



SALEM FREE MEDICAL CLINIC

P.O. Box 8157, Salem, OR 97303

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: _____

SS#: _____ 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 don't show up, 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 for you or the clinic schedule can be modified to accommodate your absence.

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, and be professional.

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. 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



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AUTHORIZATION FOR RELEASE OF INFORMATION FOR VOLUNTEERS OR EMPLOYMENT PURPOSE

****To be read and signed by every applicant before ordering a consumer report for volunteer or employment purpose****

I hereby authorize West Salem Foursquare Church, and any third party designee to conduct an investigation of my references, criminal conviction record, education, social security number verification, employment record, driving record, and other matters related to my suitability for volunteer work or employment. I further authorize my former employers, schools, credit reporting agencies, governmental agencies, and law enforcement agencies to release such information to you and/or your designee, without restriction or qualification, and without giving me any further notice of such disclosure. In addition, I hereby release West Salem Foursquare Church, its designee, my former employers and all references, from any and all claims, demands or liabilities arising out of or related to such investigation or disclosure.

I understand that I have the right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of any investigative consumer report requested by you.

I have read and understand the above information. I agree by affixing my signature below to these provisions.

Print Name: _____

Address: _____

If less Than seven (7) years, list previous address(s) to cover a seven-year period:

Print Maiden Name (If applicable) _____

Print all aliases: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number: _____

The information above is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____ Date: _____