The Community Health Clinic

Date: _____

ADULT VOLUNTEER APPLICATION

Name _____

Address _____

City _____ State ____ Zip _____ Phone _____

E-mail _____

Were you referred by someone? Yes No
If someone referred you, what is their name? _____
How did you hear about our program? (Check all that apply)

___ Newspaper ___ Friend ___ Speaking event/booth ___ Internet
___ Brochure ___ Church ___ Other _____

Are you currently employed? Yes No May we contact you at work? Yes No
Employer _____

Position _____ Phone _____

Have you had volunteer experience? Yes No
Previous volunteer experience _____
_____
_____

Hobbies, Interests, Work Experience, Educational Background _____
_____
_____

Have you ever been convicted of a crime? ___ If yes, please explain what, when, where and the disposition of the case _____
_____

In case of an emergency, who should we notify?
Name _____ Phone _____

Relationship to you _____

Physician's Name _____ Phone _____

Personal References:
Name _____ Phone _____
Address_____

Name _____ Phone _____
Address _____

Name _____ Phone _____
Address _____

Please Indicate Time Available:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

How often Available? Once a Week Twice a Week Other _____

Interests/Skills (Please indicate with a check mark which you would be willing to share as a volunteer)

___ Patient Reception
___ Special Projects (as needed)
___ Mailings or Clerical Other _____

Additional Skills/Interests _____
_____
_____

Are there any work activities or conditions you must avoid?
_____
_____

I agree to honor the policies and Mission of The Community Health Clinic. You have my permission to conduct a background check, and check all references.

_____ _____
Signature Date

Return Application to:

Community Health Clinic
PO Box 9
Topeka, IN
46571
Attn: Sharon Chupp

CONFIDENTIALITY/HIPAA POLICY

POLICY: It is the policy of the Community Health Clinic (CHC) to keep information about patients' health care private.

SCOPE: Confidential information should not be revealed to any unauthorized person including employees who have no need to know. To see a patient's information, the employee must need it to provide care or perform his or her job. Friends and family do not have an automatic right to an adult patient's confidential information. Permission must be obtained from the patient or legal representative to share confidential information with unauthorized people.

DEFINITION: Confidential information includes details about the patient's illness or condition, information about treatments, photographs or videos, health care records and conversations between a patient and health-care provider.

General patient information that is not confidential, UNLESS THE PATIENT REQUESTS, is name, date of admission, hometown or city, and gender. A patient's room number may only be given when a visitor first identifies the patient by their exact name.

PROCEDURE:

1. The patient's permission is required to share confidential information with any unauthorized person or agency. Always clarify what information is being requested and who is requesting it.
2. All patient information is to be kept covered. It must not be left where unauthorized people can see it.
3. Conversations about patients are private.
4. Phones and fax machines must be used with care. Obtain the party's name and confirm the need to know, then call back. Double check all numbers before dialing. For faxes, use a cover sheet with a warning about misuse of confidential information.
5. Confidentiality is the legal and professional responsibility of the CHC and staff. Any unauthorized use of confidential information should be reported to the Operations Director immediately.

CONFIDENTIALITY STATEMENT

I have received, read and understand the confidentiality policy of the CHC. I understand and agree that in the performance of my duties at the CHC, I must hold all patient information in confidence.

Date_____ Printed Name_____

Signature_____