Volunteer Application

Health Partners, Inc.
3070 Crain Hwy #101
P.O. Box 1865
Waldorf, MD 20601

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR APPLICATION

Thank you for considering a volunteer commitment to the uninsured of our community through Health Partners, Inc. It is important that you answer all items on this application. Please take time to list pertinent information carefully and completely. Our process is thorough because of the difficult, life preserving work we undertake. If additional space is needed, you may continue in the same format on a blank sheet of paper.

All information provided by the applicant on this form is subject to verification. All applications will be considered incomplete until two volunteer reference forms are submitted to Health Partners, Inc.

Personal Data: *(Please print clearly in ink)*

Name _____ _____ _____ Date of Birth: _____
Last First M. I.

Mailing Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone _____ Work Phone _____ Cell/Pager _____

E-Mail Address _____

Preferred Method of Contact: Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail ☐ Any/All ☐

Are you Bi-lingual? Yes ☐ No ☐ If so, what language? _____

In case of emergency, whom shall we call?

Name _____ Phone _____ Relationship _____

Employment Information:

I am: Employed Full-Time ☐ Employed Part-Time ☐ Retired ☐ Unemployed ☐ Student ☐

Current Employer _____ Title/Occupation: _____

Address _____ _____ _____ _____
Street City State Zip Code

Education: *(Check all that apply and note degrees in progress)*

☐ H. S. Diploma ☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree:

☐ Other Professional or Technical Qualifications or Certifications *(List all applicable degrees & credentials):*

(Please attach a photocopy of all current Professional Licenses)

Volunteer Information:

Previous Volunteer Experience, If Any:

Organization	Duties

Availability:

How often would you like to volunteer? ☐ One-time/Specific Project ☐ 1 per Month ☐ 1 per Week
☐ More than 1 per Week ☐ Evening /weekend outreach events ☐ Committee's (Event /Marketing)

Date you are available to start volunteering? _____

Please list the times you are available to volunteer

	Mon	Tues	Wed	Thurs	Fri	Sat
Mornings 9 -12						
Afternoon 12-1						
Evening 1 - 5:30						

Comments regarding your schedule or availability: _____

_____

Service Opportunities/Interests: What do you want to do? Order your interest by number (First Choice = 1, Second Choice = 2, etc.) For specific details contact the Clinic.

MEDICAL CLINIC

_____ Patient Screener (no medical background needed)
_____ Patient Intake (CMA, CMT, LPN, RN) (patient history, medical records)
_____ Patient Assessment (CMA, CMT, LPN, RN) (vital signs, c/c, triage)
_____ Patient Discharge (LPN, RN) (assist provider, patient education, referrals)
_____ Provider (Specialty) _____
_____ Provider (MD, DO, CRNP) Primary Care
_____ Patient Greeter (no medical background needed)

DENTAL CLINIC

_____ Provider (D.S.S.)
_____ Hygienist (cleanings)
_____ Dental Assistant (assist provider)

DISPENSARY

_____ Pharmacist (dispense meds, consult providers/patients)
_____ Pharmacist Technician (assist pharmacist and provider)

ADMINISTRATIVE

_____ Receptionist (answer phones, file, schedule appts.)
_____ Data Entry (computer skills necessary)
_____ Translator
_____ Newsletter (writer, editor, designer, etc.)
_____ Community Outreach (public speaking)
_____ Data Abstraction (statistics, MS Access)
_____ Computer Administrator (manage networks, add users)
_____ Web Designer
_____ Special Events (fundraisers)
_____ Committees (Q/A, Marketing, BOD, etc.)

HEALTH EDUCATION

_____ Diabetes Educator
_____ Nutritionist
_____ Dietician
_____ Diet Technician
_____ Counseling Services (LSW, MSW, Psychiatrists, Psychologist, LPC, CAC)
_____ Case Manager (LSW, MSW) Contact by hone to support/encourage patient to follow up with referrals
_____ Other

For Statistical Purposes Only: *(Please complete)*

Gender: ☐ Female ☐ Male

Ethnicity: ☐ African American/Black ☐ Native American ☐ Asian/Pacific Islander ☐ Caucasian/White
☐ Hispanic/Latino ☐ Other

Name and Credentials as you would like them to appear on your Badge: _____

By signing below you certify that all of the above information is correct and true to the best of your knowledge.

Applicant Signature: _____

For Health Partners Staff Only: Application Received: _____
Orientation Completed: _____Start Date: _____

HEALTH PARTNERS, INCORPORATED
Primary Care for the Uninsured
P.O. Box 1865
Waldorf, MD, 20604
Office (301)645-3556 Fax (301)645-3932

Volunteer Professional Reference Check Form

Dear Sir or Madam:

Thank you for agreeing to be a reference for our potential volunteer. Please complete this entire form. Our volunteers must have at least two written references on file before they can provide services with our organization. You may return this reference form to the potential volunteer or directly to Health Partners in a sealed envelope with your signature written across the seal. Your cooperation and quick response is greatly appreciated.

Potential Volunteer's Name: _____

Reference Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip-Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Please check one column per question:

Questions	**Unsatisfactory**	**Satisfactory**	**Excellent**
How would you rank this individual's quality of work?			
How would you rank this individual's dependability?			
What is/was this individual like to interact with as a co-worker, employee, associate or student?			
How is/was this individual's involvement with clients/ patients/customers/others?			
How would you rank this individual's leadership capabilities?			

How long have you known this individual? _____

What is your relationship to this individual? _____

In order to ensure the highest possible quality of care for our patients, please briefly describe any areas of concern that we should know about regarding this individual: _____.

Would you recommend this individual for a volunteer position with our organization? _____.

Additional comments can be written on the back of this form.

Reference's Signature: _____ Date: _____

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Potential Volunteer's Name: _____

Reference Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip-Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Please check one column per question:

Questions	**Unsatisfactory**	**Satisfactory**	**Excellent**
How would you rank this individual's quality of work?			
How would you rank this individual's dependability?			
What is/was this individual like to interact with as a co-worker, employee, associate or student?			
How is/was this individual's involvement with clients/ patients/customers/others?			
How would you rank this individual's leadership capabilities?			

How long have you known this individual? _____

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HIPAA Acknowledgement for Volunteers

As a Health Partners Volunteer I understand that every Health Partners Client has the right to privacy under the Health Insurance Portability and Accountability Act. I understand and agree to make every reasonable effort to maintain and ensure client confidentiality.

I understand that I am responsible for reporting suspected privacy violations to Health Partners Privacy Officer (Executive Director).

By signing below I acknowledge that I understand the federal privacy practices and acknowledge that I can request clarification, training and assistance in regards to Health Partners, Inc. Privacy Practices at any time.

Printed Name: _____

Signature: _____

Date: _____

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Volunteer Fitness Statement

I am committed to protecting the health and welfare of the clients of Health Partners Inc., employees of Health Partners, Inc., and others, including the public, by providing a healthy and safe environment.

I am fully competent to perform and free from any physical or mental impairment that would prevent me from performing my assigned tasks. I hereby certify that I am of good health. If my health condition should change and impact my competency, I will notify Health Partners, Inc. immediately.

Print Name: _____

Signature: _____

Date: _____

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Health Partners, Inc.
Hepatitis B and Influenza Vaccination Waiver Form
For Volunteers/Staff

I hereby wave my right to a Hepatitis B and Influenza Vaccination. I voluntarily waive these vaccinations on my own accord. I understand that should I decide at a later date that I wish to be vaccinated I need to notify the Health Partners Executive Director immediately. I also understand and sign this statement that I am responsible for any adverse reactions that may result from waiving these vaccinations.

Printed Name: _____

Signature: _____

Date: _____

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Health Partners, Inc.
Background Verification
Authorization for Release of Information

In connection with my application for a volunteer or employment position, I authorize Health Partners, Inc. and their respective agents to solicit information about my criminal and driving background history; including, but not limited, to information as to my employment, education, military service, driving record, criminal record and general public records history.

I AUTHORIZE, WITHOUT RESERVATION, ANY GOVERNMENT AGENCY OR EDUCATIONAL INSTITUTION, CONTACTED BY HEALTH PARTNERS, INC. OR THEIR AGENTS, TO FURNISH THE ABOVE REFERENCED INFORMATION.

I release Health Partners, Inc. and their respective employees, agents and agencies providing information and reports about me from any and all liability arising out of the release of any such information or reports.

Health Partners, Inc. will retain all background reports as outlined in our Record Retention Policy and Procedure.

Name: _____

Signature: _____

Date: _____

SS#:_____

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SCOPE OF DENTAL PRACTICE

In keeping with the Health Partners, Inc. Mission, we provide free, quality health care to people who might not otherwise have access to such care. This care is provided on a non-judgmental basis with respect for the dignity of the individual patient. The dental clinic is structured around a volunteer provider base comprised of general dentists, dental hygienists and dental assistants, in addition to an on-staff Dental Hygienist and Dental Administrator.

Health Partners' dental clinic is an ambulatory care facility providing services for preventive and restorative dental needs of children and adults. Potentially severe, complicated or emergent care situations should be referred to appropriate dental care settings with the requisite facilities and equipment.

Definitions of services provided: (these definitions serve as examples and do not imply a complete listing**).**

- **Self-limiting acute:** periodontal infection, caries, simple extractions
- **Stable chronic conditions:** Periodontal disease, restorative maintenance
- **Prevention:** Oral Hygiene Education, Oral Cancer Screenings, Fluoride varnish application
- **Procedures:** See Dental Diagnostic sheet

Services provided in dental clinic:

- **Initial assessment of all presenting conditions**
- **Follow up care after initial assessment if within the Scope Of Practice**
- **Appropriate referrals to other dental care facilities and or providers/specialists.**
  - **All endodontic needs, prosthodontic needs, and complicated oral surgery.**

I have reviewed and agree to work within the above Scope of Practice.

Signature: _____ Date: _____

Print Name: _____

VOLUNTEER DENTIST SUPPLEMENTAL APPLICATION

Health Partners, Inc.
3070 Crain Hwy #101
P.O. Box 1865
Waldorf, MD 20601

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR APPLICATION

Thank you for considering a volunteer commitment to our community through Health Partners, Inc. This form is to only be completed by dentists. It is important that you answer all items on this application. Please take time to list pertinent information carefully and completely. Our process is thorough because of the difficult, life preserving work we undertake. If additional space is needed, you may continue in the same format on a blank sheet of paper.

All information provided by the applicant on this form is subject to verification.

Name
_____

Are you currently in practice? ☐ Yes ☐ No If retired, what is your date of retirement
_____

Please list the name, address and phone numbers for three dentist's references currently in practice in Maryland, preferably in Southern Maryland:

_____	_____	_____
Name	*Address*	*Phone*
_____	_____	_____
Name	*Address*	*Phone*
_____	_____	_____
Name	*Address*	*Phone*

CREDENTIALS

Please include copies of No. 1 – 3 credentials with your application.

1. **Dental Licensure**
   State: _____ Number _____ Expiration Date: _____
2. **Proof of Malpractice Insurance**
   Company Name _____
   Amount _____ Expiration Date: _____
   Policy Number: _____
3. **UPIN #** _____ Expiration Date: _____
4. **DEA #** _____ Expiration Date: _____
5. **NPI #** _____
6. **Board Certifications**, If Any:
   _____
   _____
   _____

For Staff Use Only: ☐ Confirmed Privileges Date: _____ Int._____

1. Has your Federal Drug License ever been suspended or revoked? ☐ Yes ☐ No

2. Have you been involved in any liability action, or is there action pending in such case? ☐ Yes ☐ No

3. Have you been charged or convicted of a drug-related misdemeanor or felony, or is there action pending in such case? ☐ Yes ☐ No

4. Have you been censored by any county/state, dental societies, or is there action pending in such case? ☐ Yes ☐ No

5. Has there been any restriction in your state licensure, or is there action pending in such case? ☐ Yes ☐ No

6. Do you have a physical or emotional condition, including alcohol or drug dependence, which may affect or is likely to affect your ability to perform your professional duties? ☐ Yes ☐ No

**** If any of the above questions is answered YES, please provide additional information in a separate letter.****

Schedule: (Only for providers seeing patients at Health Partners)

☐ 1 Patient Every … ☐ 2 Patients Every … ☐ 3 Patients Every … ☐ Other _____

☐ 15 Minutes ☐ 20 Minutes ☐ 30 Minutes ☐ 45 Minutes ☐ 60 Minutes ☐ Other _____

Total number of patients you would like scheduled for your clinic: _____

Your Commitment: ☐ Pediatric Dental Care at Health Partners

☐ Will accept referrals seen in provider's office Referrals per Months: _____

RECOGNITION:

From time to time we perform public relations efforts to recognize our Volunteer Dentists. The following information is utilized for that purpose.

Please list the professional societies in which you are a member.

_____ _____

_____ _____

_____ _____

Please list the local newspapers that you read.

_____ _____

_____ _____

ACCEPTANCE OF APPOINTMENT

I hereby accept appointment to the volunteer dental staff of Health Partners Free Clinic. I agree to abide by the rules and regulations of the Administration, Dental Advisory Committee, as well as any amendments added thereto.

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the dental staff. All information submitted by me in this application is true to the best of my knowledge and beliefs.

_____ _____

Signature of Applicant *Date*

Please mail your completed application, together with signed Health Partners Free Clinic Scope of Practice to:

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