Moab Free Health Clinic
Your Gateway to Community Health Resources

Volunteer Application

Today's date:_____ Date of birth:_____

Last Name:_____ First:_____ Middle Initial:_____

Mailing Address:_____

City: _____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Licenses/ certifications:_____

Are you employed? (check one) NO ☐ YES ☐

Employer/ Previous Employer:_____

Have you ever volunteered anywhere else? (check one) NO ☐ YES ☐

If yes, where and for how long?_____

_____

_____

Do you speak any foreign languages? (check one) NO ☐ YES ☐

Language:_____ Skill Level:_____Language:_____ Skill Level:_____

Have you ever been convicted of a crime (felony or misdemeanor)? (check one) NO ☐ YES ☐

If yes, please explain:_____

_____

When are you available to work?

Mon:_____ Thurs:_____

Tues:_____ Fri:_____

Weds:_____ Sat: _____

Total hours you would like to volunteer:_____ per_____

What are your volunteer interests?_____

_____

Please complete both sides of application

Please provide two references (personal or professional):

Name:_____ Phone Number:_____

City:_____ State:_____ How long have you known this person?_____

Name:_____ Phone Number:_____

City:_____ State:_____ How long have you known this person?_____

Emergency Contact Name:_____ **Phone:**_____

Do you have any medical conditions or limitations that might affect your ability to perform volunteer duties?

_____

_____

Please read the following statements and sign below.
I understand and agree to abide by the following confidentiality statement:

> I shall hold in confidence all pertinent information. I shall not violate the confidential relationship between the Moab Free Health Clinic and its patients, donors, staff, volunteers, and any other party. I will not remove any written record from the Moab Free Health Clinic without expressed written permission, and I will not discuss patient or any other sensitive information with anyone, expect in the performance of my duties with the Moab Free Health Clinic.
>
> I will accept full responsibility for my actions in maintaining the confidential and privileged nature of all records and information. I also understand that disclosing information will result in immediate action up to and including dismissal from my position.

I certify that all statements herein on this information sheet are true and correct and have been given voluntarily. I understand that this information may be shared with any legal and proper interest, and I release the agency from any liability whatsoever for supplying such information. . I agree to abide by the Moab Free Health Clinic's policies and procedures. I also understand and agree to abide by all OSHA guidelines for workplace safety.

_____ _____
Volunteer Signature Date

_____ _____
Volunteer Coordinator Date

For office use:
Submitted
□ Photo ID □ Copy of Medical License, as applicable
□ State Controlled Substance License, as applicable □ DEA License, as applicable
Signed:
□ Volunteer Handbook □ HIPPA □ Credentials, as applicable

Moab Free Health Clinic
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Medical Volunteer Credentialing Form

Name:_____ Date of Birth:_____

Credentialing Information

Professional designation (MD, RN, EMT, etc.): _____

Specialty:_____

Board Certifications:_____

License Number:_____ DEA Number:_____

License State:_____

Please describe **any** medical malpractice claims within the last 10 years:

(1) Allegation: _____

Action taken:_____

(2) Allegation:_____

Action Taken:_____

Relevant Education

Institution:_____

Degree:_____ Year Graduated:_____

Institution:_____

Degree:_____ Year Graduated:_____

I certify that the above statements are correct and have been given voluntarily. I permit the Moab Free Health Clinic and its staff or volunteers to share this information in any legal and proper interest. I release the agency from any liability whatsoever for supplying such information. I understand that this information will be used to credential me for coverage under the Federal Tort Claims Act (FTCA) through the National Practitioner Data Bank (NPDB).

_____ _____

Volunteer Signature Date

_____ _____

Volunteer Coordinator Date

Please submit a copy of the following (we can make copies at the office)

□ CV
□ Photo ID
□ State Controlled Substance License, as applicable
□ Immunization Record and PPD Status
□ Copy of Medical License, as applicable
□ DEA License, as applicable

Moab Free Health Clinic
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Credentialing Checklist and Report

Name:_____ Date of Birth:_____

Professional designation (MD, RN, EMT, etc.): _____

Specialty:_____

Board Certifications:_____

License Number:_____ DEA Number:_____

License State:_____DPS Number:_____

Forms

□ C.V. or resume
□ Copy of licenses
□ Copy of photo ID
□ Immunization and PPD Status
□ FTCA Letter (Current PIN)
□ Privileging Form

FOR OFFICE USE ONLY

Results of Reference Check

Reference 1: *Reference 2:*

Results of NPDB Query

See attached query results for more information
Any malpractice claims or incidents? □ No □ Yes

Recommendation

Is it the recommendation of the Clinic Credentialing Coordinator and the Credentialing Committee to approve this volunteer to practice medicine under the auspices of the Moab Free Health Clinic?

□ No □ Yes

Approval

_____ _____
Credentialing Coordinator Date

_____ _____
Governing Board President Date

□Approved □ Not approved

Re-credential by:

HIPAA COMPLIANCE AGREEMENT

What is HIPAA?

- HIPAA stands for the "Health Insurance Portability and Accountability Act"
- It is a federal law that applies to all healthcare providers
- HIPAA protects the privacy of patient health information

What must be protected?

- **ALL** patient information must be protected and kept confidential
  - This includes the information of family members and friends
- Patient information must be kept confidential whether it is spoken, written, or electronic

Access and Disclosure of Patient Information

- Only access the amount of patient information you need to do your job
- Only disclose patient information to other people if it is part of your described job
- If it is your job to disclose patient information to other people, disclose only the smallest amount of information possible

Safeguards

- Do not discuss patient information in public areas (including the clinic waiting room/ lobby)
- When you are not using patient information, it should be stored in a secure location or concealed
- Do not borrow, lend, or exchange computer or email passwords
- Do not connect a disk or other device to MFHC electronics without prior permission
- Shred patient information when it is disposed
- Do not remove patient information from the MFHC premises

Penalties for Violation

- There are major penalties for violating the HIPAA law ranging from a $100 fine to 10 years in prison

If you have any questions about HIPAA or the MFHC's privacy practices, please contact the Volunteer Coordinator at mfhcvolutneer@gmail.com or (435) 259-1113

I understand the policies of the HIPAA and the confidentiality procedures of the Moab Free Health Clinic. I agree to abide by the procedures of the HIPAA and the MFHC.

_____ _____

Volunteer Signature Date

_____ _____

Volunteer Coordinator Date

RECEIPT AND ACKNOWLEDGEMENT OF MFHC VOLUNTEER HANDBOOK AND REFERENCE MANUAL

The Volunteer Handbook and Reference Manual is an important document intended to help you become acquainted with the volunteer program. This handbook will serve as a guide to your service to the MFHC; it is not the final word in all cases. Individual circumstances may call for individual attention.

Please read the following statements and sign below to indicate your receipt and acknowledgment of the Moab Free Health Clinic Volunteer Handbook and Reference Manual.

- I have received and read a copy of the MFHC Volunteer Handbook and Reference Manual. I understand that the policies and rules described in it are subject to change at the sole discretion of the MFHC at any time.
- I understand that my volunteer service is terminable at will, either by me or the MFHC, regardless of the length of my volunteer service.
- All writings, photographs or other artwork created that relate to any persons or experience at the MFHC will be reviewed and approved by the Executive Director prior to distribution. Review is necessary to assure confidentiality, appropriateness and accuracy of all information.
- I authorize the MFHC to use or publish any interviews, photographs, videotapes or motion pictures in any manner and any medium deemed appropriate by them. I acknowledge that I have no interest, ownership or copyrights for any pictures, images or recordings.
- I am aware of the Sexual Abuse Policy. I understand that the MFHC will not tolerate any employee or volunteer who commits sexual abuse. I further acknowledge that the MFHC will not tolerate retaliation against any individual who in good faith reports a suspected incident of sexual abuse. I understand that it is my responsibility to abide by all rules contained in this policy. I also understand how to report incidents of sexual abuse or retaliation set forth in the sexual abuse policy.
- I am aware that during the course of my volunteering, confidential information may be made available to me. I understand that all confidential information must not be released within or outside the MFHC premises or property.
- I understand that my signature below indicates that I have read, received, and understand the above statements and those in the MFHC Volunteer Handbook and Reference Manual.

_____ _____

Volunteer Signature Date

_____ _____

Volunteer Coordinator Date

Please view the complete Volunteer Handbook and Reference Manual online at www.moabfreehealthclinic.org under "Volunteer Opportunities: How to Help"

RECEIPT AND ACKNOWLEDGEMENT OF MFHC/OSHA BLOODBORNE PATHOGENS AND HAZARD COMMUNICATIONS STANDARDS TRAINING

The MFHC/OSHA Bloodborne Pathogens and Hazard Communications Standards is an important document intended to help staff and volunteer better understand OSHA standards and compliance at the Moab Free Health Clinic. A copy of these standards can be obtained from the Program Coordinator upon request and are always located in the front office as well as in the laboratory book.

Please read the following statements then fill out your information, and sign and date below to indicate your receipt and acknowledgment of MFHC/OSHA Bloodborne Pathogens and Hazard Communications Standards Training.

I acknowledge that I have received and understood training regarding the following elements:

Bloodborne Pathogens Standard:

- A copy and explanation of the OSHA bloodborne pathogen standard and the MFHC's ECP
- An explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
- An explanation of the use and limitations of engineering controls, work practices, and PPE
- An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
- An explanation of the basis for PPE selection
- Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine will be offered free of charge to all employees
- Information on the appropriate actions to take in an emergency involving blood or OPIM
- An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
- Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee or volunteer following an exposure incident
- An explanation of the signs and labels and/or color coding required and used at this facility
- An opportunity for interactive questions and answers with the person conducting the training session. Training materials for this facility are available from the Volunteer Coordinator. Copies are also maintained in the "MFHC/OSHA Bloodborne Pathogens and Hazard Communications Standards Manual."

Hazard Communications Standard:

- An overview of the OSHA hazard communication standard
- The hazardous chemicals present at his/her work area and the physical and health risks of those chemicals
- Symptoms of overexposure
- How to determine the presence or release of hazardous chemicals in the work area
- How to reduce or prevent exposure to hazardous chemical through use of control procedures, work practices and personal protective equipment
- Steps the company has taken to reduce or prevent exposure to hazardous chemicals
- Procedures to follow if employees are overexposed to hazardous chemicals
- How to read labels and MSDSs to obtain hazard information
- Location of the MSDS file and written Hazard Communication program

_____ _____

Employee/Volunteer Signature Date of Training

_____

Employee/Volunteer Printed Name

Hepatitis B Vaccination Form

You have the right to request or decline the hepatitis B (HBV) vaccination series. You should have already received training on the risks and prevention of occupational exposure to bloodborne pathogens, including HBV, and had an opportunity to ask questions. If you have not completed the training, please do so before filling out this form. If you have received the training:

1. Select Option A, B or C below, and fill in your name, signature and date.
2. Print and sign the completed form and return it to the Moab Free Health Clinic Program Coordinator.

☐ **OPTION A: REQUEST TO RECEIVE HEPATITIS B VACCINE**

I have been informed of the biological hazards that exist in my workplace, and I understand the risks of exposure to blood or other potentially infectious materials involved with my job. I understand that I may be at risk of acquiring hepatitis B virus (HBV) infection. I acknowledge that I have been provided information on the hepatitis B vaccine, including information on its effectiveness, safety, method of administration and the benefits of being vaccinated. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. I request to receive the vaccination series.

☐ **OPTION B: STATEMENT OF CURRENT IMMUNIZATION**

I attest that I have already been immunized against hepatitis B virus (HBV) infection.

☐ **OPTION C: HEPATITIS B VACCINE DECLINATION**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Employee/ Volunteer Signature Date

_____

Employee/ Volunteer Printed Name