Volunteer Application

Name _____

Date _____ Birthday _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Email _____

THIS SECTION FOR MEDICAL PROFESSIONALS ONLY:

What medical license/certifications do you have, if any?

_____

License No:_____

DEA No:_____

NPI No:_____

PLEASE ATTACH A COPY OF YOUR LICENSE TO THIS APPLICATION.

Current or previous volunteer experience_____

_____

Reason you would like to volunteer_____

_____

The clinic offers a variety of services several times a week and usually lasts several hours each time. What type of volunteer commitment are you looking to make to the clinic? Examples: weekly, biweekly, monthly, 10 hours each month, etc.

_____

Are you interested in volunteering and helping our clinic outside of clinic days? (Please Circle) Yes No

Print name_____

Signature_____

Volunteer Confidentiality Statement

Due to the nature of information available through the Helping Hands Health and Wellness Center, it is imperative that each staff member, whether paid or unpaid, understands and is committed to the issue of confidentiality.

As a volunteer of the Helping Hands Health and Wellness Center, I agree to respect and maintain the confidentiality of all information, whether written or verbal, which pertains to the services provided by the Helping Hands Health and Wellness Center and to make no voluntary disclosure of such information except to persons authorized to obtain it. I will not discuss or distribute any information pertaining to patient, donor, volunteer, Board, or staff information without the express written consent of the Executive Director or other appropriate authority.

If I encounter a patient outside of the clinic, I agree not to acknowledge the patient unless first acknowledged by the patient. At no time will I acknowledge to anyone that I know the patient from the clinic. **Failure to comply with this policy may result in termination.**

Signature of Volunteer _____ Date _____

Print Name _____

Photo Release Form

From time to time, during clinic days and events, Helping Hands Health and Wellness Center will take photographs for publication in promotional materials.

By signing this form I agree to the following:

> Helping Hands Health and Wellness Center has permission to use and publish the photographs made of me.
>
> I hereby release Helping Hands Health and Wellness Center from any and all liability from use and publication of photographs. In addition, the clinic is not liable for any damages resulting from the broadcast or publication of such materials.
>
> I authorize the reproduction, illustration, and broadcast of photographs, web broadcast, electronic storage, or distribution of said materials at the discretion of Helping Hands Health and Wellness Center.

Signature_____Date_____

Emergency Medical Release & Liability Waiver

Name _____ Date of Birth _____

Address _____ City, State _____ Zip Code _____

Emergency Contact Information:

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Allergies_____

Other Medical Conditions_____

Physician _____ Phone # _____

Are you covered by group or medical insurance? (Please Circle) Yes No

Medical/Hospital Insurance Company _____

Policy Holder's Name _____ Policy #_____

Liability Release: I certify that the information described above is accurate and complete to the best of my knowledge. I hereby release Helping Hands Health and Wellness Center, and any designated individual in charge from any legal or financial responsibility with respect to my personal participation in or contact with any known element associated with Helping Hands Health and Wellness Center.

Signature _____ Date_____

Consent for Medical Treatment: I hereby give my consent to any approved staff member of Helping Hands Health and Wellness Center to authorize medical treatment.

Signature _____ Date_____