COMMUNITY OF HOPE HEALTH CLINIC

CHHC

Volunteers in Medicine

VOLUNTEER APPLICATION

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____ **EMAIL** _____

EMERGENCY CONTACT _____ **PHONE** _____

PAST VOLUNTEER EXPERIENCE (include organization/ agency, position, supervisor)

_____

_____

EMPLOYMENT (include most recent, position, supervisor contact) _____

_____

EDUCATION / CREDENTIALS _____

Why do you want to volunteer with the clinic? _____

_____

Times and frequency of availability (e.g., weekly, semi weekly monthly) _____

_____

CLINIC SCHEDULE MONDAY 8:00am—12:00pm, TUESDAY 8:00am—12:00pm,

THURSDAY NIGHT 5:00pm—8:30pm Other times are available for office work and new patient intake.

What are your interests and skills? _____

REFERENCES: Name address and phone or email of three non-family members.

1 _____

2 _____

3 _____

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Volunteer Agreement

The volunteer agreement is intended to ensure an understanding between volunteer managers and volunteers regarding volunteer responsibilities and organization policies and procedures.

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

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 procedures, including recordkeeping requirements and confidentiality of agency and client information
3. To meet time an duty commitments or to provide adequate notice so that alternate arrangements can be made

Agreed to:

_____ _____
Volunteer Staff Representative

_____ _____
Date Date

COMMUNITY OF HOPE HEALTH CLINIC

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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/communications between myself and staff (full-time, part-time and volunteer) and communications between clients and myself strictly private and confidential.

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

_____

Signature

_____

Date

COMMUNITY OF HOPE HEALTH CLINIC

CHHC

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Consent to Photograph

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

Signed _____

Date_____