Office Use Only

Volunteer Application

Date: _____ **DOB** _____

Name: _____

Address: _____ **City**_____ **State**_____ **Zip**_____

Phone # (CELL) _____-____-_____ (HOME) _____-_____-_____ (WORK) _____-_____-_____
Email Address: _____

Reference Information:

Currently employed at**:** _____ How long: _____
Description of job responsibilities: _____

Please Check All Job Skills That May Be Valuable in Your Work at CHFHC:

____Computer (Microsoft)
____Computer (General)
____Copier/Phone/Fax/Scan
____Public Relations
____Interview Skills
____Lab/Venipuncture
____Sterilization procedures
____Pharmacy Technician
____Pharmacist

____ Filing
_____ Housekeeping
_____ Maintenance
_____ IT/ Experience with EMR systems
_____ WEB Design
_____ Willingness to serve on a committee
_____ EKG experience
_____ CNA/PCT experience
_____Any additional talents/skills

I would be available to work in the Clinic:
____Weekly ____ Bi weekly ____Monthly ____Every 4-6 weeks ____Every 2 months
____I would be available more frequently_____
____I could be called as a last-minute fill in_____

Please answer the following questions: (N/A if it does not apply)

1. Has any professional license, certificate, registration or permit you hold or have held been disciplined, or are formal charges pending in any state? Yes ___ No ___
   If yes, explain: _____
   _____
2. Except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled no contest to any offense, misdemeanor, or felony in any state? Yes____ No_____
   If yes, explain: _____
3. Have you had a malpractice judgement against you or settled any malpractice action? Yes____ No___
   If yes, explain: _____

4. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a health care professional? Yes____ No___ If yes, explain_____
   _____

5. Have you ever been excluded from being a Medicare or Medicaid provider? Yes _____ No_____

6. Have you ever had a background check? Yes ____No____ Where_____When_____

Please list 2 names and addresses for professional references:

*All information will be kept confidential *references cannot be close family relations

1. Name: _____
Address: _____
Phone #: Cell_____Home_____Work_____
Relationship to Volunteer_____

2. Name: _____
Address: _____
Phone #: Cell_____Home_____Work_____
Relationship to Volunteer_____

Q: How did you hear about CHFHC? _____
Q: What do you hope to accomplish by volunteering here? _____
Q: Have you ever volunteered for another non-profit organization? _____
Q: Do you have a church home, or not really?_____

Statement of Ethics and confidentiality:

I understand that as a volunteer of Community of Hope Free Health Clinic that all information regarding our clients, services received, eligibility status, financial information and any other aspects of patient care are STRICTLY CONFIDENTIAL and are never to be discussed outside of our clinic either with friends, family or co-workers. I further understand that even within the confines of the clinic, that caution must be taken to protect privileged information and client confidentiality at all times. Patient information is never to be released verbally or in writing without express written permission by the patient, specifically identifying to which information may be disclosed.

Volunteer signature: _____ Date: _____

Revised 11/19; Reviewed 4/23; Revised 5/24