the clinic, we depend on your being here. When you are unable to come, we are left short-handed. If you are unable to work at the clinic as you have been scheduled, please make every attempt to find someone to replace you whenever possible. If your position requires specific licensing and certification, you will need to find someone of the same credentialing. If you are unable to find a replacement, please contact your department coordinator as soon as possible so an attempt can be made to find a replacement.

**ATTITUDE:**
Make every attempt to be patient and pleasant, even when the patient is not – we are here to show God's love to each person that steps through our door. So remember to treat patients with dignity, respect, and compassion.

*Thank you for taking time out of your busy schedule to give back to the Salem community.*

I have read the above clinic guidelines. I understand it and agree to comply.

Signature: ____________________________________________ Date: ________________

**PPD SKIN TEST AFFIDAVIT/ HEP B VACCINE**

*This information is confidential*

As part of the Tuberculosis Control Plan at Salem Free Medical Clinic, medical staff members and other credentialed health care professionals who practice here will obtain skin testing for TB every two years. If you have a positive response, an x-ray would take the place of the skin test and should be current within 5 years (and redone every 5 years). Hepatitis B vaccine is also recommended. You must answer the questions below and provide a signature.

☐ I certify that I am PPD skin test (performed within the last two years) **negative** as of ___ ________________ (date performed). I currently have no symptoms of active TB disease.

☐ I certify that I am PPD skin test **positive** and have had (or am currently undergoing) appropriate evaluation and/or treatment for my positive skin test. I currently have no symptoms of active TB disease.

☐ I certify that I have been vaccinated for Hepatitis B. The series was given and completed on ________________________ (date).

______________________________________ ______________________

Signature Date

______________________________________

Printed Name

## Criminal History Screening Consent Form
Staff and Volunteers

**INSTRUCTIONS:**

Please answer all questions on this form. Do not leave any areas blank. If information requested does not apply to you, write "NA" for not applicable or the word "none."

By providing your social security number, we will use it to ensure that we do not misidentify you. Giving your social security number on this form is voluntary. If for any reason we are unable to complete this background check, we may ask you to provide additional means of identification. Your social security number will be used only as stated above. State and federal laws protect the privacy of your records.

**COMPLETE THE FOLLOWING INFORMATION:** (please print clearly)

Print Name: ______________________________________________

Date of Birth (MM/DD/YR): ____________________ Gender: ☐ Female ☐ Male

Social Security/Resident Alien Number (OPT.): _______________ Place of Birth: ________________

Address: ______________________________________________
Street City State Zip

How long have you lived in Oregon (in years)? ______________________________

If less than seven (7) years, list all states where you have previously lived and during which years:_____

______________________________________________

Maiden/all other names previously used: ______________________________

**Authorization to Release Information**
**(Release from Liability and Waiver)**

To any law enforcement agencies, civil records authorities and SFMC: I authorize you to release to SFMC any and all information and civil or criminal records naming me, including all entries where I am named as being arrested, as a suspect, as being cited for any crime, violation, infraction or offense, or as otherwise involved or named in any report by any member agency of your organization.
The information that I have provided is accurate to the best of my knowledge and may be verified, if necessary by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me, or by conducting a criminal background check. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless SFMC and employees and volunteers thereof.

Applicant Signature: ______________________________ Date: _____________