Community of Hope Health Clinic Volunteer Application

Date: ____________________

Volunteer Information

Full Name: ____DOB: ___________________

Preferred Name: ____

Address:____

City: _____________________________________State: _______ Zip: ________________

Cell Number: (_________)_______________ Email: ________________________________

Emergency Contact

Name: _____________________________________ Relationship: __________________

Emergency Contact Phone Number: ____

Clinic Position Applying for: (please select all that apply)

☐ Triage ☐ Interpreter ☐ Reception ☐ Scribe ☐ General

☐ Medical Provider: (please select credential if applicable)

☐ MD ☐ DO ☐ PA ☐ CRNP

How did you hear about CHHC? _________________________________

This application is indented to give a better understanding of your background and experience. Volunteers will not be turned away due to lack of experience.

Clinic Schedule Availability: **(please select all that apply)**

☐ **Monday Clinic AM** ☐ **Tuesday Clinic AM** ☐ **Thursday Office AM** ☐ **Wednesday Office AM**

☐ **Monday Clinic PM** ☐ **Tuesday Office PM** ☐ **Thursday Clinic PM** ☐ **Friday Office AM**

Time and Frequency of Availability: **(please select all that apply)**

☐ **Weekly** ☐ **Semiweekly** ☐ **Monthly** ☐ **Other: ____________________________**

Past Volunteer Experience **(include organization, position, supervisor contact)**

____

____

Employment History **(include most recent, position, supervisor contact)**

____

____

Education/ Credentials: ____

Are you fluent in Spanish? ☐ **YES** ☐ **NO**

Why are you interested in volunteering with the clinic?

____

____

What are your interest and skills?

____

____

References **(include name, address, and phone or email of three non-family members)**

(1) ____

(2)____

(3)____

Volunteer Agreement Form

The volunteer agreement is indented to ensure an understanding among volunteer managers and volunteers regarding responsibilities and organizing policies and procedures.

Volunteer

I, ____________________________________ agree to serve as a volunteer and commit:

Volunteer Name

1. **To perform volunteer duties to the best of my ability.**
2. **To follow agency rules, policies, and procedure; including, recording keeping requirements and confidentiality of agency and client information.**
3. **To meet time and duty commitments or to provide adequate notice so that alternate arrangements can be made.**

Agency

We, Community of Hope Health Clinic, agree to accept the services of

____ beginning ______________________

Volunteer Name Date

And we commit:

1. **To provide accurate information, training, and assistance.**
2. **To ensure supervision and provide job assessment and feedback.**
3. **To respect the skills and individual needs of the volunteer.**

Agreed To:

_________________________ ___________________________ ________________

Volunteer Signature Staff Representative Date

Volunteer Non-Discriminatory Agreement Form

- **I agree to provide considerate and respectful care for any consumer of the CHHC without prejudice or discrimination. I agree to provide services in a non-judgmental manner without regard to sexual orientation, sexual identity, gender, race/ethnicity, religion, physical capabilities, educational level, political opinion, residential or socio-economic status.**
- **I agree to be receptive to constructive suggestions and supervisions. I agree to bring any problems that may arise in the course of my volunteer service directly to the appropriate staff for resolution.**
- **I agree to abstain from using mind altering substances or alcohol when performing duties for the CHHC.**
- **I agree to fulfill my specific volunteer responsibilities to the best of my ability.**

Print Name: ____Date: ___________________

Volunteer Signature: ____

Staff Representative: _____________________________________Date: ___________________

Staff Signature: ____

Volunteer Confidentiality Agreement

I, ____, agree to serve as a volunteer with the Community of Hope Health Clinic (CHHC). As a volunteer, I will assist the clinic and its staff members in providing clients and their caregivers with information and services.

In providing volunteer services, I understand that I represent the CHHC and am bound to keep all conversations and communications among myself and staff (full-time, part-time, and volunteers). In addition, communications among clients and myself should remain strictly private and confidential.

I agree to adhere to the Community of Hope Health Clinic's (CHHC) Confidentiality Policy which states that I will not discuss or acknowledge any identifying factors regarding the CHHC consumers, including those receiving medical care/treatment

I agree to provide the Community of Hope Health Clinic (CHHC) with proper documentation of HIPAA compliance or obtain training and documentation within six (6) months of volunteer start date.

I further agree to provide volunteer services without compensation, reimbursement, financial remuneration of any kind. I will not use any client information for my personal gain.

Volunteer Signature: ____________________________________ Date: ___________________

Staff Representative: ____________________________________Date: ___________________

Staff Signature: ____

Consent to Photograph

I authorize the Community of Hope Health Clinic permission to take my photograph and to use it as the organization chooses; such as, for publicity or advertising.

Print Name: ____Date: ___________________

Volunteer Signature: ____

Staff Representative: _____________________________________Date: ___________________

Staff Signature: ____