Volunteer Application

Grace Clinic of Yadkin Valley
Phone 336-835-1467 - Fax 336-835-1469

HRC/GRACE CLINIC APPLICATION

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 Grace Clinic volunteer coordinator along with a signed 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. Thank you for your interest in being a volunteer for the Grace Clinic.

Please fill out the following information for our files.

Name:_____

Professional Title:_____

License/Certification (please include state issued, license number and expiration date): _____
_____

Street Address: _____ City, ST. Zip code: _____

Home phone: _____ Cell phone: _____

Preferred e-mail address: _____

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: _____Cell phone: _____

VOLUNTEER ASSIGNMENTS

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

_ Registration Clerk (Front Desk)
_ Waiting Room Assistant
_ Pharmacy (MARP Program)
_ Health Care Provider (MD, NP, FNP, PA-C)
_ Clinic Assistant
_ Pharmacy Technician
_ Nurse (RN or LPN)
_ Medical Laboratory Technician
_ Translators
_ Phlebotomy
_ Medical Records
_ Maintenance
_HRC Office
_Eligibility Interviewer

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.

Computer skills ☐Yes ☐No

Foreign Language _____

AVAILABILITY

During which hours are you available for volunteer assignments?

Please note that at this time clinic hours are Monday, Tuesday, Thursday from 8:30 am-5:30 pm
Tuesday evenings from 5:30 pm – appx. 8:00 pm

There are, however, tasks that can be done on non-clinic days.

☐Monday morning ☐Monday afternoon
☐Tuesday morning ☐Tuesday afternoon
☐Thursday morning ☐Thursday afternoon
☐Tuesday evening clinic
Other: _____

Availability Schedule comments:_____
_____
_____

VOLUNTEER PLEDGE

I _____ agree to:
PRINT COMPLETE NAME

- I will be conscientious in carrying out my duties and will accept supervision.
- I will conduct myself in a dignified, courteous, caring, and Christian manner.
- I will strive to make my work of the highest quality in an effort to improve the lives of others.
- I will take my suggestions, criticism, or problems to the Executive Director.
- I will consider all information which I may hear absolutely CONFIDENTIAL, and I will not seek information in regard to a patient or client.
- I will try my best to always be kind to all and to always share God's Love.

Signature: _____ Date: _____

CONFIDENTIALITY HRC/GRACE CLINIC

Confidentiality Statement for Persons Accessing Electronic Information Including but Not Limited to: Financial Records/Information—Payroll/Personal Information—Systems Applications—Patient Medical Records—All Other Computerized Applications and Data

I _____ agree to:

PRINT COMPLETE NAME

- I will keep confidential information I have access to in client/patient medical records while employed by or volunteering at Grace Clinic of Yadkin Valley;
- I will not divulge any of that information to anyone outside the clinic;
- I will not use the information for any other purpose than the collection of specified data for Grace Clinic;
- I will not access any other information from electronic systems other than that of required projects approved by the Executive Director;
- I will ensure that I keep secure the records and information extracted from electronic systems while they are in my possession;
- I will ensure that any waste paper I generate while accessing systems and recording information required will be destroyed in a manner which is permanent and which ensures confidentiality, e.g. by shredding.

Signature: _____ Date: _____

SUBSTANCE ABUSE POLICY ACKNOWLEDGEMENT HRC/GRACE CLINIC

I _____ agree to:

PRINT COMPLETE NAME

- To support our mission statement, volunteers should be free of illegal substances and abusive use of prescription drugs.
- I affirm that I do not currently engage in the illegal use of non-prescription drugs or abuse of prescription drugs.
- As a volunteer for Grace Clinic, I agree to voluntarily give body fluid samples should my supervisor so request. I understand that refusal to provide samples when requested will be interpreted as indicative of drug use and may make me subject to immediate discharge from my volunteer status.
-

Signature: _____ Date: _____

GRACE CLINIC
ANNUAL TB SCREENING

Please complete this form. Per TB Control Policy if TB Screening Form is not completed you will not be able to work until the form is completed and returned.

Name: _____

Do you have any of the following symptoms? ***Check the answers to the following questions:***	
A productive cough lasting more than 3 weeks?	☐Yes ☐No
Coughing up bloody sputum?	☐Yes ☐No
Unexplained weight loss?	☐Yes ☐No
Unexplained appetite loss?	☐Yes ☐No
Unexplained fever?	☐Yes ☐No
Unexplained night sweats?	☐Yes ☐No
Shortness of breath?	☐Yes ☐No
Chest pain?	☐Yes ☐No
Increased fatigue?	☐Yes ☐No
Have you been exposed to anyone who has or has had active TB in the past year?	☐Yes ☐No

The above health statement is accurate to the best of my knowledge. If my health status changes I will notify the Clinical Services Manager as soon as possible.

_____

(Volunteer/Employee Signature) Date

This part to be completed by Quality Assurance RN
The above review by the Clinic Manager with the following recommendations:

_____ No interventions required, repeat screening tool in one year.

_____ Chest x-ray related to unexplained signs/symptoms reported by employee.

_____ Referral made to the Health Department (in county of residence).

_____ _____

Quality Assurance RN Date

GRACE CLINIC OF YADKIN VALLEY

GRACE CLINIC

VOLUNTARY LATEX ALLERGY HISTORY

Name: _____ Date: _____

(PLEASE PRINT)

Have you ever been told by a doctor that you were allergic to latex: __Yes __No
Do your lips swell or itch after you blow up a balloon or having dental work?
Do you have swelling and/or itching after rectal or vaginal exams?

Have you ever had a reaction (swelling, rash, runny nose, itching of hands or eyes, hives, or difficulty breathing) after being in contact with any of the following? (Please check all that apply.)

__balloons	__rubber gloves	__rubber bands
__foam pillows	__elastic in underwear	__elastic waistbands
__erasers	__ace bandages	__dental dam
__condoms	__diaphragms	__powder in gloves

__none

Have you had exzema or rashes on your hands? __Yes __No
Do you have any congenial abnormalities such as spina bifita, myeloma, or myelodysplasia? __Yes __No
Have you had multiple surgeries before you were 1-year-old? __Yes __No

Are you allergic to any of the following foods: (check all that apply)

__Bananas	__Chestnuts	__ Kiwi Fruit
__Avocados	__Macadamia Nuts	__Papaya

Do you have asthma? __Yes __No

Do you have chronic respiratory problems? __Yes __No If yes, what?_____

Comments:_____
_____

Signature: _____ Date: _____

Hepatitis B Vaccinations

Confidential

Informed Refusal for Hepatitis B Vaccination

I, _____, am employed by/volunteer as a health care practitioner at Grace Clinic. I am aware and understand the effectiveness of Hepatitis B immunization, the risk of contracting Hepatitis B, and the importance of taking active prevention to reduce the risk.

_____However, I, of my own free will and volitions, and despite the Clinic's urging, have elected not to be vaccinated against Hepatitis B. I have personal reasons for making the decision not to be vaccinated.

Or

_____I have received Hepatitis's B Vaccination in the past and I will bring the supporting documentation

Or

_____I have received Hepatitis's B Vaccination in the past but unable to produce supporting documentation of immunization and I do not wish for any further intervention at this time.

_____ _____

Employee/Volunteer Signature **Date**

_____

Printed name

Address:

_____

_____

_____

Witness Signature

I have read and understand the purpose of the Grace Clinic Incident Report.

Signature _____ Date_____

GRACE CLINIC INCIDENT REPORT

_____ Date _____Department

Individual initiating Report _____

Name

☐ Patient Encounter ☐ Transcription Error ☐ Distributing Error ☐ Charting Error

☐ Accident ☐ Injury ☐ Medical treatment offered ☐ OSHA Violation

☐ Other: _____

Name of person involved_____

Chart/File # _____ Date of Incident _____

(If applicable)

Thoroughly describe the incident. Include all pertinent information and date(s) attach all relevant documentation:

_____

_____

_____

_____

_____

List all actions taken to correct the incident and date(s):

_____

_____

_____

_____

_____

Give brief description of actions taken to prevent recurrence of incident:

_____

_____

_____

_____ _____

Signature of person submitting report **Date**

_____ _____

Signature of Dept./Program Manager **Date**

_____ _____

Signature of Executive Director **Date**

Volunteer/Employment Background Check Release

Our Region's CHOICE for TECHNOLOGY & CARE

I hereby authorize **Hugh Chatham Memorial Hospital** to obtain any and all information that pertains to my eligibility for employment and/or volunteer work or student affiliation. This information will include, but is not limited to, arrest and/or criminal records, credit history, driver/motor vehicle abstract, employment verification, education verification and social security number verification. I also understand that the information below regarding sex, race and date of birth is requested for the sole purpose of gathering the above information correctly, and will not be used to discriminate against me in violation of any law.

I hereby authorize without reservation, any party or agency to furnish the above-mentioned information. I further authorize the procurement of the above-mentioned reports at *any time* during my employment or contract.

Please Print the Following Information Clearly

Personal Information (List ALL names used- Maiden, Previous Married Names, Alias ect)

Last First Middle

Name _____ _____ _____

Name _____ _____ _____

Name _____ _____ _____

Have you lived in NC for the past five consecutive years? _____ (Yes or No)

Did you receive a copy of the Summary of Your Rights under the FCRA? _____ (Yes or No)

Current Street Address _____ City _____ State _____

Zip _____ Phone _____ SSN _____ Date of Birth _____

Sex _____ Race _____

Drivers License Number _____ State Issued _____ Expires _____

I state that the information provided is accurate to the best of my knowledge. I also understand that information about my background may contain negative information about my character and style of living. My signature releases any liability against **Hugh Chatham Memorial Hospital** or its acting agents. A photo or fax copy of this release form will be valid as an original thereof, even though said copy does not contain an original writing of my signature.

Signature _____Date: _____

Manager Requesting Signature _____Date: _____

NOTICE AND DISCLOSURE REGARDING CONSUMER REPORTS

(INCLUDING INVESTIGATIVE CONSUMER REPORTS)

AND AUTHORIZATION

I understand that ***Hugh Chatham Memorial Hospital*** may obtain a consumer report about me when making employment-related decisions such as hiring, reassessment, promotion, retention, rehiring and other related decisions.

I understand that a consumer report may consist of any information gathered by a consumer reporting agency which bears on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living. It may be an "investigative consumer report" in which information about my character, general reputation, personal characteristics, or mode of living may be gathered through personal interviews with many people, including my relatives, friends, co-workers, and associates. In particular the report may include arrest and/or criminal records, credit history, driver/motor vehicle abstract, employment verification, education verification and social security number verification.

I understand that if an "investigative consumer report" is obtained, I have the right to make a written request within a reasonable period of time for disclosure of information about the nature and scope of this investigation and to receive a written summary of my rights under the Fair Credit Reporting Act.

I, _____, hereby authorize Hugh Chatham Memorial Hospital to obtain a report on my background as stated above from a consumer reporting agency

_____ _____

Name **Date**