HOUSTON COUNTY VOLUNTEER
Medical Clinic
Serving the Working Uninsured

125 Russell Parkway – Warner Robins, GA – 31088
Phone: (478) 923-9730 – Email: coordinator@hcvmc.org

Dear Prospective Volunteer:

Thank you for your interest in volunteering at Houston County Volunteer Medical Clinic!

The Houston County Volunteer Medical Clinic or HCVMC is a non-profit organization that provides free healthcare to working, uninsured residents of Houston County, Georgia.

Please complete and return the attached volunteer application. Upon return of the application we will need to obtain a copy of your government issued ID. If you wish to volunteer in a clinical capacity, attach a copy of your clinical license as well.

Your application will be processed within three (3) working days. You will receive a call back from our clinic in regards to your application.

Should you have any questions about the application, feel free to contact us 923-9730 or coordinator@hcvmc.org.

Sincerely,
Pat Butler
HCVMC Clinic Administrator

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VOLUNTEER APPLICATION

Name: _____
Address: _____
City _____ State _____ Zip _____

Primary Contact Phone Number: _____
Secondary Contact Phone Number: _____

Email address: _____

Occupation: _____
Employer: _____
Work Phone Number: _____

Emergency Contact Name/Phone: _____

Do you have any medical problems or allergies we should be made aware of?

_____

Please check the box below that best describes the area you describe to volunteer:

Licensed/Clinical volunteers:

____ Physician – Specialty _____
____ Physician Assistant
____ Pharmacist
____ Pharmacy Technician
____ PCT/CNA/Medical Technician
____ Other medical professional: _____
____ Nurse Practitioner
____ Registered Nurse
____ Licensed Practical Nurse
____ Nursing Students

General Administrative volunteers

____ Clerical Work
____ Medical Records
____ Information Technology
____ Data Entry
____ Marketing
____ Accounting
____ Fundraising
____ General help

____ **High school Student**

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VOLUNTEER APPLICATION PAGE 2

Please check all that apply. I can work:

_____ Full time _____ One day per week _____ Two days per week
_____ One day per month _____ as needed

Have you ever been convicted of a felony? Yes or No

Clinical Volunteers:
Have you ever been required by a licensing board or professional body to surrender your license, or have you ever been found guilty of professional ethic codes, professional misconduct, incompetence, or negligence, in any state or country? Yes or No If yes, explain:

_____

Clinical volunteers – please include a copy of your Georgia clinical license or certification. By signing below you authorize HCVMC to verify your professional license.

Volunteer Agreement:
I understand that HCVMC Executive Director or Medical Director reserves the right to terminate my volunteer status as a result of: a) failure to comply with the clinic policies, rules, and regulations, b) unsatisfactory attitude, work, and/or appearance, c) any other circumstances, which in the judge of HCVMC staff would make my continued service as a volunteer contrary to the best interests of the clinic.

I understand I am required to provide documentation of a yearly flu immunization (or one will be administered to me at HCVMC.)

I have read each of the above conditions and agree to be bound by them. I certify that the information I have given is complete, true, and correct to the best of knowledge and belief. I further affirm that I have not knowingly withheld any facts or circumstances in completing this application.

_____ _____
Signature Date

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Volunteer Confidentiality Statement

As a volunteer for Houston County Volunteer Medical Clinic:

1. I agree to maintain the confidentiality of patient information. Information about the patient's condition or personal affairs will not be discussed in the entry area, hallways, or other public areas in the Clinic or elsewhere where conversation might be overheard. I shall also refrain from discussing patients by name outside of the Clinic setting.

2. I agree to insure confidentiality of patients' records and/or charts by allowing only Health Care Providers access to out-of-file records.

3. I agree to withhold information about a patients' condition from relatives and friends unless authorization for release is provided by the patient.

4. I agree to use only the patient medical record numbers for the purpose of written counseling or problem coaching agreements given to volunteers.

5. I understand that violations of patient or clinic record confidentiality will result in disciplinary procedures, which may include my release from service.

Print Name _____

Signature _____

Date _____

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PHOTO RELEASE FORM

HOUSTON COUNTY VOLUNTEER MEDICAL CLINIC

I hereby grant the HOUSTON COUNTY VOLUNTEER MEDICAL CLINIC permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications and social media without payment or other consideration.

I understand and agree that all photos will become the property of the HOUSTON COUNTY VOLUNTEER MEDICAL CLINIC.

I HAVE READ AND UNDERSTAND THE ABOVE PHIOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

_____
Printed Name

_____ _____
Signature Date

If under 18, BOTH PARENTS MUST SIGN

_____ _____
Individually and as Parent and/ Date
Legal Guardian

_____ _____
Individually and as Parent and/ Date
Legal Guardian

Updated 02/21/2018

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HCVMC CHECKLIST FOR VOLUNTEER APPLICATION PROCESSING

HCVMC OFFICE USE ONLY

____ Completed application received

____ Copy of government issued ID

____ Copy of flu immunization (required when volunteering October – March)

Clinical personnel IN ADDITION to the above listed:

____ Clinical License
____ Verified license

Volunteer application processed by: _____
Signature and Date

Volunteer application approved by: _____
Signature and Date

Volunteer contacted by: _____
Signature and Date