Community Health Partners

# 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:_____

_____

_____

_____

**Volunteer Assignments**
Please check the position(s) that you are interested in. Please note that some positions require an active license.

◯Pharmacist
◯Health Care Provider (MD, DO, NP,FNP, PA-C or ARNP)
◯Clinic Assistant (CNA or MA)
◯Pharmacy Technician
◯Nurse (RN or LPN)
◯Laboratory Technician
◯Translators
◯Front Office Assistant

**Special Skills or Qualifications**
Please summarize any special skills or qualifications you may have acquired from employment, previous volunteer service, or through other activities, including hobbies. _____
_____
_____
_____
_____
_____
_____
_____
_____

**Previous Volunteer Experience**
Please list any previous volunteer experiences and your job responsibilities.
_____
_____
_____
_____
_____
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_____
_____

**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**
**945 Washington Way Suite 141**
**Longview, WA 98632**
**360-442-4165**


# 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: _____

**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: _____


## 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)

**(A) REQUESTING AGENCY/ADDRESS**

Cowlitz Free Medical Clinic
Agency

Susan Wendel
Attn

P.O. Box 2853
Address

Longview, WA 98632
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature Date

Title ( ) Area Code/Phone Number

**(B) PURPOSE**

**Check appropriate box**

- ☐ Educational School District (ESD)/School District Volunteer – no fee
- ☒ Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $35
- ☐ Adoptive Parent - $35

**Fees:** Make payable to **Washington State Patrol** by check, money order, or business account.

**Notary letters certifying the results are available upon request. There is an additional $5.00 processing fee per notary seal.**
**_____ Notarized Letter(s)**

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

Fill out

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.**

**(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

Fill Out

WSP Use Only

Applicant Right Thumb Print (Optional)

3000-240-430 (Rev. 10/05)