



Free Medical Clinic Volunteer Application

Thank you for your interest in volunteering at the Free Medical Clinic. We sincerely hope that your experience will be as rewarding for you as we know it will be for those you are helping. **Please note:** All volunteers are asked to submit to a background check and all health care professional licenses will be verified.

Application Instructions

All volunteers must complete a Volunteer Application form and return it to the Free Medical Clinic volunteer coordinator along with a signed CFMC Volunteer Agreement, Confidentiality Agreement, Model Release form, and WSP background check form.

Please note that completion and return of the Volunteer Application to the volunteer coordinator does not guarantee acceptance into the volunteer program. All applications will be reviewed, verified and kept on file.

Contact Information

Name: _____

Professional Title: _____

License/Certification (please include state issued, license number and expiration date):

Street Address: _____

City, ST. Zip code: _____

Home phone: _____

Cell phone: _____

Employer: _____

Employer Address: _____

Work phone number: _____

Preferred e-mail address: _____

Availability

During which hours are you available for volunteer assignments? Please note that at this time clinic hours are

Wednesday evenings from 5:00 – 9:00pm. Thursday afternoon from 2:00pm – 6:00pm

Weekday mornings Weekend mornings

Weekday afternoons Weekend afternoons

Weekday evenings Weekend evenings

Weekly

Bi-weekly (every other week)

Monthly (once a month)

Bi-monthly (every other month)

Quarterly (once every three months)

As schedule permits

Availability Schedule comments: _____

Emergency Contact Information

Please provide the following information for the person you would like us to contact in case of an emergency:

Name: _____

Relationship: _____

Street Address: _____

City, ST, Zip code: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Agreement & 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 will result in immediate termination of volunteer service.

Name (printed): _____

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 orientation, age, or disability.

Thank you for completing this application form and for your interest in volunteering at the Cowlitz Free Medical Clinic.

Please mail the completed application, attention Volunteer Coordinator, to:

**Community Health Partners
Free Medical Clinic
P.O. Box 2853
Longview, WA 98632**

**Or return in person to the Volunteer Coordinator (Susan Wendel) during
clinic sessions at:**

**Free Medical Clinic
1230 7th Avenue
Longview, WA 98632
360-442-4165**



Community Health Partners

Free Medical Clinic Volunteer Agreement

Thank you for your interest in volunteering at the Free Medical Clinic. 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 the Free Medical Clinic I agree to:

- ❖ Report on time for my scheduled shift.
- ❖ Notify the volunteer coordinator 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 at 442-4165 as soon as you know that you cannot work a scheduled shift.)
- ❖ Comply with all Free Clinic policies, protocols, procedures, and objectives.
- ❖ Respect all Free Medical Clinic staff and fellow volunteers.
- ❖ Respect and maintain confidentiality in regard to all personal and medical information of patients at The Free Medical Clinic.
- ❖ Provide health care services with courtesy and respect to all patients and their family members.
- ❖ Report any incidents, concerns, or disputes to the proper Free Clinic staff.

The Free Medical Clinic agrees to:

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

The Free Medical Clinic 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: _____



Community Health Partners

Free Medical Clinic 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 Community Health Partners/Free Medical Clinic 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 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: _____



Community Health Partners

Free Medical Clinic Volunteer Release Form for Media Recording

I, the undersigned, do hereby grant or deny permission for the **Community Health Partners/Free Medical Clinic** to use my image as defined by my choices below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of me for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the **Community Health Partners/Free Medical Clinic** Web site. Printed materials may also include a written story which references my name and personal quotes which I may have provided during an interview for such purpose.

Deny permission to use my image at all.

Grant permission to use my image in the following ways (mark all that apply):

Limited usage: I want my image used within the **Community Health Partners/Free Medical Clinic** setting only (not in the larger community).

Limited usage: I want my image used for educational materials only (not marketing). This could be either within the **Community Health Partners/Free Medical Clinic** or in the larger community.

Limited usage: I want my image used on printed materials only (no digital or video use).

Unrestricted usage: I give unrestricted permission for my image to be used in print, video, digital and online (i.e. CFMC Website and Facebook page) media. I agree that these images may be used by the **Community Health Partners/Free Medical Clinic** for a variety of purposes and that these images may be used without further notifying me. I do understand that my last name will not be used in conjunction with any video or digital images.

Signature _____ Date _____

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845
(Instructions on Reverse Side)

<p>(A) REQUESTING AGENCY/ADDRESS Cowlitz Free Medical Clinic</p> <p>Agency Susan Wendel</p> <p>Attn P.O. Box 2853</p> <p>Address Longview, WA 98632</p> <p>City/State/Zip</p> <p>I certify this request is made pursuant to and for the purpose indicated.</p> <p>Authorized Signature _____ Date _____ ()</p> <p>Title _____ Area Code/Phone Number _____</p>	<p>(B) PURPOSE Check appropriate box</p> <p><input type="checkbox"/> Educational School District (ESD)/School District Volunteer - no fee</p> <p><input checked="" type="checkbox"/> Non-Profit Business/Organization - no fee (Excluding Schools & ESD's)</p> <p><input type="checkbox"/> Profit Business/Organization - \$35</p> <p><input type="checkbox"/> Adoptive Parent - \$35</p> <p>Fees: Make payable to Washington State Patrol by check, money order, or business account.</p> <p>Notary letters certifying the results are available upon request. There is an additional \$5.00 processing fee per notary seal. _____ Notarized Letter(s)</p>
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Fill Out

(C) APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name(s): _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Social Security Number: _____ Driver's Lic. Number/State: _____ / _____

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

Fill Out

(D) WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Cowlitz Free Medical Clinic,
Requesting Agency

Applicant's Signature _____

Applicant's Name _____

Address _____

City/State/Zip _____

WSP Use Only

Applicant Right Thumb Print (Optional)